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 19, 1971
KINGWOOD, W. VA.
APRIL 20, 1971
NASHVILLE, TENN.
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HEALTH CARE CRISIS IN AMERICA, 1971

MONDAY, APRIL 19, 1971

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Kingwood, W. Va.

The subcommittee met at 2:10 p.m., in the Preston County Courthouse, Senator Edward M. Kennedy (chairman of the subcommittee) presiding.

Present: Senators Kennedy and Randolph.

Committee staff members present: Stanley Jones, professional staff member; and Jay Cutler, minority counsel.

Senator KENNEDY. The subcommittee will come to order.

First of all, as Chairman of the Senate Health Subcommittee of the U.S. Senate, I want to express my very sincere appreciation personally and for the members of the subcommittee, to Judge Snyder and the people of Kingwood for the kindness and courtesy they have extended to the members of our staff and to us here today.

I will make a very brief comment and then I would like to ask your own Senator Jennings Randolph, who is ranking member of the Senate Labor and Public Welfare Committee and who is extremely interested in the problems of health, not only of the people of West Virginia, but generally throughout the country, if he would be kind enough to make a comment.

It is a pleasure for me to be here. The members of my family have always been warmly received each and every time they have come to the great State of West Virginia.

Today has been no exception. We met with a number of your children outside and were greeted warmly by them. We asked them about the dentists. We learn something new everywhere we go. When I asked them how many liked to go to the dentist, practically two-thirds of the children put their hands up in the air. If we ever ask that question up in Massachusetts, everyone would hold their hand down. No one really enjoys it.

We come here today as a continuing part of our study of the health crisis in the United States. During the period of the last 8 weeks we have held extensive hearings on the health crisis. We have heard from representatives of different interests in the health area. We have listened to the doctors who spoke for the American Medical Association. We have heard from the Secretary of HEW. We have heard from the insurance companies. We have heard from a wide variety of different spokesmen for different interests.

Then last week we went out into the field. We went up to New York City to study the problems of the health crisis in one of the major urban areas of our country. The next day we went out into the suburban communities. We visited some of the wealthier communities in our country, Nassau and Westchester Counties, because we believe the health crisis doesn't only show in the quantity of service, but in the quality of service as well.

We started early today in Fairmont, W. Va., and we have tried to visit both the best health services and also the poorest. We wanted a chance to see both aspects, and we have had some opportunity to do so.

Of course we won't conclude these hearings today thinking we understood completely the problems of health care in West Virginia.

I do feel, however, that as a result of the hearings that we have had in the Nation's Capital, and the extensive field hearings that we are holding that we will learn enough to make significant recommendations to the U.S. Senate on how to improve the quality of health care in this great country of ours.

Today, at this hearing, we are interested in hearing from the people. After listening for 7 weeks to the experts and then recently listening for this last day or two to the people. I must say the most eloquent testimony has really come from the people.

So we are here to listen to the people of Kingwood and the surrounding areas describe the problems they have in health care in order that we can consider new laws which might help the people of Kingwood, W. Va., and all of rural America.

If the people speak and make their problems known, we are convinced that this country's doctors, nurses, hospitals, and citizens together can create health services which are worthy of this great country, and which offer every man, woman, and child the greatest opportunity for a healthy and productive life.

We have some witnesses who have indicated they want to speak. We are going to terminate the scheduled witnesses at about a quarter to 4, if we possibly can, and then open up the hearing for any of you who might have some comment on the health crisis.

If individuals are here now who, in the course of this hearing, want to express themselves write your name on a card and pass it to the desk here. We will try to call on you.

If anyone in the community at a later time wants to file a comment or a statement about what they think needs to be done on health, we will make that a part of the record of the Health Subcommittee.

Before starting, I would like to call on Senator Randolph.

Senator RANDOLPH. Thank you, Mr. Chairman.

Ladies and gentlemen:

You will forgive me for saying that when I come into this courtroom I remember that I first appeared here 41 years ago. That is a considerable length of time.

Senator KENNEDY. I can't say that. [Laughter.]

Senator RANDOLPH. It was before Senator Kennedy was born. It was 1930. That is a long time ago.

I take only 1 minute, because it is the hard facts that we are interested in on this tour.

I do feel that Senator Kennedy, you and the members of the subcommittee, the 14 Democrats and Republicans on your subcommittee,

indicate the intense interest within the Labor and Public Welfare Committee of the work that must be done.

I think when we come from Washington D.C., out into the field, we understand more than we can understand in any formal hearing in the Nation's Capital that we must go beyond the statistics and clothe them with people.

People, their problems, that is what we are intensely interested in in these hearings here in West Virginia and throughout the country in an effort to meet with those of you who come to testify and counsel with us.

I want to conclude by saying that we not only are listening to what you say, but we are making careful notes in our minds and hearts of what you tell us, hoping that we may interpret what you have said as constructive in aiding in the passage of legislation that will help you to help yourselves to build a better America.

That is why we are here.

Senator KENNEDY. Thank you very much, Senator Randolph.

Our first witness is Mrs. Dolores Kemphfer. She is a housewife.

We want this to be an extremely relaxed session. I am afraid Senator Randolph and I with these formal statements will make people feel ill at ease. We want everyone to tell their story and feel relaxed about it. It is an important meeting but an informal one. We hope everyone will feel relaxed.

STATEMENT OF MRS. DOLORES KEMPHFER, HOUSEWIFE

Mrs. KEMPHFER. I have had five children in 8 years. I came from a very poor family. I had this one child, Cindy Robbins, she was my second. She has bronchial asthma. I just had my fourth baby. She took pneumonia. I was staying with my husband's brother and his wife at the time. They took Cindy to the hospital. Irma stays with my little girl and she comes back and says, "Dolores, we have got to have $50 before Cindy can have oxygen." I go to pieces.

Senator KENNEDY. As I understand, when your baby went to the hospital, your neighbor came back and said to you that they needed $50?

Mrs. KEMPHFER. Before we could get her entered in the hospital. My husband had just went back to work. I had to locate him. He was working in Marlinton. I had to get the money from his boss. By that time, I went on to the hospital and made my phone calls. I was holding my little girl and I started crying. The doctor said, "If you can't take care of them, why did you have them damned kids?" Those were the words. He was very disgusted with me. I am there without money and with a sick child. I said, "How do you keep from having them?" I was never told. And I was crying. So Jerry was 14 months old, and I had my last one, Peggy Sue, who is my fifth child. She is 3 now. Amanda has rheumatic fever.

Senator KENNEDY. That is another child?

Mrs. KEMPHFER. She is my third. It was winter before last, it developed, my husband was out of work. He was on unemployment. I never asked for any aid. I canned all summer. Amanda's medicine was $12 a week. That had to come out of the $26 on unemployment.

Senator KENNEDY. Her medicine was $12 a week, and your husband

was getting $26 a week unemployment? And that left, what, $14 for you to——

Mrs. KEMPHFER. We had to ask his sister to buy fuel for the winter, and she paid our electric bill. The rest of that, we had to use what I canned from. I asked for Amanda to be on the Crippled Children's Fund. I got a rejected letter last week. I still haven't got her on it. She bleeds. She is not really a bleeder, but we have her taking hemophiliac because if she would be in an accident, she needs immediate attention, because this rheumatic fever, she will get nosebleeds and it won't stop until she goes into shock.

I have been kept out of the hospitals because I have no insurance, no money from the bank, to get them in.

Senator KENNEDY. You can't get them into the hospital?

Mrs. KEMPHFER. It is awful hard to get them in.

Senator KENNEDY. Do they ask you when you come down to get them into the hospital——

Mrs. KEMPHFER. If you have insurance or the money.

Senator KENNEDY. They ask you that before they treat the child.

Mrs. KEMPHFER. We have to have $75 at one hospital and $50 at another.

Senator KENNEDY. In the emergency room?

Mrs. KEMPHFER. Usually, when I go to the emergency room, yes.

Senator KENNEDY. Before you are able to get them in, at one hospital, you have to pay $50 and the other is $75.

Mrs. KEMPHFER. That is right. After Peggy Sue, this is my fifth one, I went to this old doctor and he was real nice. My husband had started to work for a mining company which had insurance and it covers. It was a bad risk insurance coverage because of the asthmatic, and I needed an operation. So we was a bad risk. We would have to have the policy 2 or 3 years before it would do us any good.

So my husband is working at this mining company, and they had insurance on us then. After Peggy Sue was born, I was supposed to have a tubligation. And the doctor that I was going to didn't perform this kind of an operation, but he informed another doctor that I needed it. He said he accept my insurance policy. We didn't have cash at the time. So this doctor says , "Dolores, you need it, I will pay for your operation, and I will wait for the insurance to come through." You know, I had Peggy Sue that night. The next morning he died of a heart attack. And the doctor came in and they gave me a hypo in the arm, and I thought they were getting me ready for the operation. Fifteen minutes later he said your source is gone, it just died, you either come up with the money or get out of the hospital. I picked my baby up the next day and left the hospital.

Senator RANDOLPH. May I interrupt, Senator Kennedy?

Senator KENNEDY. Yes.

Senator RANDOLPH. Is this Pocahontas County?

Mrs. KEMPHFER. No, sir.

Senator RANDOLPH. I thought you said Marlinton. I am sorry.

Mrs. KEMPHFER. I live in Aurora, W. Va. My husband worked out of Marlinton. He is on railroad construction.

Senator RANDOLPH. That is what I understood.

Mrs. KEMPHFER. He went there to work at the time.

Senator RANDOLPH. Yes; but the family, you and the children remained here?

Mrs. KEMPHFER. Yes.

Senator KENNEDY. These have been the principal experiences with the health system that you have had? Is the only time you go to the hospital or to the doctor when you have an emergency situation?

Mrs. KEMPHFER. I have to limit it to that.

Senator KENNEDY. Have your children ever seen a dentist?

Mrs. KEMPHFER. No; not really. I just got my teeth last summer. All mine went with the babies. My husband is also sickly. He gets pneumonia awful easy.

Senator KENNEDY. What does he do?

Mrs. KEMPHFER. He won't go to the doctor. He gets delirious, and I drag him to the doctor, and he doesn't know where he is.

Senator KENNEDY. Why doesn't he go to the doctor?

Mrs. KEMPHFER. He is scared.

Senator KENNEDY. Is it part of the fact he will have medical bills, too?

Mrs. KEMPHFER. Yes. He told me one time when I was pregnant, and he said, "I don't like children." I said, "Why?" He says, "Ours have always been sickly; we watch them almost die with no money." It just tears us apart, you know, to have them.

Senator RANDOLPH. Your children are in school and have shots given to them?

Mrs. KEMPHFER. Yes; I do get that. Little Peggy Sue is allergic to the shots. I have to watch her awful carefully, you know. I sponge her down or she will go into convulsions.

Senator RANDOLPH. What recommendation do you have for us for an improvement in, let's say, health or hospitalization that will help people like you that face these problems?

Mrs. KEMPHFER. I am all for this preventative medicine they have out now. After Amanda had the rheumatic fever, I went to the doctor and I tried to take the pills many a time and I couldn't. They worked on my nerves. This last time I broke out in a rash and swelled up. I took them 4 months before I would give in and realize I couldn't take them.

So I said, "I can't see having another child like this." And I can't take the pill. So he said, "Well, it is up to you, you will have to get the IUD, it is going to cost you from $40 to $50. Can you come up with it?" I said, "Yes." I went back home and I picked up the Journal and read where they are having a family planning clinic on June 26. I called my doctor and asked if I could go there. He said, "Yes." I was the first one there. I wanted to make sure they didn't run out of these things.

Senator KENNEDY. Do they usually run out?

Mrs. KEMPHFER. I don't know. But in my case, I was going to make sure they didn't. I didn't run out of babies. [Laughter.]

Senator RANDOLPH. You wanted to be there when the door opened?

Mrs. KEMPHFER. Yes. I was there when the door opened. It wouldn't work. So I went home all upset. So I go back to the doctor. He says there is nothing you can do. We didn't have insurance. So about a week or two later, infection set in. I went back and he wouldn't even

see me. I went on for another week until I couldn't move. I was so sore inside I couldn't move. So I went down and waited until his office opened up the next morning. He examined me and said:

You have got acute infection. It is set in clear in your whole system. You are going to have to have an operation. You take this penicillin and call me Tuesday at 10 o'clock and I will have you admitted.

I called Tuesday at 10 o'clock. He said:

You have no insurance, no money, they won't accept you.

So I said:

Would you get in contact with the family planning clinic in Morgantown? They will contact a doctor for me.

So he did. I went to Morgantown. That was August 19. They listened to all of my problems, all of my children, why I didn't want any more, and I was sent up to have a Tubligation and a D & C, and in my condition I had to have a partial hysterectomy.

I was on nerve medicine from the time I started having children until I had my operation. I have never taken a nerve pill, and I have seen a doctor once for my checkups.

Senator KENNEDY. How are your children now?

Mrs. KEMPHFER. Amanda still has to take medicine for her rheumatic fever.

Senator KENNEDY. How do you pay that?

Mrs. KEMPHFER. I have been getting it since this fall through the health program. But I tried to get her on the crippled children's for her blood test. She is allergic to penicillin. I can't get her in on the crippled children.

Senator KENNEDY. Your husband, as I understand it, was working one time and then they garnished the money from his salary. Was that to pay off medical bills?

Mrs. KEMPHFER. He was fired from his job because we owed a hospital bill on one of our children. They attached his wages. The policy is you straighten it up yourself with the people or they don't need your employment anymore. I tried to straighten it up. It had already gone through the court. It had to come off his wages.

Senator KENNEDY. He was fired?

Mrs. KEMPHFER. Yes, that is where we got our insurance.

Senator KENNEDY. Was he willing to pay off some of the bill?

Mrs. KEMPHFER. Yes, when we could, we tried to pay them off.

Senator KENNEDY. Just because you were unable to pay, he lost his job? Because of the payment of medical bills?

Mrs. KEMPHFER. Yes.

Senator KENNEDY. I want to thank you, Mrs. Kemphfer, for coming here and telling this story.

Finally, do you have friends in your neighborhood and in your community that have perhaps not as dramatic kind of experience, but just find that they fear going to doctors because they are going to have to pay?

Mrs. KEMPHFER. Yes, we have a lot of that.

Senator KENNEDY. Is this something your friends and neighbors feel strongly about?

Mrs. KEMPHFER. Yes.

Senator KENNEDY. Thank you very much for telling us your story.

Mrs. Wilda Hess, staff attorney, North-Central West Virginia Legal Aid Society. She has brought several clients with her and she will introduce them.

STATEMENT OF MRS. WILDA HESS, STAFF ATTORNEY, NORTH-CENTRAL WEST VIRGINIA LEGAL AID SOCIETY, ACCOMPANIED BY MRS. MALINDA PERKINS

Mrs. HESS. I would like to say that I am very pleased to be able to appear before this subcommittee. And I hope that I will be able to offer some information, facts, and situations that will be of assistance to you in drafting legislation.

There isn't any problem that we encounter more often in our work in legal aid. To furnish a little background, the North-Central West Virginia Legal Aid Society covers six counties in West Virginia: Marion County, Taylor, Tucker, Barbour, Monongalia and Preston, and there are three attorneys covering these six counties.

The problem of health care and medical expenses is one which is encountered by our clients and comes to us as a consequence.

To provide a little background information, as you doubtless already know, persons who receive welfare benefits receive a medical card which will enable them to receive free hospital and medical care.

In West Virginia, the legislature has decided that they will provide 52 percent of the basic minimum needs. Its basic minimum needs having already been determined. A single person on welfare will receive $79 per month. Two people, a family on welfare, will receive $99 per month. One adds $20 per dependent.

Often, that medical card is the most valuable resource that the welfare recipient receives. However, if a person has income of, let's say, $80 per month or $85 per month, he now has too much money to afford welfare benefits. That means that he doesn't have a medical card.

I have been given permission by some of my clients to state their situations. Last week a woman came into my office. She is 60 years old, and she has an income of $84.20 per month from social security disability. She receives these benefits because of acute arthritis in her back and leg. She has considerable difficulty in walking. She worked for 20 to 25 years as a maid, as a waitress, a cleaning woman, laundry, and her husband died fairly recently. She is a widow.

In March of 1971, she had to go to the hospital for radical mastectomy. She now owes doctor bills in the amount of $235 and a hospital bill in the amount of $853.40. That is almost $1,100. She has an income, as I said, of $84.90 per month.

She doesn't have any medical insurance and she obviously doesn't have any way of getting any in her situation.

She came to consult with us as to what she could possibly do about this. Frankly, I don't know a source. I really don't. There are so many people in a similar situation who make a little too much or receive a little too much from a pension or disability to qualify for welfare and they don't have a medical card, too young for medicare, this woman being 60.

Senator KENNEDY. What do you advise her to do?

Mrs. HESS. What do I advise her to do? That is really a tough one. What can you do? You can write the hospital. If it has been turned over to a collection agency, you write the collection agency. If she doesn't work, as she is unable to do, obviously, her salary can't be attached. If she doesn't own her own home, that can't be taken away.

But this is a woman who has worked hard all of her life. She doesn't owe a single other bill to anybody. She has always prided herself on keeping her bills paid. Now there is this overwhelming expense.

Senator KENNEDY. I suppose her disposition would be to start paying that off, if she could possibly live on $87 a month.

Mrs. HESS. Yes, I believe so. If she received only $75 a month social security disability, then she would qualify for a $4 supplement in welfare benefits and then she would have that card, which is worth a good deal to her. She is going to need to see a doctor again.

Senator KENNEDY. They can't attach any part of her social Security?

Mrs. HESS. No, they cannot.

I have with me today Mrs. Malinda Perkins, a resident of Monongalia County, who has had considerable problems with medical expenses. She would like to tell you her story.

Mrs. PERKINS. My name is Malinda Perkins. On Easter day, about 5 years ago, a neighbor of mine asked me if I would come and babysit. I couldn't go because my family was in from out of town and I hated to leave them. So she said would it be all right if Perky came. That was my third child. I said yes, but she couldn't stay too long because I was going to serve dinner and I would like to have her eat with the family. So she goes over to the neighbor's house. In the meantime, they had to get to the hospital because her mother-in-law was seriously ill and I felt like I was doing them a great favor to let her go over.

So she went over to take care of the children. She hadn't been there, I would say, 15 minutes, when she went up the stairs to get the baby and there was 17 steps, there wasn't anything to keep her from falling, so the oldest boy slipped upstairs and hid in a closet. Just as she got at the top of the stairs, he jumps out from the closet. He pushes her and down the stairs she goes. So she came to long enough to call me.

Senator KENNEDY. How old was Perky at the time?

Mrs. PERKINS. She was 14 years old. So then my son-in-law went up to see about her and when he got there, she was unconscious.

I think that year she went to the hospital 88 times.

Mrs. HESS. If I may continue for her.

Perky suffered permanent brain and spinal damage as a result of this accident. This caused her to have a type of epilepsy so that she has recurring seizures and always will have as long as she lives. The hospital bills, as you can imagine, were absolutely staggering. The people who lived next door did not have any insurance coverage of any kind and the Perkins' didn't have any insurance coverage either.

Perky has to have medication constantly and she is still subject to these seizures. The last one was on Good Friday, a little over a week ago.

The ambulance costs about $16, to be added to the emergency ward costs, I believe, about $40. That is not really being admitted to a bed in a hospital, either.

Mrs. Perkins has been participating in a program in the school system which has now come to an end. And her income will now be $150 in child support. She was getting about $80 a month.

I believe that there are quite a few pharmacy bills, and hospital bills. Of course, after a while some of the hospitals, most of them will turn the bills over to a collection agency.

Pharmacies are threatening that, too, and, of course, sometimes one borrows money to pay the hospital bills. That, of course, accumulates, too. It is a snowballing sort of thing.

Senator KENNEDY. What are the bills now, approximately?

Mrs. PERKINS. I think I have paid almost $3,000 for my daughter's injury.

Mrs. HESS. Out of her $150 a month, Mrs. Perkins is paying for the house that she lives in. Of course, she is providing food. She has a younger daughter still at home.

Senator KENNEDY. Where is Perky now?

Mrs. PERKINS. She is at home. And she didn't feel any too well today. From time to time, as Mrs. Hess said, she does have these seizures.

Senator KENNEDY. Does she go to school at all?

Mrs. PERKINS. No; she is graduated now, thank God.

Senator KENNEDY. But to the best of your knowledge, she will be staying with you for probably the rest of her life; will she?

Mrs. PERKINS. I look for her to stay, you know.

Senator RANDOLPH. How often are the seizures that you spoke of, Mrs. Hess?

Mrs. PERKINS. Now they are cut down. Good Friday was the last one. But before, maybe 6 or 7 times a week she would have seizures.

Senator RANDOLPH. Do those of the medical profession, the doctors, give you any hope for her in treatment of one type or another?

Mrs. PERKINS. Some neurosurgeons say it is possible that she may outgrow it and others think that it may be a thing that reoccurs from time to time.

Senator RANDOLPH. Dr. Nolan, I want to interrupt a moment, not asking you particularly, but you or some other physician, in a case of this kind, is there hope of outgrowing the problem?

Dr. NOLAN. I think it is possible that the frequency of seizures might diminish. But we won't know in a particular case until a considerable time has elapsed and there has been an opportunity to try different medications over the period of that time. In addition, there is always the possibility that new drugs will be developed which will suppress the motor activity and thereby diminish the seizures.

Senator RANDOLPH. Thank you, sir.

Senator KENNEDY. Your sources of income—is your husband still alive?

Mrs. PERKINS. I am divorced.

Senator KENNEDY. Your sources of income, that $150, where does that come from?

Mrs. PERKINS. From him.

Mrs. HESS. There was to be another lady with me today. It was only at the very last moment that we learned that she wouldn't be able to appear. Her name was Mrs. Denver Jones. Denver Jones is in his 50's, I believe. He has been receiving social security disability for 2 years.

He has emphysema and the heart problems which result. He is confined to bed. He needs oxygen and various medications all the time.

Mrs. Jones is in ill health, also. She has had two spinal fusions and she has to wear a back brace all the time.

Mr. Jones has to have oxygen constantly, and their income is $187.30 from social security disability and he receives a pension from the Pipefitters Local of $59.15. That is a total of $246 and some cents.

Last month they had to spend $166 for oxygen and $150 for medication. That is a total of $316 on medical bills alone and an income of $246. This is not talking about rent, food, utilities or anything of that nature.

He has been in and out of the hospital many, many times. There is no hospital insurance. They have tried very, very hard. They have borrowed from finance companies, and in order to pay the hospital bills, so now they owe not only hospital bills, and doctor bills, but four finance companies. They are a lot harder to deal with than the hospitals. They have sold everything they possibly can.

When Mr. Jones is well enough to do anything, he is always bedridden, he paints. She takes in ironing, which, of course, isn't easy to do in her condition, as you can well imagine.

They had hoped to have someone who could stay with Mr. Jones today, but it has to be someone who understands how to administer the oxygen. Three or four people who had promised didn't turn up in the end. So she is unable to be here. She wanted desperately to testify here today and present this situation.

He is, again, too young for medicare, and their income is too great for any welfare benefits.

Yes, she did tell me when I talked to her that they have told her that she can't get Food Stamps anymore. I don't know about that. I haven't looked into it at all yet.

I have a client in Preston County, a man 59 years old, married, four children. He worked all of his life until he was stricken with cancer early in 1969. At that time, they applied for welfare.

While he was waiting for social security disability benefits, the operation removed one eye and a good portion of his jaw bone. He was on welfare for some months until the social security disability benefits came through.

Now the family receives $206 a month social security disability benefits and, fortunately, all his hospital bills were paid because he was on welfare for this brief period. But now there is an operation that could be performed to restore a good portion of his face, but they don't have the money for that. They simply don't have the money for it. A collection agency was trying to collect one of the doctor bills which was why they came to me in the first place.

Senator KENNEDY. You mean the doctors that they consult have indicated to him that they could at least restore part of his face but because he lacks money, he is unable to get that?

Mrs. HESS. That is correct. At first, they had a terrible time with money for medication and sterile bandages. They were receiving $206 a month and the bandages had to be changed all the time.

There is a man 39 years old in Preston County, married, with five children, working regularly——

Senator KENNEDY. Are these all cases that you have had contact with as a worker and that you are personnaly aware of?

Mrs. HESS. These are a few I pulled out of the file the other evening. They are typical of what all of us run into. This man worked until he was injured in 1969. They are now getting Workmens' Compensation and social security disability, $227 a month; no medical benefits of any kind.

There is a case of a widow in her 80's who received $69.50 social security widow's pension. That is supplemented by welfare. So this one is a little different. She was in a hospital last summer because of a heart attack. At the time she was there, she fell out of bed while unattended in the hospital. Now that she has been returned to home for a while, there were home health aides who came at no cost through medicare to help out? The daughter in the family works in the 10-cent store and earns $40 a week take-home pay. Now the home health care has expired through medicare. The 100 visits are over. That is it. She is now listed as chronically ill rather than acutely ill. But somebody has to be with her all the time.

The daughter is paying someone, I believe, $1 an hour, to stay with her mother while she goes out and works. She doesn't want to quit her job and lose what benefits she has accrued over 20 years work, but somebody has to stay with this woman at home. She can't walk. Someone has to be with her in case she has another heart attack. What resources does she turn to? Here, it is the home health care that is the big problem.

I would like to mention that there are problems also for people who are receiving welfare. Although they have a medical card which will provide hospitalization and certain medical treatment, during the past year the welfare department was not granted the welfare commissioner's request for funds by the legislature. A lesser amount was appropriated.

The special diet allowance has been eliminated completely. That was available to persons with, for instance, arteriosclerosis or diabetes, who have to buy special foods and follow special diets. Now there simply aren't any provisions for that.

The special telephone allowance was cut off and that was provided to people who had severe heart conditions, in case they should need to call for medical assistance immediately. That simply isn't available anymore.

We encounter in another way health problems. Our transportation to reach a physician is a problem also, to get to a doctor for an examination, to get to the hospital by ambulance, to get to a clinic for treatment.

And I have talked to people who are on welfare, and I knew had a medical card and say they coundn't afford to go to the doctor. So I will say, "I know you have a medical card. Why couldn't you?" They will say, "I couldn't afford the transportation."

I would ask if they had a neighbor to help you out. And they would say, "Yes, but Mr. Smith charges $5 or $10 to take me to the

doctor every time." So she is paying in order to go to the doctor so that the care—it is the same as paying for medical expenses.

Senator RANDOLPH. You mentioned the problem of ambulance service. It is my understanding, and if I am in error someone can correct me, but I believe that the Association of Funeral Directors has voted not to use their equipment to serve as ambulances to come in cases such as you mentioned here this afternoon.

I believe that someone, individual funeral directors, or companies are still giving the service. Can someone tell me if I am right or wrong that the Association did cut it off?

Mrs. HESS. I believe there is a special setup here in Preston County now. I am not really familiar with it. But there is some organization which is in lieu of what used to be done providing ambulance services. But it isn't free. There is a cost for it.

Mrs. HILL. Before they come out and do anything, you have to have cash money for them. If it is a DPA patient, they still have the cash.

Senator KENNEDY. Before they will take you?

Mrs. HILL. It costs about $36 to come from Morgantown, for a 1-hour trip.

Senator RANDOLPH. Who made the ambulance trip? Who operated the ambulance?

Mrs. HILL. It is an ambulance service in Kingwood here. There is an ambulance service here in Kingwood. It is an independent service.

Senator KENNEDY. When did you pay the bill? Did you have to pay it before they would take you?

Mrs. HILL. They ask you before they go if you have the money to pay them. You have to have cash. When they brought my grandmother home, we had to have the cash ready. Or they wouldn't have gone after her and picked her up.

We had to get a doctor to put my grandmother in the hospital. We kept her there until Saturday. Unless we can get her into a home somewhere else, she will have to go home by herself and nobody to care for her.

Mrs. HESS. I would like to mention a couple of more things. I know time is very short.

One is that we do handle bankruptcies at Legal Aid. We have only been in existence for about a year and a half. But I think that in every case that we have handled medical expenses have been one of the large expenses and sometimes there is just no doubt about it, that is the straw that breaks the camel's back, the medical expenses. Without it, it wouldn't be necessary to file the bankruptcy petition.

I would like to refer one final case which is a Preston County case. The man is married and has three chilldren. He was injured in the Korean War and has lost one leg. He has a service-connected disability pension of $106 a month. He and his wife both worked regularly for some years until he became ill in July, 1970, and he has been unable to work since then, still under a doctor's care.

The wife worked regularly until October of 1969, when she underwent an operation for abdominal cancer. Later, complications developed and she is still under treatment for a blood ailment. She has to receive treatment at West Virginia University Medical Center weekly. He has to see a doctor every other week.

That is their total income, $106 a month.

Some of this treatment is paid for through the VA, a fraction of it, three-quarters, I believe, but even so, hospital bills have mounted up and the medical treatments, the costs have mounted just to an extraordinary amount. Of course, they really don't have enough to live on with $106 a month without the medical problems. They owe hospital bills and one hospital has turned the bill over to a collection agency.

They have a car. They have to have a car, because they have to travel back and forth to the doctor and to the hospitals. They have applied for welfare. And with $106 a month, they ought to qualify for welfare, you would think, with that many children. I think it would be about 140-some dollars in welfare. But they have been turned down on welfare because they have a car that has an assessed value of over $2,000. They can't sell this car because they owe more than $2,000. They can't trade it in, because the dealer doesn't want it, because they owe so much money on it.

He doesn't want to trade it in on a cheaper model. The bank doesn't want to refinance at a longer period in smaller payments.

We are appealing that welfare decision, by the way.

But they waited all of this time to even apply for welfare because they didn't want to. They wanted to get along as best as they could. They have gone into debt. There isn't any source for these medical bills. This is just one of such a large number of people who don't fit into either category, too young for medicare, and a little too much money for welfare; here, not even that.

But this is just one. There are hundreds and hundreds, thousands, no doubt, across the country.

Senator RANDOLPH. You spoke of the numbers, thousands and thousands. How many cases come to the attention of you and your associates in the course of a year?

Mrs. HESS. I thought you would ask that. And I don't have an answer for you.

Senator RANDOLPH. You can supply it for the record. But it would be helpful to us.

Mrs. HESS. It is really very, very difficult for me to say. I didn't have much time to prepare for this. Maybe next week I could go through the files and really find it. These are just a few in 1 year which I thought were representative. There are many others.

There is a case where we are preparing a bankruptcy petition right now. He is about to get social security disability. He needs an operation. I have urged him to go quickly while he is still on welfare because otherwise he will owe an absolutely staggering hospital bill.

Senator RANDOLPH. Mr. Chairman, with your permission, Mrs. Hess has mentioned the case of the Jones family where both husband and wife are ill. There was a rather revealing story which brings out, I think, not only the humanness of the problem, but the facts are contained. Dominion Post staff writer Susan Conte, last October 18, wrote a helpful story that will be of value to the committee. I ask unanimous consent that that article be included in our record of the hearing.

Senator KENNEDY. Without objection.

(The information referred to follows:)

[From the Sunday Dominion-Post, Kingwood, W. Va., Oct. 18, 1970]

THESE JONESES ARE TRYING TO KEEP UP ONLY WITH THEMSELVES

(By Susan Conte, Dominion-Post Staff Writer)

His life is regulated each day by periodic intake of "canned" oxygen, and his wife's day-to-day existence is marked by her constant surveillance of his condition and her worries of how to purchase more medicine and "breaths of life" for her husband.

Yet they still find time to laugh, to argue playfuly over colors in a painting and to debate who is the best actor—John Wayne, Jimmy Stewart or Gary Cooper.

The Denver Joneses, 235 Monongahela in Westover, are caught in a bind that many others experience when a disability causes them to have to rely on Social Security disability payments.

Jones, a pipefitter out of Local 152, has emphysema. His condition has steadily worsened over the years since about 1959 and he is now unable to go outside his home to work. His wife, Brenice, who never worked under Social Security, is not eligible for any benefits.

Not in good health herself, Mrs. Jones has had two spinal fusions and must wear a brace periodically. She takes in ironings as often as possible to supplement the family income, sometimes ironing from dusk to dawn to be able to buy the next day's medicine.

Disability payments under Social Security, available once a person is termed disabled, total $187.30 per month for the Jones. They also received $59.15 from a union pension.

To a lot of people, this may seem like a sizable amount to live on.

To the Jones, bills for drugs amount to more than $150 per month, and bills to keep two large oxygen tanks in their house at all times total approximately $80 per month.

These are only approximate figures and for the month of September, the bills came out to 16 cents more than their income.

Jones paints and his paintings will be available for sale at the Scott's Run Settlement House from 2 to 6 p.m. today during an open house. Mrs. Jones makes flower arangements and these will also be available at the Settlement House.

They are not asking for charity. But help is welcomed from charitable organizations and individuals.

Jones will tell you how much he hates watching his wife worry about how they will pay bills.

It's not like this man has just given up and decided to sit back and let society take care of him. He has worked throughout his life. And at the age of 53, he is still not asking but he feels there should be some type of medical program that could help him and his wife.

Social Security disability carries no hospital or medical benefits. If the Jones had some type of plan or program to qualify for medical expenses, their money worries would be over.

A check with the Welfare office reveals they are not eligible here. They have applied for "welfare disability" but have not received word on the application.

Jones cannot qualify for Medicaid because West Virginia is one of 14 states which stipulated that if a person is not eligible for welfare, he is not eligible for Medicaid.

Jones could accept some type of work in his home such as stuffing envelopes or stamping—some type of work that is not tedious and does not require precision. And he is willing to do it.

They have their bad times and they have their good times. But they could be helped permanently if the Social Security laws were revised and disability payments included medical benefits.

Rep. Robert H. Mollohan of the First District has sponsored legislation calling for revisions.

Temporary finances is necessary now to pull the Joneses out of a slump which includes their being three months behind in rent payments. Any contributions can be sent to Mrs. Violet Petso at the Settlement House in Osage.

Mrs. HESS. Every person I mentioned here was eager to have the situation explained. I said to them, "This may not help your situation, but they are all anxious that it might be of use ind rafting future legislation to help other people in the same situation."

Senator KENNEDY. Just before you conclude, tell me about yourself. Where did you go to law school?

Mrs. HESS. West Virginia University College of Law. I graduated 2 years ago.

Senator KENNEDY. Are you from the State of West Virginia?

Mrs. HESS. Yes.

Senator KENNEDY. How long have you been associated with the legal services?

Mrs. HESS. Less than a year and a half. It just opened last November; a few months after I graduated. I commenced working for them immediately.

Senator KENNEDY. Is it better or worse than you thought it was?

Mrs. HESS. It is in many ways very, very rewarding. I met so many fine people. But it is dreadfully frustrating. The *Denver Jones* case is one. I just don't know. You just don't know what to do. You can write the collection agency, you know. But they will keep after them a little bit. At any rate, they will gradually come back after the Joneses. He had a picture that he had painted sometime ago that he wanted to present today. I was working up until the last second to try to find someone to stay with him. So I didn't have an opportunity to go over and get it. But we will get it to the committee.

Senator KENNEDY. You have not only told us a good deal about health programs, but you have given us some additional reasons to support legal services.

Thank you very much.

Mrs. Grace Bartlett?

Mrs. Bartlett, I want to welcome you here before the committee. We are very appreciative of your kindness in coming. I understand your father just passed away yesterday.

We would have understood if you were unable to be with us. We are very, very appreciative. I think it reflects once again the real sense of motivation of people like yourself who are willing to make this sacrifice to be with us this afternoon. We want to welcome you here before the committee.

STATEMENT OF MRS. GRACE MARIE BARTLETT

Mrs. BARTLETT. Thank you, Senator Kennedy. I appreciate the fact that I have been able to work with Reverend Bowyar on the comprehensive health plan. We can see a number of things that have been a great concern to me and I have been able to realize that there are so many people that are not getting what is required in the way of health services.

Twenty years ago, it was determined that I had borderline Addison's disease. At that time, of course, I quit work. I was not able to go on as I should, but I come from a middleclass family and my family was able to take care of the expenses at that time that were connected with the problem.

Eight years ago, my father retired and I felt then that I was compelled to apply for social security disability, which I did, and I have received it. This amounts to about $125 a month. I went through my records and last year my medicine alone, just maintenance dosages, cost me $50 a month. I had hospitalization last May for 3 weeks, which

costs me $2,100. That is very easy to see that you can not pay these kinds of expenses and still use what you have. With the death of my father our income will be much lower yet than it is. I am single and I live at home.

I have been so fortunate that they have been able to at least make payments on hospital bills. But today, I feel overwhelmed because I know that the income is much less than it will be or would have been before and so you wonder what you should do.

Two of my brothers are associated with the medical field. I have had advice from both of them. I have a Baker's cyst behind both knees, and one of them is cutting off circulation into the foot. They said I must get this taken care of immediately.

But believe me, when you have these kinds of expenses and you honestly hope to meet them all, you think many times before you go to a doctor or you do anything unnecessary.

My father's expenses were something terrific. He was in West Penn Hospital in Pittsburgh for 15 days. This run $68 a day. No middle-class family can reasonably expect to pay the difference there. He went to my brother's home and took treatments there for 6 weeks following that.

He came home. He was home for 8 days and was admitted to the hospital. In Taylor County, our doctor situation is certainly not what it ought to be. We are very limited. We have four specialists there. We have four doctors. No doctor was really capable of taking care of him and yet it was a matter of having somebody to order medication.

Last Sunday we were told that he was much improved and could come home that day. Seeing him as a person who had been in the hospital a number of times, I realized that he was not this well and the doctor walked in the same day that he told him he could go home and said, "You are as bad as you could be."

We did not feel we were in a position to get him somewhere else because, as someone else has stated, ambulance service in this area is prohibitive. He went to the hospital by car. He came home from Pittsburgh by car because we felt that this is the only way we could handle this situation and still expect to pay the people involved.

So I strongly feel that somewhere, somehow, we are going to have to find some way we can reach all the people with adequate health care.

Senator KENNEDY. Do you have any insurance at all?

Mrs. BARTLETT. None at all. When I first got sick 20 years ago, health insurance was not this prevalent and the minute that they diagnosed my condition as being a borderline Addison problem, I was refused time and time again hospitalization.

Senator KENNEDY. We hear these insurance companies testify before our subcommittee on how they are responding to the health crisis, and how they are willing and flexible on these matters.

Yet, we hear examples time and again where they are completely ignoring the problem, completely unresponsive to the health needs in this country.

Yet, they are the basis for the administration's efforts to reform the system.

It is extraordinary that they should be the basis for reforming what

all of us who have heard these tragic stories realize is a completely inadequate health system in this Nation of ours.

You have told the story terribly well. Once again, I appreciate your being here.

Mrs. BARTLETT. I have had several contacts with the insurance company. My brother-in-law is an official with Prudential Insurance. They have told me time and time again:

"Do not make an application. You may get well enough some day. If you have been turned down once, then you will not be acceptable for insurance. So do not make an application. Make an inquiry, but not an application, because once you do, it is on the record and you will no longer be considered at any time."

Senator RANDOLPH. Senator Kennedy, I want to be very careful in my comment, but I have made recently a speech on this subject in West Virginia.

I believe there is an unconscionable gap in the insurance coverage by private firms. I believe there is a lack of comprehensive coverage that we must have.

This doesn't say that I am just a critic of private insurance programs. But this gap exists. If we cannot have at least a greater realization and finalization within the companies themselves, the legislation which Senator Kennedy proposes is a must, and a must very soon.

Senator KENNEDY. Thank you very much.

Our next witness is Mr. Charles Michaels, pharmacist and president of the Doddridge County Medical Center. He is accompanied by several members of the medical center.

STATEMENT OF CHARLES MICHAELS, PHARMACIST AND PRESIDENT, DODDRIDGE COUNTY MEDICAL CENTER, W. VA.; ACCOMPANIED BY JOHN VAN GILDER, M.D.; HOWARD SPURLOCK; JOHN DROPPLEMAN; REV. RICHARD BOWYAR, PRESIDENT, EIGHT COUNTY COMPREHENSIVE HEALTH PLANNING BOARD; AND DR. ROBERT L. NOLAN, PROFESSOR AND CHAIRMAN OF THE DEPARTMENT OF PUBLIC HEALTH AND PREVENTIVE MEDICINE, WEST VIRGINIA UNIVERSITY, MORGANTOWN, W. VA.

Mr. SPURLOCK. We are from Doddridge County, which is a rural area of less than 7,000 people. We also live in a small town of under 1,200. The economy is based on textile factory, oil and gas production, farming and cattle raising.

In the spring of 1966, the Sears, Roebuck Foundation, Aid to Rural Areas, by providing increased medical facilities, was contacted and asked to make a survey of our basic medical needs.

After the survey, it was determined that this county could very easily support three physicians. And we should prepare for the future by building a medical facility. We started a fund drive of $50,000, and this was all private money. There was no Government money involved. It came from the citizens. We concluded this January 1, 1967. Afterward, we added another $30,000 in medical equipment. Prior to this, we did have one physician servicing the whole county. He was 62 years of age and had decided to leave.

We had a public meeting with the Sears Foundation in 1966, and at that time, they gave us the impression that with this modern facility, we would be able to find us another doctor or two, as the clinic was built to take care of two physicians.

In September of 1967, we opened the clinic, and we did have a foreign graduate physician and an American lady pediatrician. They came in September of 1967, and they left in April of 1968. We spent the next 6 months pursuing all possibilities of getting another physician for the county.

Senator RANDOLPH. Why did they leave?

Mr. SPURLOCK. One had immigration problems, and the lady pediatrician was following her husband who was a music professor, and moved on. We managed to get another foreign graduate in November of 1968. He stayed until November of 1969. He left. He had immigration problems. So that leaves us where we are now, without a doctor.

In the last 40 months, we have only had a doctor for 19 months. This means that we have been without basic medical facilities for our citizens, and our citizens are welfare and also middle class, and these are the people that can pay a bill but cannot get the services.

So, actually, a national health bill won't really help us right now, because transportation is a problem to the people, we are 35 minutes away from hospital facilities. We have sent people in an ambulance into Clarksburg, and we have had people die on the way in, and immediate medical attention could have saved some of these people.

So we are up a tree. We have tried everything we now know, to get a physician. We have advertised in periodicals, medical journals, newspapers; we sent out 120 letters to medical universities all over the country and Army discharge centers. We haven't had a direct reply from any of these. We have had people come in, but for one reason or another they didn't want to locate there.

Senator RANDOLPH. Are you speaking now of the county as a whole?

Mr. SPURLOCK. I am speaking of West Virginia and the county as a whole. We have no doctor anyplace in the county, from one end to the other. We are really 35 minutes away from medical care.

Senator RANDOLPH. How far would Parkersburg be?

Mr. SPURLOCK. It would be farther than that. It would be about 40 or 50 minutes. Of course, we are in the middle of highway construction. So even if we had a great insurance program, it won't help us as much as it really should.

Senator RANDOLPH. I want at this point, Mr. Chairman, with your permission—Dr. Nolan, how many graduates come from the West Virginia University School of Medicine each year?

Dr. NOLAN. We have now reached the level of approximately 75 incoming students, and that is our prospective number of graduates each year, 75.

Senator RANDOLPH. If 75 are graduated, how many of them do their work in the State of West Virginia, and what proportion go out of the State?

Dr. NOLAN. The school has only been graduating M.D.'s—although it has a history of over 30 years as a 2-year medical school—it has only been granting the M.D. since about 1961.

So many of our young graduates are still in service or in residency training. During the last 5 years, it has not been possible to effectively

measure; and for the first 5-year period, the office of the dean has estimated that approximately 40 percent of those graduates for the first 5 years have stayed within the general region, which includes Ohio, Kentucky, Maryland, Virginia, and the contiguous States.

However, I do not have the exact data with regard to the percentage that have actually remained within the borders of West Virginia. Almost all of the students now admitted to West Virginia University School of Medicine are residents of the State of West Virginia. So it would only be two or three incoming this year who are out-of-State residents.

So it is our hope that by admitting primarily West Virginians, they will remain in the State. I think the data shows that the majority of them thus far have not done that.

Mr. DROPPLEMAN. We have a young man who is completing his medical requirements and his draft material. But he is willing to come into our area in lieu of going in the service and service us. He could come as a conscientious objector, but he is not, and he has also made that statement.

This is Dr. Van Gilder here. We are trying to find a way of getting him into an area where there are between 6,000 and 7,000 people that aren't getting any medical service.

We also feel that the West Virginia Medical School is letting us down. We are supporting the school with our taxes and our State is still primarily rural, and they should have a program to route these people back to the rural areas, definitely.

Let me take a crack at something else here. This thing is a national problem in the rural areas. We think that the Federal Government ought to implement some kind of a system to speed up the education of physicians and, if the various medical societies will not go along with it, that they do it on their own, if necessary, and get this service on a competitive basis with all the other professional services. This might alleviate some of this.

In the meantime, we are without a physician. But from observing the past, our Government, if they wish and care, could solve this general condition in a few years. If anybody has any way they can help us here on Dr. Van Gilder, we would certainly appreciate it.

Senator RANDOLPH. Mr. Spurlock, we passed the Emergency Health Manpower Act, which, in a situation such as you are expressing, Dr. Van Gilder would prove valuable. But the problem is the implementation of that legislation.

I want to ask you what is the attitude when we approach the Administration with reference to this problem?

We have no indication that there will be an implementation of the act. This is difficult for us to understand.

Mr. SPURLOCK. I spent an hour and a half Friday afternoon and I called Representative Harley Staggers' office. Is this Public Health Law 91623?

Dr. NOLAN. That is correct.

Mr. SPURLOCK. I talked to two or three people there and they routed me to a Mr. Menger who worked on the bill and was going to call me back. It was Friday afternoon and I didn't get the call back.

So I heard generally that the Surgeon General had the power to draft this man, commission him and then reassign him to a rural area.

But I tried the Judge Advocate Office of the Surgeon General's office and this gentleman didn't interpret it this way.

Then he suggested I call the Surgeon General's office of Health, Education, and Welfare. I talked with a Dr. Zapp's office. I didn't talk with him personally. He looked the act over and told me that it will be July 1972 before this is a funded act and in process and he could make application then.

By that time, this man is gone. He really didn't read this the same way, that they could reassign a man back to us, that had been taken into the service. He proceeded to tell me that the public health, Department of HEW, will commission an officer and they in turn provide services for certain Federal employees like the Coast Guard, Merchant Marine. But he didn't see anything that would help us, especially right now.

Senator RANDOLPH. We disagree with him.

Mr. SPURLOCK. I hope.

Senator RANDOLPH. I want to check this special case out. We will do it in a matter of days.

Senator KENNEDY. The Emergency Health Manpower Act passed the Congress. The authorization, I believe, was $10 million for the first fiscal year, but not one cent was requested by this administration for that program for the first fiscal year.

We hear that they are going to make a supplemental request for 1972 of approximately $10 million.

But we can try to fund that program with a fiscal year 1971 supplemental. I will put that amendment in. I am sure Senator Randolph would join us. Hopefully, if we can get Senator Magnuson, who is the real initiator of the program to join us, as chairman of the Appropriations Subcommittee on health matters, we would have a good chance of getting it.

The real lesson of this experience is, I think, the extraordinary efforts that have been made by people in this community. We often wonder what value people in a community, in a rural area or urban area, put on decent health.

What you are telling us by your story is that your community of only modest resources has been willing to make the extraordinary efforts which you have outlined here today to develop a facility and, now you are unable, because of bureaucratic rigamorale, to utilize it to get services to people.

It is an additional indictment of the whole system.

I commend what you gentlemen and the people in your community have done to try to get this kind of facility to provide health care.

Mr. SPURLOCK. We had over 800 participants in this. That means we hit about every level, from 50 cents up. We anticipated our problem and thought we would be ready for it. We sure haven't solved it by a long shot.

Senator RANDOLPH. Mr. Spurlock, you know the problem in Clay County?

Mr. SPURLOCK. I read about it.

Senator RANDOLPH. There is a nonprofit organization that has been formed where they will guarantee the salary of the physician, if he will come, $36,000 a year, the dentist $23,000 a year, and the pharmacist

$18,000 a year, and provide $4,000 for an inventory with which the pharmacist can open his shop, as it were.

This is a rather unusual effort that is being made there. I don't know whether it will succeed or not. But there is no doctor in that county just as there is no doctor in your county.

Would you take just one minute to tell me what has happened in Ritchie County just to the west, where they have had a similar problem to yours, sir?

Mr. SPURLOCK. Yes, but they have not been completely without a physician. They had three or four or—he will turn this over to a pharmacist, he would know more, because he writes a few prescriptions from Ritchie.

Senator RANDOLPH. The clinic is established there, as you know. We hope it was a stimulus to bringing in medical personnel.

Mr. DROPPLEMAN. They have been able to acquire one physician in Pennsboro and they are seeking another. There are two in Harrisville. One of them is on limited practice now. So their need is great, too. Those people down there just are worked to death. This last boy is a Colombian from Colombia, South America, and doing an excellent job. But he is looking for help. I understand if he doesn't get some additional help in there that he will possibly leave Pennsboro.

Senator RANDOLPH. I want to say, Senator Kennedy, that there is no State in the Union other than Vermont, that is more rural than West Virginia. That is why you are in the correct location in West Virginia to hear the problems of rural America and the problems are perhaps in 40 of our counties, or more, out of the 55. We can repeat this story in varying degrees, but with the same intensity in all of them.

Mr. SPURLOCK. I told you we were 35 minutes away from medical facilities. This means that we can get the patient into the hospital in 35 minutes. But it doesn't mean he is going to see a doctor. He can be there from a half hour to 3 hours. We run into circumstances where it is almost impossible to find a physician at night or early morning. They are just not available.

Dr. VAN GILDER. I would like to give my position on this. I am a native West Virginian. I graduated last year from the West Virginia University School of Medicine. It has always been my intention to return to West Virginia to practice. I had originally planned to gather more training before this. But the draft situation intervened. I am quite concerned about the problems of rural health care in West Virginia.

If I were able to go to this community, my intent would be to try to set up comprehensive health services, including possibly 1- or 2 day a week specialty services, services of home health nurses, and social services.

I understand there is a good Public Health nurse there. But I think she is tremendously overworked. If I should try to get more training, I would try very hard to get a replacement, continuity of care for the people, if I were to leave.

I also hope to involve the university in this, to hopefully make or encourage them to fulfill their obligations in the State that Mr. Spurlock has delineated.

I applied to the Public Health Service under the Emergency Health Manpower Act. I received a polite form letter last week telling me that they had no need for people with my particular level of training.

I have also talked to West Virginia Congressman Staggers and Congressman Mollohan, to try to find out what the status of my application was. Apparently they have not been able to find anything out because I have not heard from them.

I would be quite happy to go, not as part of the Public Health Service, as a private, independent physician, if this act can be implemented by that time.

It seems to be the intent of the Congress and of the President, as he signed the bill, that physicians be exempted from military service to meet the specially demanding needs of the Nation. If the act can be implemented, I really think that it is a shame that I can't be exempted apart from that piece of legislation to do this.

Thank you.

Senator KENNEDY. Mr. Bowyer.

Reverend BOWYER. I would like to speak as the President of the North Central West Virginia Health Planning Association, which covers most of the counties that you have been in today and others, and speak also of another county which faces similar problems, Gilmer County, which has attempted to meet this in a somewhat different way than Doddridge County has done. A group of consumers of medical care have formed the Gilmer County Medical Center, Inc., in an effort to seek Hill-Burton moneys and build a medical complex and thereby attract physicians.

They have two elderly physicians that have almost ceased practicing now and two osteopaths who are practicing in the county that are also near retirement age.

However, as we look at situations such as Doddridge County and others, we find that the total solution may not simply be a matter of having adequate facilities in order to attract doctors into a situation. The problems seem to be much more complex than this.

It seems to me, too, as we have heard these comments that have been made this afternoon, describing many of the situations throughout West Virginia, that the situation of the war effort is further complication of our medical problems. It is illustrated here. And secondly, in the fact we have heard many stories within our own area of experience who are wounded or injured on the battlefield and were very promptly able to receive medical care, and yet, this is unable to be done for the citizens who are here, and those soldiers, who once they have gotten out, come back home.

I would like to say something about some of the problems in and the alternatives which I feel are important in dealing with this overall situation.

It seems to me, we may have to look elsewhere for solutions to the crisis than merely to doctors or to equipment or facilities. But these are complicated, in our area, for instance, by the poor nature of roads and the difficulty of travel over our State's beautiful terrain and further aggravated by the general shortage of facilities and personnel that we have.

So, practice doctors in every location are already carrying very heavy patient loads and some of our hospitals are placing patients in

the hallways, which, of course, is not necessarily an indication that there is a shortage of space, so much as it indicates unnecessary hospitalization and the poor organization of delivery services.

Oftentimes insurance programs are designed to put people in the hospital who could be treated much more cheaply and much more efficiently perhaps outside.

I think statistics will show that the largest amount and the largest percentage of money for health services which are spent by the West Virginia Department of Welfare goes for hospitalization, which is the highest cost to service ratio of medical services. Virtually none of it goes for prevention. The stories you have heard this afternoon I think have borne this out.

It should be noted that many of our doctors are older and without the benefit of more recent training. The same is true of other health providers. Not only do they lack up-to-date training, board certification is often not attained by doctors practicing in specialties. While modern medicine is available to many at West Virginia University or at Fairmont or in our hospital, it is often effectively denied to many of our region's residents.

The tragedy of the poor and aged I think is clearly discernible but the very nature of the problem means that many who could generally afford care could not get it or cannot get to it.

I am convinced that several factors must be brought to bear upon our current medical crisis. In priority is planning which must be inclusive and regional and it must be genuine. I think Government incentive for serious planning is imperative.

A business which is wracked with inefficiency and outlandish costs must come to terms with its ways. More attention must be given to preventive care. Plans and programs must be devised which will reduce the need to travel about to see several doctors or to make trips to labs or other ancillary services. Drug costs must be reduced.

Hospitals must include the EKG departments and others which otherwise encourage profiteering by private practice physicians. There must be incentives for planning and for participation in planning, or conversely, penalties or lack of benefits for hospitals who do not.

In my own county, the Fairmont Clinic and a very few local doctors will join in planning efforts. Other medical facilities and most of the doctors will not. This makes it nearly impossible to plan seriously and effectively. Consumer participation is mandatory. Public facilities and programs should be required to include on their boards and in their decisionmaking significant percentages of consumers who reflect and represent the population of the service area.

Finally, I would underscore the need for a patient-oriented or service-directed system. Probably the major weakness of medical centers associated with medical schools is their impersonality. Much of this is understandable since their primary function is education and training. But service must be made more humane.

If it cannot be done in the medical school setting, then doctors need to be trained out in the area where patients live, work, suffer, and die. The profit motive is basic in our society, but humanity is even more basic. The health industry must place service to patients ahead of profits, and any other approach is evidence, I think, of a truly sick society.

When I look over our region and assess my own immediate community and analyze my own family's health needs, and the available services and the costs, I see the need to encourage group practice wherever feasible, and above all, to provide a system of prepayment which enables all to have equal access to equal service.

I do not believe this can or will ever be achieved without active consumer participation in the planning and in the policing of the health industry.

Thank you.

Senator KENNEDY. It is a good statement.

Mr. Michaels?

Mr. MICHAELS. Senator, we want to thank you for permitting us to appear before the committee. In regard to our particular case in Doddridge County, we feel that were you to have a hearing there we could cite many cases of the inability of people to meet medical costs. However, the critical problem in Doddridge County is the lack of a doctor.

Again, thank you.

Senator KENNEDY. Senator Randolph mentioned a county that has offered a guaranteed yearly salary. That is an extraordinary effort for a county to make.

I don't think the total burden should be on one community to solve their health crisis. It is a national concern and we ought to be able to respond to it in a national manner.

I think we have to offer the special incentives that have been suggested here to get doctors to rural areas.

But the burden, I don't think, ought to be assumed by a community in and of itself. A progressive tax system should spread the burden nationally.

But you mentioned very briefly the efforts you made trying to get some medical staff for your community.

Have you said all you would like to say on that question?

Mr. SPURLOCK. Are we talking finances?

Senator KENNEDY. How you are going to attract people?

Mr. SPURLOCK. We don't know. We think we have tried about everything. If you have an idea, we will go that way.

Senator KENNEDY. That brings me to S. 3.

We will have a mechanism built into that system that will allow a doctor to go on out into the country and practice without being disadvantaged financially. If a man has motivation, concern, and the desire to do so, he will be able to practice quality medicine out in rural areas. And he and his family won't be disadvantaged financially.

"Under that legislation we are not going to put the extraordinary burden on a single community to get together these resources alone.

Mr. SPURLOCK. It is not a matter of economics in our county. The money is there, the patient load is there, they will patronize a doctor if he will come. In fact, a young doctor can start off much better there than he can in the city where it is more competitive. This is a solution to our problems right here, if you can tell us the way to get him.

Dr. VAN GILDER. He is quite right. Physicians practicing in rural West Virginia don't have any economic disadvantages. The things that make it unattractive are professional isolation, social isolation,

things like inadequate school systems. I think people in Doddridge County assure me that the school system is fair in a general instance. This is the problem. Part of the reason I would like to involve Doddridge County is not only for their benefit, but for mine.

Senator KENNEDY. Thank you very much, gentlemen.

Dr. Davis, Delroy Davis, M.D., general practitioner in Kingwood, public health officer and past president of the West Virginia Academy of General Practice.

We would like to ask Miss Iris Allsopp to also come to the table.

STATEMENT OF DELROY DAVIS, M.D., GENERAL PRACTITIONER, KINGWOOD, W. VA., AND PUBLIC HEALTH OFFICER AND PAST PRESIDENT, ACADEMY OF GENERAL PRACTICE; ACCOMPANIED BY MISS IRIS ALLSOPP, ADMINISTRATOR, PRESTON MEMORIAL HOSPITAL

Dr. DAVIS. Senator, I have been asked to give a statement as to the need of health care in Preston County.

After I hear the plight of our neighboring counties in West Virginia, of Doddridge, Gilmer, and others, I feel like, perhaps, our need is not nearly as great as once I imagined.

First, before I go on with our testimony, Mr. Senator, I have been requested to ask for a transcript of the record for the West Virginia State Medical Association.

Senator KENNEDY. Fine.

Dr. DAVIS. They are concerned with this problem.

Senator KENNEDY. We will be glad to make it available. If you can indicate where you want it sent, we can get it sent to you as soon as we have a supply.

Dr. DAVIS. Thank you, sir. I will indicate after we get through.

For purposes of discussion, I would like to divide the medical needs of Preston County into two categories: First, the need of practicing medicine as far as the need of practice of medicine in the county is concerned; the other is the need of the county from a public health standpoint.

I believe Preston County is the fifth largest county in the State, as far as land area is concerned. It has a population of 25,000. There is a medical manpower shortage. The present doctor census consists of one general surgeon, one internist with a subspecialty in cardiology, four full-time general and family practitioners and one part-time practitioner.

There is also a staff of resident physicians at Hopemount State Hospital for chronic disease.

Five of our physicians are over the age of 50. Two are over the age of 45. In the past year, two physicians in the county have died and have not been replaced.

One physician has left the county for a residency in neurosurgery.

There is a need soon for at least two or three family practitioners in the county. Ideally, four or five practitioners would satisfy our needs.

With this increase, we could probably support another general surgeon and another physician in the subspecialty.

Experience in looking for a partner in family practice this past year has brought approximately 100 applications from the specialists, mostly surgeons who would be willing to do general practice until they could do their specialty.

We received only four inquiries from general physicians. I believe this illustrates the deficiency in the curriculum of the medical schools in not training general physicians.

For this reason, I don't need to urge you, you have already supported the Yarborough-Rooney bill, but your continued support of the Yarborough-Rooney bill for the training of general physicians in the departments of family practice within the medical schools, not in divisions under another discipline of medicine.

Senator KENNEDY. I couldn't agree with you more. We passed the Family Practice bill overwhelmingly—I think in the House and Senate there were only six votes in opposition to it. That would have provided a real stimulation in terms of general practitioners. Then the Congress adjourned at Christmastime for 3 or 4 days, and the President pocket-vetoed that legislation. I think his act is unconstitutional, and we are hoping to test this constitutional question. Any fair reading of the Constitution would indicate it is only when the Congress actually adjourns for the year, sine die, that he would have a pocket veto.

By its pocket veto, the administration avoided giving reasons to the Congress for vetoing that legislation.

It also avoided giving us a chance to express our views of this issue and to try to override the President's veto. He didn't give us that opportunity.

Therefore, I share your sense of frustration. We are trying to test this case before the Court of Appeals. We are also attempting to have the House Appropriations Committee fund the bill and hopefully to test it before the Supreme Court.

But all this means delay for those who are trying to provide additional help and assistance to general practitioners.

This is just a point I thought that might be of some interest to not only you, but to our friends here, who might wonder why the Congress hasn't acted in this kind of legislation.

Dr. DAVIS. As for legislation in the care of patients, there is a group of patients—and I can't reiterate Mrs. Hess' request greater—that are not now covered by medicare or any other program that needs immediate correction, the paraplegics, the patients in any age group, but mostly in the 40–50 plus year age group who become totally disabled from any cause, and cannot gain medical help or hospitalization for physician's care.

May I digress just a little bit from my statement? I think medicare covers an awfully lot of ground. It is not very discriminating in the people that it includes. It includes everyone past 65.

There is a great number of people in this country, fortunately, past the age of 65 that remain in good health and are perfectly able to withstand their own costs. I think certainly under medicare or some other Government program there needs to be a catastrophic policy that covers people like Mrs. Hess mentioned.

Early experience in West Virginia just recently with the new revision of the Department of Welfare into regional offices rather than

county offices so far has not been good. If there are specific questions, I will be glad to answer these.

I believe the consensus of our present physicians in the county is that medical care is adequate for the patients that come to our attention.

But improvements can be made, mostly in the area of socio-economics; in the area of logistics; and an increase in medical and paramedical personnel. We need a home nursing service.

We need convalescent and nursing homes. Certainly, we also need better public relations in the education of the entire population.

Under public health needs, may I say that our Public Health Department in the county consists of one part-time health officer with an assistant. We have one public health nurse. We have one sanitarian.

We could immediately use a full-time public health director. We could immediately use an additional nurse and an additional sanitarian.

We could also use a social worker. We need expanded physical facilities.

Preston County is fortunate that it is adjacent to Monongalia County and the medical center. We have tried to cooperate with them in several new programs that they have tried to put on in the county, especially one in the Bretz area.

I thank Dr. Nolan for helping out with the birth control clinics in the county, in the back areas which our own health department cannot reach.

Dr. Wiles has included us in his maternal and infant care program at the university. This has provided the university with much needed obstetrical patients. Dr. Wiles does not need a station wagon to transport patients back and forth to the hospital.

I have not discussed fees. I know very little about the economics of government. However, if we must continue inflation by raising the minimum hourly wage, this, in turn, raises the cost of supplies and office personnel and must eventually raise fees.

I believe that concludes my statement.

Senator KENNEDY. Doctor, do you consider health a matter of privilege or right for Americans?

Dr. DAVIS. It is both.

Senator KENNEDY. If it is a matter of right, then it is total and it is comprehensive, I would assume.

Dr. DAVIS. Yes, sir.

Senator KENNEDY. You might have those who for one reason or another have privileged opportunities, but it seems to me that if we say health is a matter of right, there is a responsibility on the health system to reach out into the community and find the areas of greatest distress and do something about it.

Is that something that this country ought to be attempting to do, if we realize that this is a matter of right? Is that a goal we ought to be headed for?

Dr. DAVIS. I think this is the goal we should be headed for. I think it is a goal that we have tried to get to. But to the present day, we haven't quite reached this goal.

Senator KENNEDY. I would take issue in terms of whether we as a country have really tried to reach out. As a matter of fact, I am quite confident that, for example, the administration's proposals in terms of deductibles are quite to the contrary.

We hear this afternoon, of people who go on into emergency rooms and are required to pay fees before they get any service. It seems to me that rather than reaching out to find people that need help, the system as it exists today works to their disadvantage. It discourages people from utilizing the health system. That would be the conclusion I would draw from the comments we have heard today, as well as from the fact that we need coinsurance or deductibles or cutoff dates to insure people don't use the system until they're really very sick.

It seems that the system works contrary to reaching out. It only responds to those who have emergencies, and even then, it often appears to be inadequate.

Do you have any reaction to my sweeping statement?

Dr. DAVIS. Yes; we have taken in an awful lot of ground, Senator.

Emergency rooms are a problem countrywide. They are abused in many ways. I can't say for the rest of the country. I can speak for Preston County.

I know that welfare patients, or the people who are on welfare, as I told your secretary the other day, we have very little chance to do any charity work anymore.

Senator KENNEDY. That isn't the point. The whole system works against the poor.

The administrator of a hospital, if he is going to keep the doors open at all, can only afford certain kinds of service. They have to balance their budget and, therefore, can provide only so many services to the disadvantaged or the poor.

It seems to me it is more the system than it is the motives of the people involved.

The question is whether we are going to add on to that system, patch it up a little bit, and put a "Band-aid" on it and say you have reformed the system, or whether we are going to really come to grips with some significant change in the system.

Dr. DAVIS. I think this has to come from attitudes. This is the one encouraging thing I have seen among medical students of the past year or two, that these people are more socially conscious than we have ever been before. These are freshmen and sophomore students we talked to; how they will be when they are juniors and seniors, I can't say.

Miss ALLSOPP. About the national health program, this is probably the route we are going to go and this is perhaps one way we can provide care for the disadvantaged and the whole population. But I think some concern must be given not only to the financing of health services, but I think there needs to be a whole new concept of how are you going to deliver health care, how are you going to reach all of these people? I think there needs to be an ideal program for the consumer, the provider, the medical staff, the whole bit.

Senator KENNEDY. I couldn't agree with you more.

Miss ALLSOPP. You can throw money into the fund, but if you don't do something about the way you are going to deliver these services, if you are not going to help alleviate the shortages of medical personnel—we have a shortage of doctors in the county. You have a problem in recruitment, how are you going to get these people to come here? This affects the occupancy rate of the hospital. People don't want to live in rural areas any more.

I think somebody needs to rebuild the image of the general practitioner and do something about family practice, because these are the people who have devoted all their lives to the maintenance of health more than anybody else I know of.

Senator KENNEDY. That is a good observation.

Miss ALLSOPP. In a rural area, you have the same problems as the metropolitan area in the operation of a hospital, but they are compounded here by many things: lack of medical personnel. If we want to get people to fill the professional jobs in our institutions, we have to provide some way to educate the people within our county, because these are the people that then have some obligation to return to the county and to work for us.

So we have systems whereby we send people to school and also we have been connected with West Virginia University which has a telecture continuing education program for nursing, which has been a real asset.

In this rural hospital, the things that prevent us from extending our services and having more modern equipment is the fact that inadequate reimbursement programs with welfare and so forth, do not provide for a reserve to update our equipment. So we do have problems.

We have the same problems as everybody else has. We have to compete with people in metropolitan areas for the personnel that we have. This is not an industrialized area, so there are no major group insurance programs and we have many people with no ability to pay.

We also have a problem with patients in the hospital who are no longer certificated by medicare for continued care. They have no place to go. There is a great need for nursing home care, care for the elderly, and the disabled, these people who come in an age group that are not covered by medicare and are not eligible for welfare.

Dr. DAVIS. Senator, I would like to make one comment: I don't believe you can legislate love, which is what a great number of these elderly patients need. I don't think you can legislate social concern, unless people themselves wish to do it.

Senator KENNEDY. I am sure you are right.

What you can do is pass legislation that gives an advantage to young people like this girl from legal services who came up this afternoon. That gives some voice to voiceless people and some hope to people who think that there is nobody who is interested and concerned so that they raise their voices, as you raise yours, about the needs of the health crisis.

It strikes me that if all Americans would just tell it as it is in health, we would get major reform overnight.

But the American people are just too proud. We have problems. But it is a part of our national character, that we try and resolve them ourselves.

It is only when we are just backed up completely against the wall that we seek help, whether it is from a hospital, a doctor or a Legal Services Office.

So we suppress all this. Yet we will be spending more money on health next year than we will be spending on national defense and getting much, much less for it than in years past.

It affects us as individuals, and we don't want to complain about it. That is not part of our character. The greatest strength of our character in this particular instance is, I think, the greatest roadblock to improvement, because if people started to holler bloody murder about it, they would get some action. Unfortunately, it is the individual that has that $5,000 medical bill, and we go ahead and pay it off for $8 or $9 a month.

It is about time we started to do something about our health crisis. We have to change the system to fix it.

Blue Cross said, "We can't hold costs down." Blue Shield says, "We can't do it." Hospital administrators, doctors, everyone says it isn't their fault. In fact, it isn't anyone's fault. It is the whole system's fault.

And the person that is paying for it is the consumer, as we heard here today.

We need your help, and Miss Allsopp's. We can't legislate love and affection and all the rest, but perhaps we can legislate some paramedical personnel that will be interested in looking out into these hills for people that are suffering from thyroid problems and measles and pneumonia and a lot of other things, and willing to give them a little help.

I think there are tens of thousands of young Americans and old Americans who would do this. Take a look at the Teacher Corps, for example, VISTA volunteers, Peace Corps people. They are ready to go out and help.

What is wrong with our health care system that we can't encourage such people to do this work in the area of health?

Dr. DAVIS. You have an opportunity in legislating some new legislation to take care of these people that aren't covered now, I believe.

Senator KENNEDY. You are very kind to come. We appreciate it very much.

Dr. DAVIS. It is our privilege to be here.

Senator KENNEDY. Thank you very much.

We are going to now have open hearings. I will ask everyone if they can limit their comments to 2 or 3 minutes.

We have some names that have been filed. Is Mrs. Emma Steelman here, and Mrs. Anna Likens?

STATEMENT OF MRS. EMMA STEELMAN AND MRS. ANNA LIKENS

Mrs. STEELMAN. This is Mrs. Anna Likens. She is currently a client applying for public welfare. I would like her to tell you her story.

Mrs. LIKENS. I am a widow. I have been a widow for the past 12 years. And I need a lot of medical attention, and I don't have no money whatsoever to pay for any medical attention. I have been trying to get on welfare, on the medical list ever since last October. So far, I have not been able to receive one cent for medical attention.

Mrs. STEELMAN. We talked today about people on welfare, more or less, like they have got it made. They get medical coverage. But I would like to explain the plight of some of the people trying to get on welfare.

Mrs. Likens applied for welfare in October. The type of welfare that she would be eligible for is aid to the disabled. To determine that she is disabled, we have to have medical documentation that she cannot work.

As you can see by looking at her, I don't think she is someone that we would want to put out and make her go to work, but still our taxpayers, people that write welfare policy, state in order to get on welfare you must be considered disabled.

She applied in October, was able to get an appointment with the doctor, the last of November.

We received his report in December. This was sent into our State review team. It was made up of doctors, social workers and so on.

The medical was not enough to state that she was completely disabled. They asked for an orthopedic consultation.

We were not able to get this appointment until April 13.

Mrs. Likens has just had her medical orthopedic evaluation. Now it will take another 6 weeks before we will get that medical report. Then this will be sent in to the State office.

In all respects, she probably will be eligible for welfare, but look how long it has taken.

Senator RANDOLPH. Mrs. Likens, how old are you?

Mrs. LIKENS. I am 62.

Senator RANDOLPH. Are you in what we call good health or are you needing medication?

Mrs. LIKENS. I need medication.

Senator RANDOLPH. How long have you been trying to receive it?

Mrs. LIKENS. Since last October.

Senator RANDOLPH. And have received no assistance?

Mrs. LIKENS. None whatever.

Mrs. STEELMAN. I might add that Mrs. Likens is a little bit better off than most of our pending AD applications, because her husband died leaving her with social security, or she was eligible for social security of $56 a month.

So we have many welfare clients who have pending applications that have no income, but still $56 a month is not enough to live on.

Senator RANDOLPH. Do you own your own property?

Mrs. LIKENS. Yes, sir; such as it is. It isn't very good but it is a home to live in.

Senator RANDOLPH. What are the taxes a year on your property?

Mrs. LIKENS. I don't remember.

Senator RANDOLPH. What is the cost of the upkeep of your property?

Mrs. LIKENS. There hasn't been no upkeep paid, because I haven't had the money to pay any. But the valuation of my home is $1,700.

Senator RANDOLPH. What is the appraised value of your property?

Mrs. LIKENS. $1,700.

Senator RANDOLPH. You have a problem. Is that problem the problem of thousands of other people in West Virginia, or would it be hundreds of other people?

Mrs. STEELMAN. I would say if everybody that was in her situation or many kinds that could be eligible for welfare that applied, that are, say, 50, 60 years old that are trying to manage to live on, very, very small incomes, maybe small social security checks, some of them would be eligible for welfare.

But they are too proud to apply. Some of them have medical problems. They never go to the doctor. On the way up I asked Mrs. Likens if she would go to the doctor if she had money. She said yes. She

has trouble bending: like scrubbing the floor, things like this, she is in pain a lot of the time, but she can't afford any medication for the pain.

Senator KENNEDY. I think we have a problem that we can't better help Mrs. Likens.

Thank you very much.

Mrs. Rondalyn Cool.

Mrs. Cool is director of the emergency food program for Webster County.

STATEMENT OF MRS. RONDALYN COOL, DIRECTOR, EMERGENCY FOOD PROGRAM FOR WEBSTER COUNTY, W. VA.

Mrs. COOL. I am employed by the Office of Economic Opportunity, and I am the director of the emergency food program in Webster County.

I am employed by an organization called United Appalachian Poor People, which is an outgrowth of a CAP program that was in Webster County in about 1967. They were more or less run out of town.

Mainly, what I would like to bring up today is that a few years ago when a new administrator took over our hospital, it was some $2 million in the red. Today, that hospital is several million dollars to the good. It has added a couple of extra wings. But Webster County is considered possibly the poorest county in the State, with 68 percent of the population with incomes below $3,000.

When the new administrator took over, the county hospital placed a sign in the entrance room which read "Anyone wishing to receive services from this hospital must make previous financial arrangments." That statement is really adhered to in the respect that the poor people, anyone that goes into the hospital, cannot go in without a $50 advance. Just last month, there was a case where a man came into the hospital with a stroke and was refused because he didn't have the $50 down payment.

In my work, I come in contact with several expectant mothers that go to the hospital to have their babies delivered and are refused, because they don't have the money in advance. My field workers have driven, and each month they drive two or three of these women to other hospitals out of the county because they are refused help in our county memorial hospital.

Another point I would like to bring up is that I had a case last month where a woman had applied for welfare assistance in the earlier part of November, and just about a week ago, she finally got an answer, a denial, which took about 4½ months to get her case processed, which should not have taken any more than 30 days, according to the law. This is not just one case. These are cases that I come into every day.

Another women, in particular, was denied entrance into the hospital to deliver her baby. I had 2 months before the time of delivery talked to all the agencies in town, including the health agency and the doctor. I could not make arrangements for this woman to be taken care of. She had no income whatsoever. She was not eligible for welfare assistance, because she had no children. So when the time came for this woman's baby to be delivered, we had to take her out of the county to have it delivered, which was about a 2½ hour drive.

These cases are very, very common.

Senator KENNEDY. Thank you very much. That is very helpful.

Senator RANDOLPH. Before you leave, are most of the patients that come to the county hospital in Wesbster persons who have worked in the lumbering and/or mining industries of that county? Would you say more lumbering or more mining?

Mrs. COOL. Lumbering, probably, because the mining in Webster County has gone down considerably. Of course, you know, the lumber business in the wintertime, there are 3 or 4 months there that it is almost completely halted.

Senator RANDOLPH. The economy of Webster County is hard hit, isn't it?

Mrs. COOL. Yes, it is.

Senator RANDOLPH. It is one of the most difficult of the counties of our State now to really have a population that is strong and able to take care of itself now.

Thank you for coming.

Senator KENNEDY. Mr. Vernon Watkins.

STATEMENT OF VERNON WATKINS, PRESIDENT, NEWBERG COMMUNITY ORGANIZATION, NEWBERG, W. VA.

Mr. WATKINS. I represent the town of Newberg, with a population of about 494 people. About one-third of them are retired persons, which I am very interested in, because I am going to be one of those retired persons in a few years. Our medical facilities—we used to have a doctor there about 20 years ago but we have not had any. We are about 14 miles from Grafton Hospital, about 14 miles from Kingwood.

Our old people are the most important people we have today. They are stepped on in about every way. They don't have the income as we have heard it told here today. Most of them have income of around $80 to $100 and to try to keep a house on it and electric and telephone, and to try to get somebody to take them to a doctor is hard.

Our public transportation in Preston County is worse today than it was 40 years ago. We used to get Kingwood public transportation 30 or 40 years ago and today you can't. In Newberg, or most any place in the county. We have one bus line that runs from Oakland to Morgantown and that is about it.

Everybody, if he doesn't have a car, just about walks today. We are one of the largest counties in the State, strung out over these hills and hollows, you might say.

We have an ambulance service in this county which is inadequate today. We have two ambulances serving the whole county.

I am in the coal mines. I am director of safety for a coal mine. I had to set up a plan to get men to the hospital as quick as possible. This service just started the 1st of March. I am not taking anything away from the people that run the ambulance. But it takes 30 minutes to get to Newberg, which is 14 miles. I checked with an accident we had down there last week, and also about 2 to 3 weeks ago, we had a man who had a stroke and the ambulance was called at 15 after 3. He came to the home at around 4 or 4:15. By the time they got him to the Grafton Hospital, it was 5 o'clock and the doctor had already left. They called the doctor and he stayed a while and left because he thought the man had died on the road or something, and the doctor had to be called back out again.

Our dentist is another thing we have a shortage of in Preston County. I have two grandchildren living with me and both of them needed repair for their teeth. My wife called two dentists here in Kingwood. One said the appointment would be three months away. She thought she would get something a little closer than that. She called another and he said he didn't work on children under 12 years old.

She then called Grafton, one place in Grafton, a dentist we had, and they give her a date, this was late January, the 12th and 14th of May. Those were the appointments he had available.

It is just hard for old people to get out and get to this. I am very much in favor of social security taking over our health and welfare because I believe it is a good thing. I believe it would be cheaper in the long run for everybody. It would serve more people.

Senator KENNEDY. Thank you very much. That is a very good statement. It expresses the problems and limitations of dental services, which S. 3 covers.

Thank you very much.

Mrs. Shirley Dalton?

The House of Representatives has a 1-minute or 2-minute rule which we don't have in the Senate of the United States. But we are going to ask you to try to summarize in a couple of minutes.

STATEMENT OF MRS. SHIRLEY DALTON

Mrs. DALTON. The most important thing that I want to bring out about medical care here is this: To me, a mother of seven, right now I am in a mess. So I have been taking barbital. I have been on it for 9 years. I ran out of my pills last month.

I went to the university hospital. I sent up a girl to pick up my pills. The doctor told me I would have to have an examination before I could get any more medicine. So they sent me a letter to come to the hospital to go through an examination so I could get my pills. I left home at nine o'clock in the morning. I paid $4.50 to get to the hospital. I set over there until 2 o'clock. When the doctor called me in, he told me he didn't even know what I was there for.

I called back and I talked to the social worker at the hospital. She told me that she had collected my chart, nobody had sent me a notice to come to the hospital and she didn't even find in my chart where I had been on phenobarb.

Now I can't get no medicine and nobody can find a chart where I have been taking this medicine. So I have been wondering if I have been taking these pills all of this time for nothing or do I really need them? What are you supposed to do? How are you going to find out?

Senator KENNEDY. It's the question of quality. How do you even know you get prescription drugs that you are getting the right one?

I suppose a lot of people worry about that.

Mrs. DALTON. But they told me I had to take them the rest of my life. I have my epilepsy at night, never in the daytime. But I have never been without pills. But now I can't go get my pills because they can't find my chart. Nobody knows who gave them to me. What is a person supposed to do? Some of the hospitals and doctors I would like to get an answer from on that.

One other thing: I have got a daughter that is 15 years old. She has to take gym in school like everybody else does. So she had the tissues pulled out of her knee. So the schoolteacher called me about 11 o'clock. I had no way to get down there to take her to the hospital. So at 12 o'clock that afternoon, my brother-in-law come up and I got him to take me down to the school. When I got down there her leg swelled up that big. So we took her over to the hospital. One of the doctors came out and looked at her and he said he felt something was pulled out of her knee. So he said try to straighten her leg out.

My God, anybody knows with your leg swelled up like that, you can't straighten it out, so he just jerked the leg and pulled it. She screamed. He said take her home, if she is going to be a baby, I am not going to work on her. I took her to another hospital and they did find out something was pulled out of the leg and she had to wear one of those tight things around her leg for over 2 weeks and on crutches.

Me, on welfare, I have got a medical card, so this to me, this is what it is to me. You die, OK. If you live, it is OK, because they don't matter.

Senator KENNEDY. How is your daughter now?

Mrs. DALTON. She is OK. But still she has trouble. She wasn't supposed to be taking gym, not doing anything that would pull her leg. If she don't take it, she gets zero on her report card, so what are you going to do? You have got to listen to the teachers. So I hope you get something to work. I hope you get it out.

Senator KENNEDY. Thank you very much.

Professor Linsky?

STATEMENT OF BENJAMIN LINSKY, PROFESSOR ON AIR POLLUTION CONTROL, AND SAFETY ENGINEERING, UNIVERSITY OF WEST VIRGINIA

Mr. LINSKY. Senator Kennedy, I am Benjamin Linsky, professor on air pollution control, and safety engineering at West Virginia University.

I would like to add these very few words to your deliberations by pointing out that in the United States we have Federal aid to education services, including medical education; we have Federal aid to housing, financing services; we have Federal aid to highway services, we have Federal environmental protection services, we have Federal aid to food services, and it looks like it is about time that we got full Federal aid to full health services even in the rural areas, including transportation, whether by stationwagon, ambulance or vertical airplane.

Senator KENNEDY. Thank you.

Mrs. Eloise Milne, social worker, West Virginia Department of Welfare.

STATEMENTS OF MRS. ELOISE MILNE, SOCIAL WORKER, WEST VIRGINIA DEPARTMENT OF WELFARE, AND MRS. HILL

Mrs. MILNE. Thank you very much. I was unaware until last evening that I might have an opportunity to speak. I will try to make this brief.

Most of the problems I am connected with have already been dealt with by Mrs. Steelman with the Welfare Department, by Mrs. Hess with the Legal Aid Society. I did want permission for Mrs. Hill to speak briefly regarding the ambulance transportation. I will present this very briefly, as I said.

The problem we are experiencing with ambulance transportation in this county is due primarily to the fact that the ambulance company has decided—they have the contract—the funeral home is no longer providing an ambulance service. So they cannot do this.

Our local ambulance owner has decided not to accept medicare. Then we have the elder people that are not covered by medicare payments. They must have the cash.

Then with the department of welfare, we cannot bill or the ambulance company cannot bill for the department of welfare for the transportation unless medicare is billed previously.

So we have worked very closely together in this problem. But they say the paper work is prohibitive. This is very often the case with physicians and other people. They don't need the medical cards sometimes because it is prohibitive, the paper work is tremendous.

You have the burden of additional secretarial help, bookkeeping help and so forth. When you deal with medicare and welfare forms, you need the help.

I did get permission to explain the plight of one lady who is currently in the hospital. I was asked to bring a recipient of nursing home services, because as a social worker with the department of welfare, this is what I am primarily concerned with. My caseload consists of 400 of the elderly, disabled, and chronically ill.

The lady that is currently in the hospital is not a welfare recipient. She isn't eligible, because her social security benefits are $74 a month. But according to our current policy, her assets must be below $1,000. Right at the moment, her medicare days have been used up. Her assets of over $1,000 will be terminated in 1 month. So she will become a welfare recipient. But the plight she is in now is the same as these other 400 people. There are no nursing homes for her to go to. We have not a single nursing home in Preston County. We are fortunate enough to have Hopemount State Hospital for the chronically ill, but for the past several months no one has been able to be admitted there due to the lack of funds. They could open up 150 beds.

Senator RANDOLPH. Just explain the situation.

I think, Mr. Chairman, we ought to know within a few miles here that there is a facility, a hospital, once operated for the tuberculosis patients. Tell us again what you are saying.

Mrs. MILNE. There is not enough funding at the moment to admit any more people into Hopemount State Hospital.

Senator RANDOLPH. How many are there now?

Mrs. MILNE. I couldn't answer that. Maybe Mrs. Hill could.

Mrs. HILL. I was over there about 2 weeks ago and talked to Mr. Lovett. He is head of the hospital. He told me he had 400 beds that could be in use, and at the time there is about 135 because it has no funds. He said if they couldn't get some transferred from some other source that he was going to have to cut down on the food for the patients. He put it like this: not starving to death, but cut down.

We also have two other hospitals in West Virginia that are low on funds and are putting their patients out into these private little concerns. That is why we can't get no patients, because they have to have it in the State hospitals.

Mrs. MILNE. I would also add that one morning last week I called 18 nursing homes in this State and in adjoining States trying to get—at that time, I had six placements to make. I couldn't get one, because the State of West Virginia pays $300 to AAA nursing homes. For instance, the one I called in Virginia, they paid $490 for welfare clients. So, therefore, they were keeping their empty beds for their own, and rightfully so.

But Mrs. Hill was fortunate this morning in that she got her mother into a nursing home within a 40-mile radius of her. But when you consider the expense it is to the taxpayers for even long-distance phone calls attempting to place people, when we have such a lack of facilities, like I say, we have no nursing homes here. We have custodial homes for ambulatory patients in this rural area, but no nursing homes.

Thank you.

Senator KENNEDY. Thank you very much.

Mrs. HILL. I also want to tell you that over at Hopemount in our State Hospital, Eloise told me to go over there and see about whether we could get my mother-in-law in or not. While I was talking to him, he told me he couldn't take any patients until after July.

If he was funded then, he could take them. So I started checking around then to see how far she would be down on the list. And within a mile where I live, there is a man signed up to go to Hopemount and it has been over a year ago. He is 135 on the list. Over 8 months ago there was another woman that is within a quarter of a mile where I live, she signed up and got ready to go, but she is 50 on the list.

So there would be no chance whatever that the beds would be filled up now, if even they signed them up to get them in over there. Who makes the decisions whether our tax money goes to take care of our senior citizens or our older people or whether it goes to get a bushel of rocks? I have never been asked to go to anything like this. Do the Senators just take it on themselves to make these laws without asking the people?

Senator KENNEDY. The Congressmen and Senators are supposed to be voting your interests. Sometimes they do and sometimes they don't.

Mrs. HILL. This is the first time I have ever seen anybody come out to talk to the public like this. I am a little over 27. So it has been a long time.

I think if they are going to make the rules and laws to go by, if the DPA goes by it, I think they ought to come out and get the public need of what we need in our communities.

I want to thank you both.

Senator KENNEDY. I couldn't agree more. We spend $5,300 to kill a Vietcong and we spend $1,000 for an American living on welfare. What is important? I think it is probably more important, personally, that we start looking out after the people here.

Mrs. HILL. I went in homes after homes when I know old people are laying there in pain and suffering. They have a humane society

to take care of animals, but our old people, we just don't care about them.

Mrs. MILNE. I think Dr. Davis' statement a while ago, regarding the group between age 50 and 65 that have no coverage whatsoever, this is the group we have to reach. It is very, very sad.

Senator KENNEDY. Thank you very much.

STATEMENT OF SAMUEL F. BORDY

Mr. BORDY. There is a certain hospital in Morgantown. I am not mentioning any names. I had two heart attacks, and I went after the second one I had to the emergency room. They wouldn't even leave me in the emergency room because I was on welfare. It took me an hour and a half before I could get hold of a nurse. Then she treated me like I was a dog or something, take you out in the hallway and strip down and give you a shot in the hallway, and turn you loose like you was a wild animal or something. So I don't think that is right.

Senator KENNEDY. I don't think it is right, either. I appreciate your making your statement. Thank you very much.

It is just the kind of statement we are interested in. It shows people who have emergency situations and how the health system responds to them.

STATEMENT OF PRESTON BROWNING

Mr. BROWNING. I would like to question your financing of the program. I don't think anyone will deny the need for the program. My question is: The 1 percent of the employees, plus 3.5 percent on the payroll, are we going to still pay this on top of our regular Internal Revenue?

Senator KENNEDY. You are going to pay it on top of income taxes, that is right, and it is going to amount to anywhere from $15 to $20 billion a year nationally. But you also are going to have reductions in taxes for medicaid and other programs, and you are going to have no insurance premiums.

Mr. BROWNING. Will this do away with medicare and medicaid?

Senator KENNEDY. Effectively, yes.

Mr. BROWNING. What about private consumer costs to the doctor?

Senator KENNEDY. In what respect?

Mr. BROWNING. On a regular call for a physical or for medical examination?

Senator KENNEDY. The plan would pay these costs. These costs should be lower too. We hope to develop different delivery systems. We are going to have incentives within this bill that will encourage group practices. Let me stress also that it will maintain private hospitals and private practice in many instances.

There will be the possibility of private services. But the emphasis is going to be on group practice.

We will also try to develop health maintenance organizations and neighborhood health centers, and we will set strict Federal standards in terms of quality control.

We hope various groups will compete to see who is going to provide comprehensive services for a particular community. One group will

say, "I will do it for x." Another will say, "I will do it for x dollars minus $1,000."

Based upon competition which is going to drive health costs down, we will provide more efficiencies in the health systems.

We are going to change the system dramatically with national health insurance. There shouldn't be any question about it.

The question always comes up, "Can we afford this?" I will ask you: "Can we afford not to do it?"

I think we have each used more than our minute. I am sure you have some more to say. I will be glad to respond to any of the questions you have. I am always glad to do it.

Mr. BROWNING. I was looking at the pamphlets passed out concerning the bill you introduced. You said we will take one percent and up to $15,000 a year.

Senator KENNEDY. That is right.

Mr. BROWNING. This covers all personnel employed in the United States?

Senator KENNEDY. That is right. There are certain parts of nursing home care which we don't cover. There are certain kinds of psychiatric care we don't cover. We should include it in the legislation. I am flexible in terms of coverage. We have taken the best of the recommendations of the medical economists.

I am for covering drugs also. If I think I could get the support in the Senate, I will put these things through. I think we have a basic program designed to carry out fundamental reforms. It is one we can defend in terms of costs. But I personally would support expansion of it.

Mr. BROWNING. The provision for taxes, concerning Internal Revenue Service, what kind of loopholes are there in that that people can use, such as taking Health Security Act tax as a deduction on their Internal Revenue Service? Can this be done?

Senator KENNEDY. I don't believe it can be.

Mr. BROWNING. Eighty-five percent of the taxes are paid between salaries of $8,000 and so on.

Senator KENNEDY. If there is a loophole there, we will close it. I don't have any problem in terms of the loopholes. I was a sponsor of the minimum income tax, which I think was the most significant and important tax reform measure before the Senate in the last Congress. Unfortunately, we were only able to get 22 votes in the Senate. I am realistic about tax loopholes and I am all for closing that up.

The real point is that we are already paying for health care now. You are paying for it now. And you are paying for all kinds of inefficiencies. We think if we eliminate the inefficiencies, we can supply more care to more people at the same cost.

The administration said our program would cost $77 billion. They took inflated figures. I am not willing to accept their figures.

But this country is spending $70 billion on health care this year. Our program isn't to go into effect for another year.

In effect, even using their figures, it would only cost $7 billion more next year than this year, and we'd provide more services.

People say our plan is socialized medicine—it's Federal control—it's all kinds of bad things. But it's none of these. It's most like social se-

curity or medicare. It extends social security and medicare type programs to everyone instead of just to those over 65.

We have got a lot of problems with the program. It is not perfect. We are wide open to recommendations. We would welcome them. We are going to have a tough time getting it through Congress.

Senator RANDOLPH. Mr. Chairman, as we conclude this formal hearing, there is one phase that we have not discussed which I think should be included in our record, which is the problem of the closing, which is imminent, of beds in the veterans hospitals in the State of West Virginia. Thirty-six beds are to be eliminated at the veterans hospital in Clarksburg, which is approximately an hour and 15 minutes from Kingwood. Those beds would be unavailable to veterans.

Throughout the State it is a very real problem.

I want personally—I am sure the chairman would express it officially—to thank the people who have come here this afternoon.

I watched you as you sat there very quietly, earnestly a part of this hearing, not speaking, but thinking with us, and Mr. Chairman, I hope that the record can be kept open and if the people sitting in this audience have thoughts, that these can be addressed to the Subcommittee on Health for consideration in connection with this hearing.

Senator KENNEDY. We will keep the record open for 10 days. Any comments you would like to make, write to us and we will make them a part of the record.

Send it to Edward Kennedy, Senate Health Subcommittee, U.S. Senate, Washington, D.C. We are going to be there another 5 years, anyway. [Laughter.]

Senator RANDOLPH. Senator, I want to express appreciation for the subcommittee coming into West Virginia today.

I think the hearings, some 3 hours of testimony and comment, have been most helpful. I know that our conference later today with the university officials, including the doctors and students there, will be of value.

Our visits here in Kingwood and in Fairmont have all contributed to a good record.

Thank you very much for coming.

Senator KENNEDY. Thank you very much.

At this point I order printed all statements of those who could not attend and other pertinent information submitted for the record.

(The material referred to follows:)

West Virginia University

MORGANTOWN, WEST VIRGINIA 26506

School of Medicine

April 28, 1971

The Honorable
Edward M. Kennedy
Chairman, Subcommittee on Health
Committee on Labor and Public Welfare
U. S. Senate
Washington, D. C. 20510

Dear Mr. Chairman:

We are writing in follow up to the hearings held in Kingwood, West Virginia, on April 19, 1971. The enclosed material is submitted for the record in response to the interest expressed by your staff in data we have been developing about some isolated rural West Virginia counties.

Attached are nine tables concerning a six-county area which we have labelled "The Gilmer Circle" (Braxton, Calhoun, Doddridge, Gilmer, Lewis, and Ritchie Counties). These counties are located in central West Virginia and consist of a land area of 2,300 square miles and a population of 61,875. The most populous county is Lewis with 17,847 persons and the least populated is Doddridge (6,389). However, in size, Braxton and Ritchie are the largest.

None of the counties has an urbanized area and the only county with an urban center is Lewis, which has 41 percent of its population living in and around the city of Weston (7,323). The other five counties are totally rural. The six counties have 15 towns, six of them between 1,031 and 2,183 population, and the other nine of them quite small (two below 160; five others 220, 252, 267, 397, and 412; and the final two, 591 and 795.) The latter town is the only one in Calhoun County. Eleven of the 16 towns have lost population during the last decade and Glenville, the town with the greatest gain, has increased its population through a rising college enrollment. There is a population loss of 10 percent in the "large" towns, small towns, and the country area, and a 15 percent loss in the cities (based on one city only--Weston).

Declining Population

During the last 20 years the six-county region has lost 23.3 percent of its population. (See Table 1.) During the decade of the 1950's the loss was 15 percent and during the 1960's it was 10 percent. With a declining population there is now an average of 27 persons per square mile in the six-county area, down from 35 persons per square mile twenty years ago. Doddridge has the lowest density (20 persons per square mile.)

Table 2 shows the changes in age groups for the state and the individual counties. For each county the population loss is greatest for young children. In some counties the decrease in the under 5 years of age group is over 50 percent. For example, in Calhoun county the under 5 group represented one person out of every eight in 1950; today it is one person out of every 14. In some of the towns one rarely sees a small child. Older children are also fewer proportionately.

In all but Gilmer the 20-44 year group is reduced and the 45-64 year group has also decreased in the entire region. The only population gain is in the elderly (65 and over) in three counties, but in three others, even this group has been reduced. Between 1960-1970, this was a change for Doddridge, Lewis, and Ritchie, which had posted gains in the aged population during the 1950's. The decrease in the number of elderly in 1960-1970 in these counties is contrary to state trends. Statewise the 45-64 year group has increased, but this is not true for the region under study.

The atypical population distribution has resulted in a substantially lower birth rate and a higher crude death rate in this area as compared to the United States as a whole. In two counties the crude death rate exceeds the birth rate resulting in a decline in the natural population. Combined with out-migration, one can understand why the population has declined so drastically.

Although not documented, there are indications that some persons over 55 are returning to these rural areas (when they are laid off from their jobs in the cities or are disabled). This means that the out-migration of younger workers and able-bodied, middle-aged workers is even greater than the statistics show. The people that are left are largely the poor, the sick, the disabled, and the aged. Yet, the public services (welfare, health, mental health) are very weak and cannot handle this needy population. Hospital beds, physicians, and other medical resources are virtually nonexistent in many areas.

Economic Activity

Per capita income (1965) ranged from $951 to $1,449 in the six Circle counties and was even lower in some of the neighboring counties (e.g., Clay, $712; Wirt $715). (See Table 3.) Unemployment in June 1970 was below five percent in Gilmer, but rose to nine percent in three counties and was 15 percent in Calhoun, despite the fact that many workers have left this region. The most workers were employed by the government (schools, city and county work, post offices), as manufacturing was light in the six-county area. Only a small proportion of the work force is engaged in agriculture. Although the region contains enormous recoverable coal reserves, there is actually very little mining. The accident rate in the region is extremely high (Table 4) compared to the state as a whole and considering the small amount of mining.

Typical of these counties is the following description of economic activity in one county. The major sources of wages and salaries in Braxton County in 1965 were the government (15 percent of the total), transportation,

communication, and public utilities (seven percent), and wholesale and retail trade (eight percent). Manufacturing contributed just four percent of the wages, and farming, less than two percent. The leading industries and chief agricultural products are lumbering, natural gas, coal, dairy, livestock, poultry, and hay and grain. Such basic farming products as eggs and milk both declined in volume between 1954 and 1964. (Egg production dropped 77 percent and milk production dropped 46 percent.) Coal production was just 3,000 tons in 1968. There were two underground coal mining operations in 1968 and these employed only six production employees who worked an average of 76 days each throughout the year.

Braxton lost almost one-third of its population during the last 20 years. Unemployment was 9.3 percent in June 1970 and employment has declined. Per capita income in 1965 was $1,036. Transfer payments in 1965 totaled $3,655,000, one-fifth of the total personal income. These include old age, welfare, veteran, pension, and similar government and business payments. Seventy-two percent of the transfer payments were paid by the Federal government, 25 percent were paid by state and local governments, and three percent, by businesses.

The Poor

There are an overwhelming proportion of poor families in the Gilmer region (5,458 of the region's 16,844 families were classified as poor in 1966). Ritchie has 27 percent of its families rated poor by Social Security standards of income and family size, but Braxton, Calhoun, and Gilmer had 37-39 percent of their families rated below the poverty level. Only 10-12 percent of all counties in the United States have a higher proportion of poor families than are found in Braxton, Calhoun, and Gilmer Counties. (See Table 5.) These counties all have a higher proportion of poverty families than the state as a whole.

Welfare payments are quite low, and there appear to be wide differences among payments to recipients within the six-county region (e.g., Table 6 shows average payments for Braxton lower than those in the other five counties). Average monthly payments for Aid to Families with Dependent Children is about $90. As can be noted, only a small proportion of the poverty families are on welfare. The reason for this is that most of the poor families belong to the working poor--wage earners at minimal salaries.

Health Resources

Throughout the region there is a shortage of health practitioners, and the few practicing physicians and dentists are overworked, consequently. The following is a description of health resources in Gilmer County. Glenville, the county seat, is the home of two osteopaths, two general practitioners, and one dentist. However, the two general practitioners are both over 80 years of age and in poor health; the two osteopaths, both nearly 60 years and aged beyond their years, have exceedingly busy practices. One of them fills in as the physician for Glenville State College since the College has been unable to recruit its own doctor. The dentist resident in Glenville is young and conscientious; he handles virtually all the dentistry for Gilmer, as well as caring for residents from neighboring counties. He is too busy to serve the schools.

The local health department consists of the health officer who is over 80 years of age and has been paralyzed for several years; a public health nurse, near retirement; and a clerk. The county has not been able to recruit a sanitarian. The entire county health budget was $19,229 for fiscal 1970 (and it is doubtful that even this much was spent). Only $591 was from federal sources; local appropriations covered 71 percent of the budget.

There is no hospital in Gilmer County; the closest hospitals are up to an hour away (a 25-bed hospital in Grantsville, Calhoun County, and a new hospital which is being built in Weston, Lewis County, to replace the present hospital facility). Presently the residents of Gilmer County must travel to one of the neighboring counties when in need of hospitalization or specialization. One former resident recalled traveling 60-100 miles for medical care, and this, over roads and terrain that are rugged. It is the hope that the Interstate Highway 79 will be completed within a few years, reducing travel time to urban medical centers. Glenville will be about 15 miles from the Interstate. Gilmer County desperately needs transportation to out-of-county hospitals, as well as emergency care and local practitioners. In a county where about half of the families earn less than $3,000 annually and welfare costs are far higher than the state norm, travel is too expensive for the majority.

It should be pointed out that Gilmer County and these other rural counties support their health budgets with local and state funds and receive very little federal assistance. (See Table 7.)

Tables 8 and 9 show the distribution of physicians, dentists, and hospital beds in the six-county area. Some counties do not have hospitals. Residents of these counties must travel long distances for hospital and emergency care over narrow, winding roads. In the wintertime, travel over these roads is extremely slow and hazardous.

Clay and Doddridge Counties do not have any physicians or dentists. Population ratios run up to one active dentist to 14,111 persons in Roane County. Many of the physicians and dentists are between 55 and 70 years. Considering that in 1963 Gilmer County had five physicians; Braxton, 17; Doddridge, 10; Clay, five; and Ritchie, 15, it is clear that when physicians have retired or died, they have not been replaced.

Nurses, sanitarians, and other health practitioners are in exceedingly short supply in these rural areas.

We are currently studying the problems of rural health delivery and are seeking ways of attracting physicians to rural areas. The recently passed Emergency Health Personnel Act of 1970 could be helpful to West Virginia.

Using new types of manpower such as nurse practitioners, physician's assistants, and health aides will help, but not alleviate the situation. Needed for areas such as these are massive federal support to assist in

organizing and financing the immediate delivery of primary care and, then, the long-range programs to train family physicians and new types of manpower.

We support the idea of comprehensive national health insurance as one way of alleviating the financial burden of paying for care. However, payment mechanisms alone cannot solve the problem of health care for rural populations.

We appreciate the privilege of offering our comments, and thank you, Mr. Chairman and members of the Subcommittee, for your consideration of our views.

Sincerely yours,

Jerome L. Schwartz

Jerome L. Schwartz, Dr.P.H.
Visiting Professor of Public
Health and Preventive Medicine

and

Robert L. Nolan

Robert L. Nolan, M.D., J.D.
Professor and Chairman
Division of Public Health
and Preventive Medicine

JLS:nmt

Encls.

Table 1

POPULATION DATA, 1950 TO 1970

State, Gilmer Circle, and Neighboring Counties of West Virginia

	Census Population			Percent Net Change			Percent Net Migration	Percent Natural Population Gain	Live Birth Rate	Crude Death Rate
	1950	1960	1970	1940-50	1950-60	1960-70	1950-60	1950-60	1969*	1969*
West Virginia	2,005,552	1,860,421	1,744,237	+ 5.4	- 7.2	- 6.2			16.8	10.8
Gilmer Circle Counties										
Braxton	18,082	15,152	12,666	-16.5	-16.2	-16.4	-28.4	12.2	12.7	14.4
Calhoun	10,259	7,948	7,046	-17.6	-22.5	-11.4	-32.2	9.7	16.2	12.9
Doddridge	9,026	6,970	6,389	-17.4	-22.8	- 8.3	-27.4	4.6	12.8	16.6
Gilmer	9,746	8,050	7,782	-19.1	-17.4	- 3.3	-24.3	6.9	13.7	12.9
Lewis	21,074	19,711	17,847	+ 5.4	- 6.5	- 9.5	-12.8	6.3	15.8	13.0
Ritchie	12,535	10,877	10,145	-18.5	-13.2	- 6.7	-17.8	4.6	16.9	14.9
Neighboring Counties										
Barbour	19,745	15,474	14,030	+ 0.6	-21.6	- 9.3	-29.7	8.1	13.6	13.8
Clay	14,961	11,942	9,330	- 1.6	-20.2	-21.9	-41.2	21.0	17.7	11.0
Monongalia	60,797	55,617	63,714	+18.6	- 8.5	+14.6	-19.7	11.2	15.9	9.1
Nicholas	27,696	25,414	22,552	+15.1	- 8.2	-11.3	-25.9	17.7	16.6	11.2
Preston	31,399	27,233	25,455	+ 3.2	-13.3	- 6.5	-26.4	13.2	17.0	10.9
Roane	18,408	15,720	14,111	-11.4	-14.6	-10.2	-22.7	8.1	14.1	12.2
Taylor	18,422	15,010	13,878	+ 7.5	-18.5	- 7.5	-25.2	6.7	15.4	13.7
Webster	17,888	13,719	9,809	+ 1.1	-23.3	-28.5	-38.3	15.0	20.5	16.7
Wirt	5,119	4,391	4,154	-20.9	-14.2	- 5.4	-19.6	5.4	14.5	13.5

*The live birth and total death rates for the U.S. were 17.7 and 9.5, respectively, per 1000 population in 1969.

Sources: Bureau of the Census, U.S. Department of Commerce: Final Population Counts. January 11, 1971.

Bureau of the Census, U.S. Department of Commerce: U.S. Census of Population: 1960 Final Report PC (1)-50A. U.S.G.P.O., 1961.

Information Center, Office of Economic Opportunity: "Community Profile Project." Computer Printout, OEO, Charleston, W. Va., received December 1970.

Division of Vital Statistics, West Virginia Department of Health: Public Health Statistics of West Virginia, 1969. West Virginia State Department of Health, Charleston, W. Va.

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Table 2

POPULATION BY AGE GROUPS, 1950, 1960 AND 1970

State and Gilmer Circle Counties of West Virginia

	Population			Percent of Total			Percent Increase or Decrease	
	1950	1960	1970	1950	1960	1970	1950-60	1960-70
West Virginia	2,005,552	1,860,421	1,744,237	100.0	100.0	100.0	- 7.2	- 6.2
Under 5	240,107	196,295	139,021	12.0	10.6	8.0	-18.2	-29.2
5-19	562,809	558,637	508,309	28.1	30.0	29.1	- 0.7	- 9.0
20-44	720,383	560,666	511,954	35.9	30.1	29.4	-22.2	- 8.7
45-64	343,727	372,307	390,833	17.1	20.0	22.4	+ 8.3	+ 5.0
65 & over	138,526	172,516	194,120	6.9	9.3	11.1	+24.5	+12.5
Braxton	18,082	15,152	12,666	100.0	100.0	100.0	-16.2	-16.4
Under 5	2,110	1,548	962	11.7	10.2	7.6	-26.6	-37.8
5-19	5,740	4,865	3,639	31.7	32.1	28.7	-15.2	-25.2
20-44	5,281	3,798	3,173	29.2	25.1	25.1	-28.1	-16.5
45-64	3,181	3,079	2,993	17.6	20.3	23.6	- 3.2	- 2.8
65 & over	1,770	1,862	1,899	9.8	12.3	15.0	+ 5.2	+ 2.0
Calhoun	10,259	7,948	7,046	100.0	100.0	100.0	-22.5	-11.3
Under 5	1,251	766	534	12.2	9.6	7.6	-38.8	-30.3
5-19	3,447	2,545	2,058	33.6	32.0	29.2	-26.2	-19.1
20-44	2,984	2,018	1,814	29.1	25.4	25.7	-32.4	-10.1
45-64	1,683	1,681	1,640	16.4	21.2	23.3	- 0.1	- 2.4
65 & over	894	938	1,000	8.7	11.8	14.2	+ 5.0	+ 6.6
Doddridge	9,026	6,970	6,389	100.0	100.0	100.0	-22.8	- 8.3
Under 5	1,007	653	471	11.2	9.4	7.4	-35.2	-27.9
5-19	2,609	2,009	1,827	28.9	28.8	28.6	-23.0	- 9.1
20-44	2,684	1,674	1,514	29.7	24.0	23.7	-37.6	- 9.6
45-64	1,733	1,564	1,524	19.2	22.4	23.8	- 9.8	- 2.6
65 & over	993	1,070	1,053	11.0	15.4	16.5	+ 7.8	- 1.6
Gilmer	9,746	8,050	7,782	100.0	100.0	100.0	-17.4	- 3.3
Under 5	1,061	768	540	10.9	9.5	6.9	-27.6	-29.7
5-19	2,992	2,537	2,534	30.7	31.5	32.6	-15.2	- 0.1
20-44	3,088	2,195	2,224	31.7	27.3	28.6	-28.9	+ 1.3
45-64	1,700	1,624	1,460	17.4	20.2	18.8	- 4.5	-10.1
65 & over	905	926	1,024	9.3	11.5	13.1	+ 2.3	+10.6
Lewis	21,074	19,711	17,847	100.0	100.0	100.0	- 6.5	- 9.5
Under 5	1,961	1,533	1,274	9.3	7.8	7.2	-21.8	-16.9
5-19	4,889	4,638	4,344	23.2	23.5	24.3	- 5.1	- 6.3
20-44	6,876	5,481	4,859	32.6	27.8	27.2	-20.3	-11.3
45-64	4,656	4,937	4,420	22.1	25.1	24.8	+ 6.0	-10.5
65 & over	2,692	3,122	2,950	12.8	15.8	16.5	+16.0	- 5.5
Ritchie	12,535	10,877	10,145	100.0	100.0	100.0	-13.2	- 6.7
Under 5	1,295	1,036	779	10.3	9.5	7.7	-20.0	-24.8
5-19	3,312	2,927	2,771	26.4	26.9	27.3	-11.6	- 5.3
20-44	3,659	2,716	2,570	29.2	25.0	25.3	-25.8	- 5.4
45-64	2,591	2,387	2,283	20.7	22.0	22.5	- 7.9	- 4.4
65 & over	1,678	1,811	1,742	13.4	16.6	17.2	+ 7.9	- 3.8

Source: Date from U. S. Census. Calculations by West Virginia State Department of Health and Div. PH&PM Rural Health Services Research Program.

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Table 3

ESTIMATED PERSONAL INCOME BY SOURCE, 1965

State and Gilmer Circle Counties of West Virginia

	West Virginia	Braxton	Calhoun	Doddridge	Gilmer	Lewis	Ritchie
Per capita personal income (in absolute dollars)	$ 2,065	$ 1,036	$ 1,084	$ 951	$ 1,205	$ 1,449	$ 1,252
Total personal income* (in thousands of dollars)	3,749,730	15,317	8,430	6,741	10,192	28,844	13,265
Total wages and salaries	2,526,042	7,530	4,610	3,855	6,416	18,385	8,102
Farms	8,000	56	34	36	44	105	68
Mining	320,800	309	672	523	2,817	1,654	1,473
Contract construction	133,100	376	65	350	528	268	148
Manufacturing	829,500	652	937	281	147	4,533	2,534
Transportation, communication, and public utilities	256,001	1,057	842	958	599	3,088	789
Wholesale and retail trade	331,200	1,337	283	281	316	2,509	743
Services	207,300	1,185	253	223	427	1,844	649
Government	370,041	2,401	1,687	1,103	1,408	4,067	1,572
Proprietors income	288,163	757	587	489	378	1,531	521
Property income	456,814	3,163	1,239	849	1,488	3,843	1,828
Transfer payments	415,682	1,655	1,858	1,481	1,767	4,673	2,624

*Totals do not add because certain miscellaneous sources of income have been ommitted.

Source: Leyden, Dennis R. and Rader, Robert D.: County Personal Income, West Virginia, 1962-1965. West Virginia University Economic Development Services, Number 11, Bureau of Business Research, December 1968.

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Table 4

ACCIDENTS FOR INSURED EMPLOYEES UNDER WORKMEN'S COMPENSATION,
YEAR ENDING JUNE 30, 1970

State, Gilmer Circle, and Neighboring Counties of West Virginia

Area	Total accidents	Fatal accidents	Non-fatal accidents	Number of employees	Accidents/ $1 million wages
West Virginia	55,317	197	55,120	470,713	19
Gilmer Circle Counties					
Gilmer	76	2	74	920	20
Lewis	359	0	359	2,599	30
Doddridge	98	1	97	775	35
Ritchie	178	0	178	1,525	28
Calhoun	75	0	75	1,712	7
Braxton	214	2	212	1,572	41
Neighboring Counties					
Wirt	38	0	38	218	46
Roane	173	0	173	2,180	21
Clay	51	0	51	606	23
Nicholas	1,204	6	1,198	3,890	54
Webster	87	2	85	904	16

Source: State Workmen's Compensation Commissioner: Unpublished data, undated.

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Table 5

POOR FAMILIES, 1960 AND 1966

State, Gilmer Circle, and Neighboring Counties of West Virginia

	Number of Families		Poor Families[a] Number		Poor Families[a] Percent		Percent U.S. Counties Having Lower Percent of Poor Families[a]		Percent County Families of State Total	Percent Poor Families in County of State Total
	1960	1966	1960	1966	1960	1966	1960	1966	1966	1966
West Virginia	462,100	482,900	139,400	105,900	30.1	21.9			100.0	100.0
Gilmer Circle Counties										
Braxton	3,681	3,278	1,923	1,265	52.2	38.6	89	90	0.8	1.2
Calhoun	1,993	1,817	1,009	670	50.6	36.9	87	87	0.4	0.6
Doddridge	1,756	1,974	733	602	41.7	30.5	77	74	0.4	0.6
Gilmer	1,911	2,034	955	763	50.0	37.5	87	88	0.4	0.7
Lewis	4,562	4,950	1,698	1,398	37.2	28.2	68	70	1.1	1.3
Ritchie	2,865	2,791	1,094	760	38.2	27.2	72	65	0.6	0.7
Neighboring Counties										
Barbour	3,838	3,396	1,863	1,229	48.7	36.2	85	86	0.8	1.2
Clay	2,625	2,251	1,530	1,051	58.3	46.7	95	98[b]	0.6	1.0
Monongalia	13,777	15,457	3,558	3,012	25.8	19.5	54	37	3.0	2.8
Nicholas	6,013	5,467	2,570	1,829	42.7	33.5	78	81	1.3	1.7
Preston	6,549	6,079	2,894	2,140	44.2	35.2	80	84	1.4	2.0
Roane	3,767	3,590	1,597	1,150	42.4	32.0	77	78	0.8	1.1
Taylor	3,878	3,829	1,485	1,090	38.3	28.5	72	69	0.8	1.0
Webster	3,149	2,673	1,798	1,185	57.1	44.3	94	96	0.7	1.1
Wirt	1,143	1,082	469	311	41.0	28.7	76	70	0.2	0.3

[a]In the typical county in the United States in 1966 there were 1,221 families ranked as poor. This represented 15.1% of total families in that "typical" county.

[b]Ninety-eight percent means that only two percent of all U. S. counties had a greater proportion of poor families than Clay County.

Source: Information Center, Office of Economic Opportunity., "Community Profile Project." Computer Printout, OEO, Charleston, W. Va., received December 1970.

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Table 6

WELFARE PAYMENTS BY CATEGORY, JULY 1968 - JUNE 1969

Fifteen Selected Counties of West Virginia

County	Old Age Assistance			Aid to the Blind			Aid to the Disabled			Aid to Fam w/Depen Chil		
	Annual Payments	Avg. Cases	Avg. Mo. Payments	Annual Payments	Avg. Cases	Avg. Mo. Payments	Annual Payments	Avg. Cases	Avg. Mo. Payments	Annual Payments	Avg. Cases	Avg. Mo. Payments
Gilmer Circle counties Area totals	$ 951,257	1,039		$ 23,172	33		$232,677	376		$1,269,855	703	
Braxton	96,142	187	$ 42.84	2,981	6	$ 41.33	48,621	109	$ 37.17	360,252	193	$ 89.50
Calhoun	67,982	108	52.45	1,102	2	46.00	37,625	62	50.56	272,902	130	95.98
Doddridge	65,981	62	88.68	777	1	65.00	13,739	20	57.25	55,596	22	89.91
Gilmer	62,604	102	51.15	3,172	5	52.80	31,782	51	51.94	176,356	92	99.90
Lewis	502,786	449	93.31	9,288	13	59.54	68,506	97	58.86	269,111	193	90.92
Ritchie	155,762	131	99.08	5,852	6	81.17	32,404	37	72.97	135,637	73	96.62
Neighboring counties												
Barbour	73,969	115	53.60	7,519	12	52.25	46,296	81	47.63	279,929	129	86.15
Clay	51,041	104	40.89	1,736	3	48.33	39,206	81	40.33	445,395	210	92.24
Monongalia	199,530	171	97.24	8,584	10	71.50	62,869	74	70.80	256,379	139	113.04
Nicholas	87,110	142	51.12	4,306	7	51.29	50,516	99	42.53	319,215	167	96.28
Preston	75,917	128	49.42	4,239	9	39.22	43,662	85	42.81	264,685	138	93.51
Roane	276,862	284	81.24	1,625	4	33.75	49,939	84	49.55	330,421	163	102.62
Taylor	78,985	92	71.54	2,270	1	189.00	22,997	37	51.78	146,733	62	95.89
Webster	85,176	166	42.76	4,511	7	53.71	46,256	80	48.19	492,809	264	93.52
Wirt	25,051	45	46.40	1,410	2	59.00	11,043	21	43.81	35,317	24	95.21

Source: West Virginia Department of Welfare: Annual Report, July 1, 1968 to June 30, 1969. Charleston, W. Va.

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Table 7

WEST VIRGINIA LOCAL HEALTH BUDGETS, FISCAL YEAR 1970

State and Fifteen Selected Counties of West Virginia

County	Budget and Sources							Local Appropriations					
	Total	Federal		State		Local		County Court	Municipality	Board of Ed.	Home Health	Other	Per Capita
		Amount	%	Amount	%	Amount	%						
State	4,095,707	728,198	17.8	599,497	14.6	2,768,012	67.6	1,358,494	511,034	328,525	245,551	324,408	2.35
Barbour	27,030	6,701	24.8	5,579	20.6	14,750	54.6	6,200	1,900	6,000	--	650	1.93
Braxton	19,354	595	3.1	10,072	52.0	8,687	44.9	3,540	--	4,500	--	647	1.53
Calhoun	23,049	434	1.9	4,763	20.7	17,852	77.5	5,039	--	5,150	--	7,663	3.27
Clay	31,271	9,771	31.2	9,542	30.5	11,958	38.2	4,368	--	4,368	--	3,222	3.35
Doddridge	18,560	365	2.0	4,390	23.7	13,805	74.4	7,413	--	600	--	5,792	2.91
Gilmer	19,229	591	3.1	4,988	25.9	13,650	71.0	5,594	--	3,911	--	4,145	2.47
Lewis	26,439	2,410	9.1	7,557	28.6	16,472	62.3	13,140	1,179	1,764	--	389	1.48
Monongalia	702,167	447,154	63.7	23,518	3.3	231,495	33.0	94,850	8,934	16,500	112,211	--	11.02
Nicholas	34,970	2,352	6.7	11,526	33.0	21,092	60.3	8,286	--	7,000	--	5,806	1.55
Preston	33,580	1,600	4.8	13,241	39.4	18,739	55.8	12,739	--	6,000	--	--	1.32
Ritchie	15,500	428	2.8	4,484	28.9	10,588	68.3	3,894	--	3,894	--	2,800	1.53
Roane	21,809	582	2.7	7,016	32.2	14,211	65.2	5,905	300	8,006	--	--	1.55
Taylor	42,355	1,396	3.3	9,657	22.8	31,302	73.9	4,000	2,000	3,500	21,302	500	3.05
Webster	21,941	570	2.6	8,568	39.1	12,803	58.4	2,500	--	4,477	--	5,826	2.24
Wirt	12,789	5,138	40.2	1,651	12.9	6,000	46.9	3,000	500	2,500	--	--	3.08

Source: West Virginia State Department of Health: "Local Health Budgets - 1970 Fiscal Year." Unpublished data, Charleston, W.Va., June 30,1970.

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Table 8

ACTIVE* PHYSICIANS AND DENTISTS

AND PRACTITIONER RATIOS PER POPULATION, 1971

Gilmer Circle, Neighboring, and Nearby Counties of West Virginia

	Physicians		Dentists	
	No.	Ratio	No.	Ratio
Gilmer Circle Counties				
Braxton	3	1/4,222	2	1/6,333
Calhoun	2	1/3,523	0	--
Doddridge	0	--	0	--
Gilmer	2	1/3,891	1	1/7,782
Lewis	6	1/2,975	2	1/8,924
Ritchie	4	1/2,536	1	1/10,145
Neighboring Counties				
Clay	0	--	0	--
Nicholas	10	1/2,255	5	1/4,510
Roane	6	1/2,352	1	1/14,111
Webster	4	1/2,452	1	1/9,809
Wirt	½	1/8,308	1	1/4,154
Nearby Counties				
Barbour	18	1/779	3	1/4,677
Preston	6	1/4,243	7	1/3,636
Taylor	5	1/2,776	3	1/4,636

*Not included are aged physicians who have limited practices, spend part of the year in Florida, or are disabled.

Source: Telephone calls to each county.

Table 9

HOSPITAL DESCRIPTION AND STATISTICS

Gilmer Circle and Secondary Counties*

	Lewis[1]		Calhoun	Braxton	Roane		Nicholas	Webster
Name	Jackson Memorial	Weston State	Calhoun General	Gassaway	Gordon Memorial	Spencer State	Sacred Heart	Webster
Town	Weston	Weston	Grantsville	Gassaway	Spencer	Spencer	Richwood	Webster Springs
Control	Non-profit	State	County	Corp.	Corp.	State	Church	County
Service	Med/Surg	Psych	Med/Surg	Med/Surg	Med/Surg	Psych	Med/Surg	Med/Surg
Stay (term)	Short	Long	Short	Short	Short	Long	Short	Short
Beds	47	2,075	25	22	36	1,037	65	74
Admissions	nr	1,722	nr	990	nr	1,455	2,782	2,107
Census	nr	1,789	nr	20	nr	952	52	48
Occupancy (%)	nr	91.2	nr	91.5	nr	91.8	79.4	64.7
Bassinets	nr	0	nr	5	nr	0	12	6
Births	nr	0	nr	207	nr	0	264	97
Total expense	nr	$5,141,000	nr	$229,000	nr	$2,249,000	$603,000	$424,000
Payroll	nr	$3,366,000	nr	$149,000	nr	$1,526,000	$367,000	$246,000
Personnel	nr	730	nr	30	nr	322	107	72
Approvals	B/M	M	B/M	B/M	B/M	M	J/B/M	J/C/B/M

*No hospitals in Doddridge, Gilmer, Ritchie, Wirt, or Clay Counties. [1]General Osteopathic Hospital, Weston, now closed.
nr--non-reporting
B--Blue Cross; M--Medicare; J--Joint Commission on Accreditation of Hospitals; C--Cancer, American College of Surgery
Source: Hospitals - Guide Issue. Journal of the American Hospital Association, August 1, 1970.

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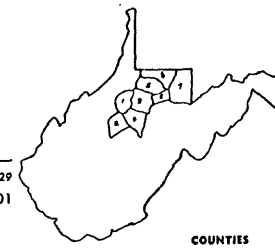
Health Planning ASSOCIATION OF
NORTH CENTRAL WEST VIRGINIA
A NON-PROFIT CORPORATION

POST OFFICE BOX 1329
CLARKSBURG, WEST VIRGINIA 26301



COUNTIES
1. DODDRIDGE
2. GILMER
3. HARRISON
4. LEWIS
5. MARION
6. MONONGALIA
7. PRESTON
8. TAYLOR

OBSERVATIONS ON HEALTH CARE PROBLEMS IN
NORTH CENTRAL WEST VIRGINIA

Senator, as the President of the Health Planning Association of North Central West Virginia it is both a personal privilege and an honor to our agency to have this opportunity to participate in these hearings.

Our Region includes eight (8) counties only three (3) of which have sizeable "urban" populations. Of the three Morgantown has the benefit of the West Virginia University Medical Center and two other hospitals. Clarksburg has the Veteran's Administration Hospital and two recently merged general hospitals. Fairmont has the Fairmont General Hospital and the Fairmont Emergency Hospital which is owned and operated by the State of West Virginia for persons in various state institutions, but which also serves a sizeable number of both indigent and working people of Marion County with care far below acceptable standards. Of the other five (5) counties, only three (3) have hospitals in the county.

Much of the region is rural and small town. There is a diversification of businesses and small industry in addition to mining. The unemployment rate in the region is high in the more rural counties, but is offset somewhat statistically by better conditions in the three major cities.

Our problems are great in terms of health care. There is a critical manpower crisis. Statistics would be misleading if careful attention were not

given to the fact that much of the medical personnel in Monongalia County, the home of the Medical Center, is not involved at all in primary care. Further, if it were not for the existence of a major group practice in Fairmont, the shortage of manpower would be critical in that county. The Fairmont Clinic also operates a branch in Harrison County which helps further to alleviate the burdens there. The Board of the clinic also operates the State's largest home health service which reaches into several counties with significant care across a wide spectrum of medical services. Monongalia County also has a well-staffed Health Department which extends some of its services, especially maternal and infant clinics, into Preston and Taylor Counties. I mention these factors as being highly significant for those who have the benefit of their services. But also to underscore the fact that were it not for the United Mine Workers Welfare Fund's establishment of a group practice clinic with two satellites which has some 70% of its patient load from among mining families, and the location of the State's only medical school in the region, our situation would be tragic. The situation is virtually that serious in some parts of the region.

Doddridge County has had a delegation appear for these hearings to tell of the crisis there. Others have testified to the problems in rural Preston County. But the situation is also grave in Gilmer County and in other counties which it borders which are outside the boundaries of our association. A group of consumers in Gilmer County has organized the Gilmer County Medical Center, Inc. and has initiated efforts to secure federal funds from various sources, but most notably, Hill Burton monies, to build a medical complex. But it should be noted that this is principally an effort to attract doctors and ancillary personnel. Although Glenville State College is located in the county seat, the county is otherwise considered totally rural. Some 54% of the population are low income. Roads in and out of the county are poor. The nearest hospital

is more than 25 miles away. For most medical specialties it is necessary to travel upwards of 40 miles. Much of the population is aged.

Glenville has two aged physicians who have practically ceased to practice and two doctors of osteopathy, both of whom are approaching retirement age. There is one young dentist which the Medical Center, Inc. has attracted and one physician came as a result of these efforts, but left after a short time. Given the experience of Doddridge County, we cannot place too much confidence in the possibility that a new, modern, well-equipped facility will attract doctors or other personnel. It may be imperative to look elsewhere for solutions to the crisis. Alternatives are complicated, however, by the poor nature of roads and the difficulty of travel over our State's beautiful terrain. It is further aggravated by the general shortage of medical facilities and personnel. Solo practice doctors in every location are already carrying very heavy patient loads. Some of our hospitals are placing patients in the hallways. That, of course, is not necessarily an indication of the shortage of space so much as it may indicate unnecessary hospitalization and poor organization and delivery of services. It is encouraged by much of the existing insurance programs. It eats away needlessly at precious Welfare dollars. Statistics will show that the largest amount and percentage of money for health services spent by the West Virginia Department of Welfare goes for hospitalization, the highest cost to service ratio. Virtually none goes for prevention. In further describing the problems of our area's health care it should be noted that many of our doctors are older and without the benefits of more recent training. The same is true of other health providers. Not only do they lack up to date training, Board certification is often not attained by doctors practicing specialties. While modern medicine is available to many at West Virginia University or in some other hospitals or Fairmont Clinic, it is often effectively denied to many of our region's residents. The tragedy of the poor and the aged is clearly discernible.

But the very nature of the problem means that many who could generally afford care cannot get it, or cannot get to it.

I am convinced that several factors must be brought to bear upon our current medical crisis. Of high priority is planning. This must be inclusive, regional and genuine. A business wracked with inefficiency and outlandish costs must come to terms with its waste. More attention must be given to preventive care. Plans and programs must be devised which will reduce the need to travel about to see several doctors or to make long trips to labs or other ancillary services. Drug costs must be reduced by moving toward such plans as generic buying and prescribing. Hospitals must include EKG departments and others which otherwise encourage privateering by private practice physicians. There must be incentives for planning and for participation in planning or conversely, penalties or lack of benefits for those who do not. In my own county, Marion, the Fairmont Clinic and a very few solo doctors will join in planning efforts. Other medical facilities and most of the doctors will not. This makes it nearly impossible to plan seriously and effectively. Consumer participation is mandatory. Public facilities and programs should be required to include on their boards and in their decision making significant percentages of consumers who reflect and represent the population of the service area.

Finally, I would underscore the need for a patient oriented or service directed system. Probably the major weakness of medical centers associated with medical schools is their impersonality. Much of this is understandable since their primary function is education and training. But service must be made more humane. If it cannot be done in the medical school setting, then doctors need to be trained out in the areas where patients live, work, suffer and die. The profit motive is basic in our society. But humanity is even more basic. The health industry must put service to patients ahead of profit. Any other approach is evidence of a truly sick society.

When I look over our region, assess my own immediate community, and analyze my own family's health needs and the available services and the costs, I see the need to encourage group practice wherever feasible and above all to provide a system of prepayment which enables all to have equal access to equal service. I do not believe this can or will ever be achieved without active consumer participation in the planning and the policing of the health industry.

Thank you for your openness to our situation and for the opportunity to present these facts and factors to you and your committee.

Reverend Richard Bowyer

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SECTION 1. THE AREA

A. Geography and Population

The area covered by the Health Planning Association of North Central West Virginia (HPA) has been designated as Region V by the West Virginia Department of Commerce. The State of West Virginia is divided into nine such regions, each one considered to be appropriate for multi-purpose planning and economic development. Region V, sometimes referred to as the Upper Monongahela Valley Region, consists of the eight north central counties of Doddridge, Gilmer, Harrison, Lewis, Marion, Monongalia, Preston, and Taylor. The total land area of the eight county region is 2,963 square miles. The topography is generally quite rugged, with many steep slopes rising from narrow valleys to mountain regions. Only Preston County in the extreme eastern part of the region, adjacent to Maryland, contains a major amount of level land, and this is found principally along river valleys and in plateau areas. This topography provides a relatively small amount of agricultural land in the region, and makes transportation difficult.

According to the 1960 Census of Population, the region had a total population of 274,164 persons, with a range from 6,970 inhabitants in Doddridge County to 77,856 in Harrison County. The West Virginia Blue Book, Vol. 51, for 1967 lists 41 incorporated municipalities within the area. However, only ten of these are listed as urban places in the County and City Data Book for 1967, a statistical abstract supplement of the U. S. Bureau of the Census. Those urban places are listed on the following table (fig. I.1).

fig. I.1

Population of Urban Places

City	County	Population (1960)	Population (1950)	Increase (%)
Bridgeport	Harrison	4,199	2,414	73.9
Clarksburg	Harrison	28,112	32,014	-12.2
Fairmont	Marion	27,477	29,346	-6.4
Grafton	Taylor	5,791	7,365	-21.4
Kingwood	Preston	2,530	2,186	15.7
Mannington	Marion	2,996	3,241	-7.6
Morgantown	Monongalia	22,487	25,525	-11.9
Shinnston	Harrison	2,724	2,793	-2.5
Weston	Lewis	8,754	8,945	-2.1
Westover	Monongalia	4,749	4,318	10.0
		109,819	118,147	-7.05

Thus at the time of the 1960 census, 109,819 persons or 40% of the area population were listed as living in urban places. On the other hand, 164,345 persons or 60% of the area population were listed as living in rural areas. It should also be noted that 84.4% of the urban population of the area is located in three counties--Harrison, Marion, and Monongalia. In the other five counties the urban population is only 17,078 persons, or 15.6% of the urban population of the area.

During the decade between 1950 and 1960 every county in Region V lost population, as is indicated in the following table (fig. I.2).

fig. I.2

County	Population (1960)	Increase 50-60 (%)	Urban (%)	Negro (%)	65 Years and Over (%)
Doddridge	6,970	-22.8	---	---	15.4
Gilmer	8,050	-17.4	---	---	11.5
Harrison	77,856	-8.7	45.0	1.7	11.4
Lewis	19,711	-6.5	44.4	.5	15.8
Marion	63,717	-10.9	47.8	4.3	11.1
Monongalia	55,617	-8.5	49.0	2.0	9.6
Preston	27,233	-13.3	9.3	.4	10.2
Taylor	15,010	-18.5	38.6	1.3	13.6

Thus the table indicates an average loss per county of 13.3% of the county population. Declining employment in traditionally important activities, especially agriculture and mining, as well as an inability of the regional economy to absorb those displaced from these activities and those newly entered into the labor market would appear to be the major reasons for the continued decline in regional population.

Of the 274,164 persons living in the area at the time of the 1960 census, a very small percentage of that total were Negro. Doddridge and Gilmer are indicated to have no Negro population, while Marion County has the highest percentage with 4.3%. Of the cities, Fairmont in Marion County had the highest number of Negro citizens, 5.9% of its population being black. 3.1% of Clarksburg's population was Negro at the time of the 1960 census.

B. The Economy of the Area

According to the West Virginia Department of Commerce, in 1965 the principal sources of employment for the area were agriculture, mining, and manufacturing. Agriculture employed 5.2% of the total employed persons in the area as opposed to 5.6% in the state as a whole; mining in the area employed 11.3% as opposed to 8.5% in the state; and manufacturing employed 20.7% of the area population as compared to 22.8% of the population in the state. The regional rate of unemployment for the same year was 6.5% below the state rate, but still above the rate which prevailed in the Nation at that time. Gilmer County exhibited the highest rate of unemployment (11.1%) while the lowest rate was to be found in Marion County (5%).

Unemployment rates for the region are given for the past four year period on the following table (fig. I.3):

fig. I.3

Unemployment Rates- By County- 1965-66-67-68

	1965	1966	1967	1968
United States	4.5	3.8	3.8	3.6
West Virginia	7.7	6.8	6.3	6.4
Region V	6.5	5.8	5.1	5.4
Doddridge	*	*	*	*
Gilmer	11.1	9.1	9.3	7.2
Harrison	7.4	6.9	5.1	4.2
Lewis	7.9	6.0	7.1	8.7
Marion	5.0	4.6	4.5	4.2
Monongalia	5.4	4.7	4.1	4.0
Preston	7.4	6.5	7.8	8.8
Taylor	*	*	*	16.3

*During 1965-66-67, Doddridge, Harrison, and Taylor Counties were reported as one labor market area. In 1968, Taylor County was reported as a separate labor market area.

Sources: Rates for the United States were taken from Monthly Labor Review, May 1969, vol. 92, no. 5, U. S. Dept. of Labor, Bureau of Labor Statistics. Source of the West Virginia rates is the West Virginia Department of Employment Security.

In West Virginia as a whole, agriculture has traditionally been an important industry. Because of the topography and the general soil condition, farming has been conducted for the most part in West Virginia on a small scale with limited production. There are very few large farms

in the state comparable to what would be found in the great agricultural states from Ohio westward to the Rocky Mountains. In 1961, total farm income in the state of West Virginia was at its lowest level since 1943.

Agriculture has been declining in Region V in recent years much as it has elsewhere in the state. Between 1954 and 1964, the number of farms in the region decreased 42.9% from 10,903 to 6,228. The total farm acreage declined 26% from 1,209,962 acres to 895,962 acres. Nevertheless, from the points of view both of employment and contribution to the gross regional product, agriculture continues to be a significant element of the regional economy. In 1964, the total value of farm products sold in the region amounted to 13.9 million dollars, or 15% of the total value of all farm products sold in the state.

Coal was first discovered in West Virginia in 1742, and following the Civil War, coal mining developed into a major industry in the state. Coal is now found in 44 of the 55 counties, and underlies more than half of the total area of the state.

Region V is one of the principal coal producing regions of the state and annually produces about 1/4 of the total state production of bituminous coal. Within the region, Marion County is the principal producer, ranking fifth among all the counties in the state. Because of the nondisclosure rules relating to operations of individual mining firms, it is difficult to obtain reliable estimates of the total quantity and value of coal production in the region. In 1965, the quantity mined was probably in excess of 25 million tons with a marketed production value in excess of 150 million dollars. Total mining employment in the region amounted to nearly 10,000 persons,

almost 1/3 of which was concentrated in Marion County. Harrison, Marion, Monongalia, and Preston Counties together accounted for over 89.6% of the total regional employment in mining.

A large percentage of the population of the area is directly connected with the mining of coal. The importance of coal production has been on the decline now for several years, and this has vitally affected the area's economy. Further mechanization of the mines has resulted in a great drop in the need for miners with the result that much unemployment has developed in the mining industry.

Manufacturing is the largest single employer in Region V, accounting for approximately 21% of the total regional employment. In 1963, the value added by regional manufacturing amounted to 148.2 million dollars, or slightly more than 8% of the state total. This placed the region in third place among the regions in the state. The manufactured products of Region V include primary metals, fabricated metals, wearing apparel, wood products and, most notably, products made of glass. The cities of Morgantown, Fairmont, Clarksburg, and Weston have long been famous for the high-quality glass produced by their factories. A major factor in the prosperity of the glass industry has always been the importation of foreign glassware, and consequently, the industry has consistently demanded relatively high tariff rates on the basis that it cannot compete with the products of the low wage glass workers of Belgium, Czechoslovakia, and other foreign countries.

The figures for median family income vary widely among the counties which make up Region V. The counties which are the most populous, the most highly urbanized, and the most industrialized--Harrison, Marion,

and Monongalia--have the highest levels of income. Conversely, those rural counties having heavy concentrations of employment in either agriculture or mining, and high levels of unemployment--Doddridge, Gilmer, and Preston--are observed to have the lowest income levels. It should be noted, however, that in no instance do median income figures for the counties approach the median levels found in the nation as a whole. These figures are presented in the following table (fig. I.4).

fig. I.4

Median Income Figures

	Population (1960)	Number of Families (1960)	Median Family Income (1960)	Families Under $3,000 (%)	Families Over $10,000 (%)
United States			$5,660	21.4	15.1
West Virginia			4,572	32.6	8.4
Doddridge	6,970	1,756	3,041	49.5	2.1
Gilmer	8,050	1,911	2,719	54.7	3.0
Harrison	77,856	20,706	4,969	26.6	8.0
Lewis	19,711	4,562	3,503	43.2	5.2
Marion	63,717	17,278	5,153	25.3	10.2
Monongalia	55,617	13,777	4,515	29.6	8.7
Preston	27,233	6,549	3,214	46.4	3.6
Taylor	15,010	3,874	3,425	44.7	2.8

Source: County and City Data Book, 1967, A Statistical Abstract Supplement, U. S. Department of Commerce, Bureau of the Census.

The above table makes it readily apparent that in terms of income, we are dealing with one of the poorer sections of one of the nation's poorest

states. In five of the eight counties, the number of families having an income of less than $3,000 is more than double the figure for the nation as a whole, and the remaining three counties are substantially above the nation also, in terms of the number of low-income families. Gilmer County, the poorest in income, has a median family income equal to 48% of the national median.

C. Death Rates

The tables found in this section deal with the available information on death rates by age, race, and sex, including infant and maternal mortality rates.

fig. I.5

Deaths, Infant and Neonatal Deaths, Number and Rate by County in 1967*

	Deaths		Infant Deaths		Neonatal Deaths	
	Number	Rate	Number	Rate	Number	Rate
West Virginia	19,257	10.6	750	25.6	560	19.1
Doddridge	93	13.8	1	12.2	-	-
Gilmer	93	11.3	-	-	-	-
Harrison	958	12.9	27	23.5	26	22.7
Lewis	260	13.1	7	24.6	6	21.0
Marion	748	12.3	22	22.9	18	18.7
Monongalia	559	10.1	27	27.7	20	20.5
Preston	230	10.9	8	16.5	7	14.4
Taylor	169	11.6	4	19.5	4	19.5

*As reported in Vital Statistics, 1967, Division of Vital Statistics, West Virginia Department of Health.

The Division of Vital Statistics also reported four maternal deaths for the state as a whole, a statewide maternal death rate of .2 for the year 1967.

D. Description of Health Resources in the Area

The following is a listing of the county health departments and the personnel they employ. This information was obtained from questionnaires completed at the request of Frederick Zeller, Director of the Office of Research and Development, West Virginia University, in 1968.

fig. I.6

County Public Health Services

County	Professional Personnel	Full Time	Part-Time
Doddridge	County Health Officer	-	-
	Public Health Nurses	1	-
Gilmer	County Health Officer	-	1
	Public Health Nurses	1	1
Harrison	County Health Officer	1	-
	Public Health Nurses	8	-
	Sanitarians	4	-
	Laboratory Technician	1	-
Lewis	County Health Officer	-	1
	Public Health Nurses	-	-
Marion	County Health Officer	-	1
	Public Health Nurses	7	-
Monongalia	County Health Officer	1	-
	Public Health Nurses	15	-
	Sanitarians	4	-
Preston	County Health Officer	-	2
	Public Health Nurses	1	-
	Sanitarians	1	-
Taylor	County Health Officer	-	1
	Public Health Nurses	5	-
	Sanitarians	1	-
	Speech Therapist	1	-

(now 3)

It should be noted that only two of the eight counties report having a full time health officer. Doddridge County not only did not have the service of a County Health Officer, but reported further that there was not a physician in the entire county, the only one having left the state. This fact is not shown in the following table which was prepared from information contained in the Report of the Health Advisory Committee of the Appalachian Regional Commission (1965). The reported data is for 1963.

fig. I.7

Number of Health Personnel (1963)

County	Doctors (MD & DO)	Dentists	Active RN's
Doddridge	1	2	4
Gilmer	3	1	5
Harrison	71	39	271
Lewis	13	5	39
Marion	64	37	179
Monongalia	129	46	245
Preston	11	7	31
Taylor	8	5	32

For the same year, 1963, the West Virginia Department of Mental Health issued the information listed in the following table:

fig. 1.8

Health Personnel/Population Ratio (1963)

	Physician Ratio	Dentist Ratio	Public Health Nurse Ratio	Sanitarian Ratio
AMA STANDARD	1/700	1/2,000	1/5,000	1/15,000
West Virginia	1/1,153	1/2,494	1/12,700	1/19,755
Doddridge	1/7,473	1/3,736	1/7,473	1/7,473
Gilmer	1/2,204	1/2,939	1/8,817	
Harrison	1/1,608	1/1,080	1/10,338*	1/14,473
Lewis	1/2,562	1/4,100	1/20,898	1/20,494
Marion	1/1,006	1/9,892	1/9,892	1/29,677
Monongalia	1/518	1/917	1/8,713	1/26,139
Preston	1/1,643	1/3,756	1/26,293	1/26,293
Taylor	1/1,578	1/3,551	1/7,101	1/14,202

It should be pointed out that the data for Monongalia County in the preceding table includes the West Virginia University Medical Center, making it the only county within the region to meet the AMA ratio of physicians to population, and one of two to better the state ratio. However MANY OF These PHYSICIANS NEVER ENGAGE IN PRIMARY PATIENT CARE /

More detailed information on the physicians within the region is provided in the following table (fig. I.9).

More detailed information on the physicians within the region is provided in the following table. (fig. I.9)

fig. I.9

Major Professional Activity--December 31, 1966

County	total non-fed	total	Patient Care					other prof. act.	inactive
			Solo, Partnership, Group, and Other Practice						
			G.P.	medical specialties	surgical specialties	other specialties	hosp. based		
W.Va.	1,732	1,575	533	222	398	150	272	83	74
Doddridge	1	1	1						
Gilmer	4	3	2		1				
Harrison	63	55	20	6	18	8	3		8
Lewis	12	9	3		3	1	2	1	2
Marion	57	52	19	12	15	3	3		2
Monongalia	194	116	13	7	15	5	76	73	5
Preston	12	11	7		1	1	2		1
Taylor	8	8	6		1	1			

Again, it should be remembered in considering the preceding table that Monongalia County's data includes the personnel of the West Virginia University Medical Center. Also, the sole physician listed for Doddridge County has since departed.

Turning to facilities, we begin with the following list of general hospitals within the area (fig. I.10), inventoried from 1/1/67 to 12/31/67.

fig. I.10

facility	county	control	licensed capacity	total capacity
Saint Mary's Hospital	Harrison	non-profit	193	178
Union Protestant Hospital	Harrison	non-profit	150	131
Stonewall Jackson Mem. Hosp.*	Lewis	non-profit	47	70
Fairmont General Hospital**	Marion	city	207	242
Monongalia General Hospital	Monongalia	county	104	105
St. Vincent Pallotti Hosp.	Monongalia	non-profit	90	66
Preston Memorial Hospital	Preston	county	72	72
Grafton City Hospital***	Taylor	city	52	94
		TOTALS	915	958

* The Stonewall Jackson Memorial Hospital is a new hospital being constructed under the E.D.A. Program. Bids opened 6/18/68. This facility replaces the General Osteopathic Hospital in Lewis County.

** At the time of the survey, the Fairmont General Hospital's 242 bed total capacity was under construction. One hundred sixty-one beds were replacements, while 81 beds represented an addition.

*** At the time of the survey, the Grafton City Hospital's 94 bed total capacity was under construction. Forty-four beds were being remodeled and the remaining 50 beds represented an addition.

Fairmont Emergency Hospital
Patients: 68

Fairmont Emergency Hospital was established in 1899 for the purpose of treating persons injured in their usual occupations. The hospital accepts surgical and maternity pay cases and is the surgical clinic for the Industrial School for Boys at Pruntytown, the Industrial School for Girls at Salem, the West Virginia Training School at Saint Mary's, the Children's Home at Elkins, the Medium Security Prison at Huttonsville, the Spencer State Hospital at Spencer, the Weston State Hospital at Weston, the Barboursville State Hospital at Barboursville, the Forestry Camp at Davis, Lakin State Hospital at Lakin and from the West Virginia Penitentiary at Moundsville. No charge whatsoever is made for these cases. The work of the current year at regular hospital prices represents more than the total cost of the operation of the institution. The purpose of the institution at present is rapid service surgical rehabilitation.

Hopemont State Hospital
Patients: 322

Hopemont State Hospital on a 600-acre tract of land, formerly known as Hopemont Sanitarium, is located at Hopemont, near Terra Alta, in Preston County and was founded in 1913 as a tuberculosis hospital. In 1965 legislation was enacted to change the name of the hospital and convert it to an institution for both chronically ill and aged and infirm.

The institution consists of four fireproof hospital units under one roof. Also, Conley Hospital, a separate unit, is used to hospitalize tuberculous prisoners under maximum security regulations. Other units of the hospital consist of residences, nurses' home, main dining hall, post office and laundry.

A registered Holstein herd is maintained to provide pasteurized and homogenized milk for the institution, and a piggery provides pork.

Weston State Hospital
Patients: 1,950

The Weston State Hospital is located in the City of Weston. It is the oldest state institution in West Virginia, authorized on March 22, 1858, by an act of the Virginia Assembly. There was considerable delay in the construction of the hospital due to the Civil War, and the first patients were received on October 22, 1864. The hospital has grown from an initial capacity of 35 patients to 1,600.

The hospital is maintained and equipped to provide adequate treatment for all types of mental and nervous illness, both voluntary and court committed.

The hospital plant includes specially constructed buildings to take care of all criminally insane in the State, mentally ill tubercular patients, and two geriatric buildings for men and women. A section of the male wards is designated as the West Virginia Soldiers' Home and is administered by the hospital medical staff. All war veterans are admitted here for treatment. The hospital is equipped to provide various types of treatment, including psychotherapy, occupational and recreational therapies and electro-shock therapy. The facilities consist of a laboratory, x-ray, social services, pathology department, psychology department and an In-service Training Program for the psychiatric aides.

There is a Vocational Rehabilitation Center on the grounds and a Half-Way House for the training and rehabilitation of the mentally ill.

The hospital has 615 employees including 11 physicians, a dentist, 13 registered nurses, a registered dietician, a chiropodist, beautician, and barber. A consulting staff of local physicians help provide additional services to the patients.

A registered herd of Holstein cows is maintained, thus providing the hospital with an adequate supply of high grade milk, processed in a modern, pasteurized plant fully approved by the State Board of Health. A coal mine at the Western end of the farm operated by the Hospital furnishes coal for the four boilers in the power plant which supplies the heating, hot water and steam requirements for the Institution.

The building and outlying farms occupy some 600 acres of land in Lewis County. The hospital grounds are large and spacious with many shade trees and provide excellent facilities for the patients.

West Virginia University Hospital
Morgantown, West Virginia
Bed Capacity: 434

Established 1960; service area entire State. This is primarily a teaching hospital for West Virginia University. There is a waiting list for patients who are to be admitted to the hospital but this tends to be seasonal. Special services: Psychiatric, Pediatric, Obstetrics, Intensive Care, Out Patient Clinic, Special Treatment Units.

VA Hospital
Clarksburg, West Virginia
Bed Capacity: 200

Established March 12, 1951. Service area North Central West Virginia, Eastern Ohio, Southern Pennsylvania, Garrett County, Maryland.

This is a Federal hospital and only veterans can apply for services here. They have no waiting list. The services are short-term and those offered are: surgical, medical, psychiatric and out patient.

HEALTH CARE IN WEST VIRGINIA

The survey of a topic of such inclusiveness as "health care" is bound by certain limitations. In the first place it is not possible to touch more than superficially on any one facet of the topic, let alone offer much depth analysis of the whole scope of health concerns. Further there are the combined limitations and benefits of a consumer's point of view. There has been no direct input into the analysis by providers of health care.

Perhaps something should be said about the advantages and disadvantages of a consumer perspective. It lacks the precise data and comprehension of technical aspects of the problem. It may very well fail to assess adequately the role of the provider in both problem and solution and fail to see modifying or contributing factors of professional inter-relationships on the one hand or physical-mental-environmental factors on the other.

The consumer role is the largest part played in the whole drama of health care. Thus it is valuable to see the problem from that perspective. The provider viewpoint is often made known through meetings and the media and it is often the only view heard or expressed. There are advantages to all in presenting another point of view. Accepting the importance in our society of enlightened self-interest, one must never lose sight of the fact that even when enlightened, self-interest is a basic factor in all social, economic and political issues. It seems, however, that the self-interest of the consumer is more likely to be in common with more persons across a much broader section of society than is that of the provider. Federal and State Government has recognized this in providing in programs of Comprehensive Health Planning for boards to be at

least 51% consumer in their composure. Public Law 89-749 provides for comprehensive health planning.

I. WHAT IS THE ISSUE?

Given these factors and the overwhelming complexity of the field of health care, it seems wiser to focus primarily on the problems associated with the delivery of services. One could develop separate papers on specific problems in environmental health such as air and stream pollution, or on mental health, or on problems related to hunger and malnutrition, family planning, maternal and child care or many other important health care issues. But at the core of all of this there must be services and there must be ways of making these services available to those for whom they are intended. The central issue in health care, to those who prepared this paper at least, is the delivery of services.

II. WHAT ARE THE RELEVANT FACTS?

There has been considerable focus in recent years on the problem of the poor. For example, an Heal th, Education and Welfare document published in December 1967 (Human Investment Programs "Delivery of Health Services for the Poor") reveals that

> among persons with family incomes of less than $2,000, about 29 percent have chronic conditions with limitation of activity, as contrasted with less than 7.5 percent among persons with family incomes of $7,000 or more.....
>
> Persons with family income of less than $2,000 have more than double the days of restricted activity per year than persons with an income of $7,000 or more. For males in the working age group 45-64, the lower income group has three and one half times as many disability days -- 49.5 in the under $2,000 income group compared to 14.3 in the over $7,000 income group.

> In one year, a larger proportion of persons who live in low income families have multiple hospital episodes than those in higher income groups. The length of hospital stay is longer for the poor....., and they are more often hospitalized for non-surgical conditions. This exists in spite of the fact that the poor are much less likely to have hospital insurance to cover the bill.

Increasingly students of the health system in America are underscoring the fact that "Middle America" suffers from the same dificiencies of the system as do the poor. We would stress the fact that problems of the delivery of health services affect most of the people of the State of West Virginia and that the poor, white and non-white, experience the problem to a considerably greater degree than the non-poor. Because of the number of low and moderate income persons in West Virginia, the following from the same HEW document quoted above seems appropo to the State as a whole:

> The following are a few salient reasons for the poor health status of the low income population:
>
> 1) The current "system" in which the poor receive health services perpetuates fragmented emergency-oriented medical care which is often relatively inaccessible in terms of time and location.
>
> 2) Despite recent legislation, inability to pay for services remains an important barrier to the poor's quest for health care.
>
> 3) Medical facilities and health manpower are particularly scarce in areas with a high concentration of poor.

The problem is one of availability and accessibility of services. Medical facilities and physicians are concentrated in larger population centers. For example, a random survey of 21 low income communities was conducted in April and May of 1970 in Marion County covering 177 families representing 709 persons. Problems of getting medical services were reported as follows:

43.2% listed distance to a health facility as being a problem
27.8% lack of public transportation
23.4% lack transportation
3.6% lack private transportation

The 169 families responding (to this question) must travel an average distance of 9.4 miles to a doctor. The least number of miles to travel is 1 and the greatest number of miles is 30. The distance to a hospital for 124 families responding is an average of 19,23 miles. (Conducted by Marion County Community Action Association)

There are many places in West Virginia where these problems are much more acute.

A closely related problem is the near total lack of planning for and co-ordination of services. Various facilities such as hospitals exist in many communities with no effort to combine and exchange services. Thus the cost of care is increased while efficiency of service from which the consumer benefits directly is decreased. Solo practice and a general attitude ranging from resistance to outright hostility toward group practice perpetuates inefficiency and reduces the general quality of care. There is abundant evidence that for quality care a high degree of co-operation and sharing of resources by providers is basic. Without being in any way critical of solo practice physicians, this is a major reason why Congressional leaders, Public Health Service personnel, Health, Education and Welfare staff, insurance leaders, labor unions, and our last four Presidents say without hesitation that pre-paid group practice is foremost in the solution of our American health crisis. A U.S. Department of Commerce publication, "U.S. Industrial Outlook 1970" states that:

> Prepaid group practice has demonstrated that health costs are reduced by removing financial barriers to preventive medicine, early treatment and choice of needed medical services.

The crisis in health care compounds itself by the lack of preventive medicine. This is the biggest factor for the poor. They can't possibly afford anything but crisis care, never seeing a doctor until it is an absolute necessity often of life or death. This keeps the death rate of newborns and infants high. (HEW figures for 1967 show that West Virginia had a 25.6 per thousand infant death rate as compared to 22.4 for the nation. The neonatal death rate for West Virginia was 19.1 compared to 16.5 for the nation.)

It keeps cost high also, for when the patient, poor or middle class, finally comes there is so much background data to work up and side problems to be dealt with that could easily have been prevented in early stages even by periodic check-ups. Such things also affect quality, for the physician, already over worked, simply cannot do all that needs to be done for all the people who come. And he is now so overwhelmed with patients (many refuse to take anyone new except in a genuinely dire emergency) that he cannot possibly do any general preventive care.

There are others who insist that the problem is one of money. Few in West Virginia seem to see it as essentially a matter of organizing health care for more efficient and effective service. This includes scrutinizing existing medical services of all kinds in terms of future federal and/or state financial aid, and planning with much more care for the future.

This paper was prepared by Richard Bowyer in consultation with Claude Arnett. Mr. Arnett is currently employed in the On the Job Training Program of the West Virginia Federation of Labor. He has had experience as an organizer of the HEAT organization in Marion County and in work with the Community Action Association. He has been active in the development of comprehensive health planning in Region V of the State and is a member of the Board of the Marion County Health Planning Association.
Mr. Bowyer is president of the board of the Health Planning Association of North Central West Virginia, a member of the West Virginia Public Health Association, and a member of the Ad Hoc Committee on Continuing Education of the State Office of Comprehensive Health Planning.

HEALTH RELATED DATA, MARION, MONONGALIA & PRESTON COUNTIES, West Va.

Table of Contents

Compiled by
Division of Public Health & Preventive Medicine
West Virginia Univ. Medical Center
Morgantown, West Va. 26506

Marion, Monongalia and Preston County Hospitals

	Marion		Monongalia			Preston	
Name & Location	Fairmont Emergency Hospital	Fairmont General Hospital	Monongalia General Hospital	St. Vincent Pallotti Hospital	W.V.U. Hospital	Hopemont State Hospital	Preston Memorial Hospital
Administrator	J. C. Morgan	O. B. Ayers	W.B. Rhodes	Sr. M. Pia	E.L. Staples	H.C. Rocha	I. Allsopp
Control	12	14	13	23	12	12	13
Service	10	10	10	10	10	48	10
Stay	S	S	S	S	S	L	S
Beds	58	207	116	90	434	300	56
Admissions	993	8,468	3,780	3,043	11,721	195	1,564
Census	30	186	76	67	349	196	30
% Occupancy	51.2	89.8	72.6	75.0	81.1	65.2	54.2
Newborn Data							
Bassinets	10	30	18	12	20	--	17
Births	63	1,078	415	186	820	--	204
Expense							
Total	335	2,780	1,093	1,028	7,140	1,380	492
Payroll	--	1,756	621	740	--	1,004	309
Personnel	61	384	175	161	949	329	82

Source: Hospital Guide Issue, August, 1970

LOCAL HEALTH DEPARTMENT BUDGETS

1970 FISCAL YLAR*

	Marion	Monongalia	Preston
Total Budget	125,036	702,167	33,580
State & Federal Funds	27,333	470,672	14,841
Percent State&Federal	28%	67%	44%
LOCAL APPROPRIATIONS			
County Court	33,212	94,850	12,739
Municipality	11,703	8,934	
Board of Education	22,000	16,500	6,000
Home Health	25,959	111,211	
Other	4,829		
TOTAL Local Funds	97,703	231,495	18,739
Percent Local	72%	33%	56%
Population, 1970 Census	61,356	63,714	25,455
Per capita expense	2.04	11.02	1.32

*West Virginia Department of Health Annual Budget, Fiscal Year 1970.

LICENSED PHYSICIANS BY COUNTY OF PRACTICE** LOSS OR GAIN 1959-69

County	Loss or Gain between 1959-1969
Marion	-18
Monongalia	+91
Preston	-4

From The Medical Licensing Board of West Virginia

Figures do not include osteopaths.

**(Note: Many physicians are licensed in more than one state; licensure does not indicate active practice, e.g. the +91 for Monongalia County includes resident physicians and those in research and teaching at the University, also retired physicians invariably retain their licenses though inactive.)

GENERAL INFORMATION

Three Counties in West Virginia

	West Va.	Marion	Monongalia	Preston
Population 1950[1]	2,005,552	71,521	60,797	31,399
1960[1]	1,860,421	63,717	55,617	27,233
1970[2]	1,744,237	61,356	63,714	25,455
Percent Change				
50-60	-7.2	-10.9	-8.5	-13.3
60-70	-6.7	- 3.7	+14.6	- 6.5
Size (Sq. miles)[3]	24,282	314	369	654
County Seat		Fairmont	Morgantown	Kingwood
County seat population(1970)[4]		24,405	29,074	2,894
Birth rate, 1969[5]	16.8	16.3	15.9	17.0
Crude death rate, 1969[5]	11.6	12.5	9.1	10.9
Infant mortality rate, 1969[5]	23.3	18.3	13.1	4.3*

* 2 infant deaths reported.

ECONOMIC INFORMATION
Three Counties in West Virginia

	West Va.	Marion	Monongalia	Preston
Income				
Per capita personal income(1965)[6]	2032	2502	1974	1271
Median Family Income, 1960[7]	4572	5453	4515	3214
Percent Families < 3000, 1960[7]	32.6	25.3	29.6	46.4
Percent Families > 10,000, 1960[7]	8.4	10.2	8.7	3.6
Socioeconomic Ranking				
On Occupation, Education and Income (among 55 West Va. Counties)[8]		15	8	41
Economic Activities				
Pop activities 1965[6]				
(Thousands of dollars)(Wages&Salaries)				
Mining	320,800	25532	15427	6275
Government	370,041	10024	15448	4113
Manufacturing	829,500	35867	13297	3588
Transport, Communication, and Public Utilities	256,001	10085	3742	3146
Wholesale and Retail Trade	331,200	11527	9356	2373
County Labor Force, 1970[9]				
Total Work Force		24750	27060	7360
Unemployment		870	1300	510
Rate		3.5	4.8	6.9
County Court Budget, 58-59[10]		14300	7850	5400

PUBLIC ASSISTANCE AWARD EXPENDITURES BY CATEGORY
FISCAL YEAR ENDED JUNE 30, 1969[12]

Category of Assistance	Marion	Monongalia	Preston
Old Age Assistance Total	222,468	199,530	75,917
Average Number of Cases	247	171	128
Average Monthly Awards	75.05	97.24	49.42
Aid to the Blind Total	3,942	8,584	4,239
Average Number of Cases	7	10	9
Average Monthly Awards	47.00	71.50	39.22
Aid to the Disabled Total	79,658	62,869	43,662
Average Number of Cases	114	74	85
Average Monthly Awards	58.23	70.80	42.81

FOOD STAMP PROGRAM
SUMMARY OF PARTICIPATION BY COUNTY
FISCAL YEAR ENDING JUNE 30, 1969[12]

	Marion	Monongalia	Preston
Average No. of Households Participating Monthly	558	384	436
Total Cash Paid for Stamps During Year	245,810.25	158,550.00	200,037.00
Bonus Coupons (Increased Purchasing Power)	157,229.75	111,161.75	142,563.00
Total Value Food Stamps Issued	403,040.00	269,712.00	342,600.00

REFERENCES

1. U.S. Decennial Census

2. Final Population Counts, 1970, Bureau of the Census (December, 1970).

3. West Virginia Blue Book, 1969.

4. Preliminary Reports, pc(p1)-50, 1970 Census of Population, West Virginia U.S. Department of Commerce.

5. Vital Statistics, West Virginia Department of Health, 1969.

6. County Personal Income, West Virginia, 1962-65, Leyden, D.R. and Rader, R.D. Bureau of Business Research, College of Commerce, West Virginia University Economic Development Series No 11, December, 1968.

7. Bureau of the Census, U.S. Department of Commerce: U.S. Census of Population, 1960, pc (1)-50A.

8. Thompson, J.M., Goldsmith, H.F. and Stockwell, F.G. Socioeconomic Ranking of Counties in the Northeastern United States from Virginia to Maine, 1960. Mental Health Study Center, National Institute of Mental Health. Lab Paper No. 13, November, 1965.

9. Department of Employment Security, Charleston, West Virginia.

10. Municipal and County Budgets in West Virginia, 1958-60. Bureau for Government Research, West Virginia University, Publ. No. 27.

11. Rankings of the Counties, 1970. Research Report. West Virginia Education Association, Charleston, West Virginia.

12. West Virginia Department of Welfare, Annual Report, 7-1-68 to 6-30-69, Charleston, West Virginia.

PRESTON COUNTY, West Virginia

Land area in square miles			645
Urban places in square miles			1.6
	1950	1960	1970
Persons per square mile	49.0	42.0	39.5

	Urban	Rural/farm	Rural/nonfarm
*Percent population	10.1	14.4	75.5

Table I

Population Distribution and Percent Change 1950 - 1970**

	Preston County				State of West Virginia			
Age Group	1950	1970	No. Change	% Change	1950	1970	No. Change	% Change
Under 5	3,929	2,206	-1,723	-43.9	240,107	139,021	-101,086	-42.1
5-19	9,284	7,585	-1,699	-18.3	562,809	508,309	- 54,500	- 9.7
20-44	10,336	6,917	-3,419	-33.1	720,383	511,954	-208,429	-28.9
45-64	5,232	5,552	+ 320	+ 4.4	343,727	390,833	+ 47,106	+13.7
65 and over	2,618	3,195	+ 577	+22.0	138,526	194,120	+ 55,594	+40.1
Totals	31,399	25,455	-5,944	-18.9	2,005,552	1,744,237	-261,315	-13.0

*Source: OEO Community Profile Project. Computer Printout, OEO, Charleston, W.Va.

**Source: U.S. Census.

Preston County, West Va.

Table II

Poor Families, 1960 and 1966

	Number of Families		Poor Families[a]				Percent U. S. Counties Having Lower Percent of Poor Families[a]		Percent County Families of State Total	Percent Poor Families in County of State Total
			Number		Percent					
	1960	1966	1960	1966	1960	1966	1960	1966	1966	1966
State of West Virginia	462,100	482,900	139,400	105,900	30.1	21.9			100.0	100.0
Preston County, W. Va.	6,549	6,079	2,894	2,140	44.2	31.2	80	84[b]	1.4	2.0

[a]In the typical county in the United States in 1966 there were 1,221 families ranked as poor. This represented 15.1% of total families in such a "typical " county.

[b]Eighty-four percent means that only sixteen percent of all U. S. counties had a greater proportion of poor families than Preston County.

Source: OEO Community Profile Project. Computer Printout, OEO, Charleston, W. Va.

2069

Health Characteristics (Preston County)

Five year average infant mortality rate 1961-1965[1] 27.9

Physician to population ratio 1/4,242
Dentist to population ratio 1/8,485
Health officer part-time contributes approximately ½ day per week to public health duties
Public health nurse to population ratio 1/25,455
Public health sanitarian to population ratio 1/25,455

General hospitals 1
Beds 54

County Health department budget - 1970[2]

	Total	Federal %	State %	Local %	Per Capita Exp.
Preston County	33,580	4.8	39.4	55.8	1.32
Monongalia County[a]	702,167	63.7	3.3	33.0	11.02

Approximate per capita governmental expenditures for health contrasting rural West Virginia with urban Washington, D.C.

West Virginia - Combined expenditures of W.Va. Departments of Health, Welfare, and Mental Health. 1970 Fiscal Year

7,823,000 State Department of Health
15,500,000 State Department of Welfare (Medicaid)
17,400,409 State Department of Mental Health
40,723,409 TOTAL

$\frac{41,000,000}{1,700,000}$ = $24.12 per Capita

District of Columbia - Total expenditures of the D.C. Department of Public Health. 1969-1970[b]

$\frac{89,000,000}{800,000}$ = $111.25 per Capita

Sources: [1]West Virginia Department of Health, The Past Twenty Years of Maternal and Infant Health in West Virginia. Compared with the U.S. 1946-65, June 1968.
[2]West Virginia State Health Department.

Footnotes: [a]Comparison with Monongalia County, where the resources of West Virginia University are located, shows relative inability of rural counties in lacking sophistication in grantsmanship and health manpower to compete for and capture Federal funds for health.
[b]District of Columbia figures include equivalent appropriation categories for mental health and welfare cited as separate items in West Virginia.

Other Socio-Economic Characteristics (Preston County)

Income[1]

Total Personal Income (1965)	$33,773,000
Total wages and salaries	21,917,000
Total transfer payments	5,277,000
Per capita personal income (1965)	1,271
Median family income (1960)	3,214
% families < $3,000 (1960)	46.4%
% families > $10,000 (1960)	3.6%

Public Assistance

Average Monthly Public Assistance Cases July 1968 - June 1969[2]

Total	360
OAA	128
AB	9
AD	85
AFDC	138

Education[3]

Median school years completed	8.6
% completed < 5 years	10.6
% completed high school or more	25.7

Housing[4]

All occupied housing units	7,681
All housing units with plumbing facilities	5,869
All housing units lacking plumbing facilities	2,656

Sources:

[1]Leyden, Dennis R. and Rader, Robert D., County Personal Income West Virginia, 1962 - 1965, Bureau of Business Research, W.V.U., December, 1968.
[2]W. Va. Department of Welfare: Annual Report, July, 1968 to June, 1969, Charleston, West Virginia.
[3]1960 Census
[4]1970 Census

information series 12

population change in WEST VIRGINIA 1960-70

a preliminary study

OFFICE OF RESEARCH AND DEVELOPMENT
Appalachian Center/West Virginia University

A PRELIMINARY STUDY OF POPULATION CHANGE IN WEST VIRGINIA, 1960-1970

The 1970 data are final Population Counts (PC[V1]50, December, 1970) of the 1970 Census of Population and Housing. The Births and Deaths for January 1 to March 31, 1970 are not available so that the total number April 1, 1960 to December 31, 1969 is adjusted by ¼ of the 1969 Births and Deaths as the best estimates of the adjustment needed.

The table displays 1970 Census figures, the 1960 Census Counts, the net change 1960-1970, the rate of change 1960-1970 based on the 1960 Census base, the Births and Deaths April 1, 1960 to December 31, 1969, plus ¼ of the 1969 Births and Deaths, net migration numbers, and the rate of net migration with the 1960 Census figure serving as the base.

The two Censuses and the Births and Deaths are basic data, the other items are calculations. Net change is 1970 Census figures minus 1960 Census divided by 1960 Census and multiplied by 100. Net migration is 1970 Census minus the sum of the 1960 Census plus the natural increase. The rate of migration is net migration divided by 1960 Census multiplied by 100.

According to the final figures in the table, the state lost 116,184 of its 1960 base population and has had a net out migration of 263,454. These figures compare with 145,000 net loss for 1950-1960 and a net out migration of 447,000 for the 1950-1960 period.

The greatest source of net out migration, percentagewise, was from the southern coal counties which sustained the heaviest losses in the 1950-1960 decade, with substantial losses occurring among rural counties of central West Virginia. Kanawha County had the greatest absolute loss and greatest out migration, though percentagewise McDowell County was the highest in each instance.

It is not possible, at this time, to indicate the sequence of the loss on an annual basis. While there is evidence that the direction of population change may be reversed in some areas of the state, in others, where high levels of unemployment remain, the key to a reverse of direction – job opportunities in the local labor markets – is lacking.

The Census figures in the table are final, but some revision will be attempted in July 1971 when 1970 Births and Deaths data will be available. In the light of the substantial population change, it was believed to be valuable and of considerable interest to have these data available at this time.

LEONARD SIZER
Associate Professor of Sociology
West Virginia University

ACKNOWLEDGEMENTS

The author wishes to acknowledge the assistance of the Computer Center of West Virginia University in programming and in performance of the calculations, the Division of Management Resources of the Agricultural Experiment Station in preparing certain of the data, and Donald R. DeLuca, graduate assistant, in the Division of Social and Economic Development of the Appalachian Center.

THE FINAL COUNTS OF 1970 CENSUS AND SOME PRELIMINARY INFORMATION ON THE COMPONENTS OF CHANGE, 1960-1970

County	1970 Census	1960 Census	Net Change	Rate Change	Births	Deaths	Net Migration Change	Rate Change
Barbour	14030	15474	-1444	-9.3	2603	1900	-2147	-13.9
Berkeley	36356	33791	2565	7.6	6854	3998	-293	-0.9
Boone	25118	28764	-3646	-12.7	4840	2379	-6107	-21.2
Braxton	12666	15152	-2486	-16.4	2596	1733	-3349	-22.1
Brooke	29685	28940	745	2.6	5163	2675	-1743	-6.0
Cabell	106918	108202	-1284	-1.2	20037	11539	-9782	-9.0
Calhoun	7046	7948	-902	-11.3	1518	877	-1543	-19.4
Clay	9330	11942	-2612	-21.9	2253	1011	-3853	-32.3
Doddridge	6389	6970	-581	-8.3	1032	945	-667	-9.6
Fayette	49332	61731	-12399	-20.1	9607	6689	-15317	-24.8
Gilmer	7782	8050	-268	-3.3	1484	930	-822	-10.2
Grant	8607	8304	303	3.6	1808	899	-605	-7.3
Greenbrier	32090	34446	-2356	-6.8	6247	3646	-4956	-14.4
Hampshire	11710	11705	5	0.0	2176	1391	-779	-6.7
Hancock	39749	39615	134	0.3	7683	3568	-3980	-10.0
Hardy	8855	9308	-453	-4.9	1611	998	-1066	-11.5
Harrison	73028	77856	-4828	-6.2	13363	9128	-9063	-11.6
Jackson	20903	18541	2362	12.7	4064	1761	59	0.3
Jefferson	21280	18665	2615	14.0	4253	2208	570	3.1
Kanawha	229515	252925	-23410	-9.3	46209	21943	-47675	-18.8
Lewis	17847	19711	-1864	-9.5	3197	2406	-2655	-13.5
Lincoln	18912	20267	-1355	-6.7	4173	1938	-3590	-17.7
Logan	46269	61570	-15301	-24.9	10997	5003	-21294	-34.6
McDowell	50666	71359	-20693	-29.0	12817	6340	-27169	-38.1
Marion	61356	63717	-2361	-3.7	10595	7548	-5407	-8.5
Marshall	37598	38041	-443	-1.2	6548	3988	-3002	-7.9
Mason	24306	24469	-163	-0.6	4346	2245	-2254	-9.2
Mercer	63206	68206	-5000	-7.3	11761	7604	-9157	-13.4
Mineral	23109	22354	755	3.4	4763	2497	-1510	-6.8
Mingo	32780	39742	-6962	-17.5	8365	3649	-11678	-29.4
Monongalia	63714	55617	8097	14.6	10228	6419	3287	5.9
Monroe	11272	11584	-312	-2.7	1748	1359	-701	-6.1
Morgan	8547	8376	171	2.0	1596	979	-445	-5.3
Nicholas	22552	25414	-2862	-11.3	4805	2302	-5365	-21.1
Ohio	64197	68437	-4240	-6.2	11829	8831	-7237	-10.6
Pendleton	7031	8093	-1062	-13.1	1198	861	-1398	-17.3
Pleasants	7274	7124	150	2.1	1268	749	-369	-5.2
Pocahontas	8870	10136	-1266	-12.5	1866	1243	-1889	-18.6
Preston	25455	27233	-1778	-6.5	5104	2766	-4115	-15.1
Putnam	27625	23561	4064	17.2	4276	1997	1785	7 6
Raleigh	70080	77826	-7746	-10.0	12672	7695	-12722	-16.3
Randolph	24596	26349	-1753	-6.7	5264	2981	-4036	-15.3
Ritchie	10145	10877	-732	-6.7	1753	1517	-967	8.9
Roane	14111	15720	-1609	-10.2	2452	1662	-2398	-15.3
Summers	13213	15640	-2427	-15.5	2361	1944	-2833	-18.1
Taylor	13878	15010	-1132	-7.5	2273	1978	-1427	-9.5
Tucker	7447	7750	-303	-3.9	1376	1020	-658	-8.5
Tyler	9929	10026	-97	-1.0	1726	1303	-520	-5.2
Upshur	19092	18292	800	4.4	3346	2137	-409	-2.2
Wayne	37581	38977	-1396	-3.6	6948	3274	-5069	-13.0
Webster	9809	13719	-3910	-28.5	2561	1374	-5096	-37.1
Wetzel	20314	19347	967	5.0	4186	2224	-995	-5.1
Wirt	4154	4391	-237	-5.4	746	577	-406	-9.2
Wood	86818	78331	8487	10.8	16850	8318	-44	-0.1
Wyoming	30095	34836	-4741	-13.6	6262	2409	-8594	-24.7
STATE	1744237	1860421	-116184	-6.2	337646	190353	-263454	-14.2

FAMILY SERVICE ASSOCIATION

364 HIGH STREET

TELEPHONE 292-9468

MORGANTOWN, WEST VIRGINIA

April 23, 1971

The Honorable Senator Edward Kennedy
Chairman of Senate Sub-Committee on Health
Senate Building
Washington, D. C.

Dear Sir:

Family Service Association of Morgantown, West Virginia, serves hundreds of rural families. As executive director I wish the following comments entered as testimony for the hearing conducted in Kingwood, West Virginia.

The poverty in which so many rural families must live so jeopardizes the health of children, adults, and the aged, that any national program dealing with health services is bound to be excessively expensive and completely inadequate unless the legislation for adequate incomes accompanies legislation for health services. The problems of income adequate to provide for decent food, clothing, and shelter, cannot be separated from the problems of health maintanance and prevention of illness.

Babies, small children, and adults have more health problems because they live in houses without windows, their resistance is lowered by malnutrition and they lack shoes and warm clothing. In Morgantown, West Virginia, incongruous as this seems, there is not one business which delivers coal to people who still heat their houses (shacks) with coal-burning stoves.

There are only a few doctors willing to diagnose or treat "malnutrition" as a medical problem; worm infestations in children and adults are generally ignored. In West Virginia, the Crippled Childrens Program (Department of Public Welfare) provides medical services for children of any parent (not only welfare parents). This program specifically excludes children with "terminal" illness. In the past two years three children in this area have had leukemia and their working parents became completely dependent upon charity for the medical treatment of their children. No program covers children who were dying.

The problems of prejudice must be recognized and dealt with if a national health insurance program is ever to really be of benefit to the rural poor. Based on my day to day experiences as a social worker, I see too much evidence of prejudice and discrimination toward poor people by health providers to believe that a

national health insurance program would not primarily benefit the middle incom group. Most doctors seem to have punitive attitudes toward poor people. Ther will need to be special incentives for providing medical services to the poor for doctors generally to want to reach out to the poor. These consumers need to have more power in the medical services market place.

I also believe that the proposed legislation needs to (if this is possible) reward doctors for prevention rather than treatment. A major proble with our health services delivery system is that health jobs are dependent upo people continuing to get sick, not on helping people stay healthy.

Sincerely,

Patricia M. Keith (Mrs.)
Executive Director

PMK/sd

UNITED STATES DEPARTMENT OF AGRICULTURE
FARMERS HOME ADMINISTRATION

SURVEY--WATER AND WASTE DISPOSAL SYSTEMS

RURAL AREAS--WEST VIRGINIA

A. Total Population (West Virginia)	1,860,421
B. Urban Population (FHA definition):	
27 Municipalities (population of over 5,500)	571,174
10% Additional (fringe area)	57,117
	628,291
C. Rural Population (FHA definition--A, B)	1,232,130
D. Number of Households (Rural areas) (3.51)	322,544

Water:

A total of 787 communities (245 towns and villages--542 other communities) either need a community water system or enlargement or improvement in their present system. There are 120,284 households involved with an estimated cost of $150,804,000.

Sewer:

A total of 682 communities (235 towns and villages--447 other communities) either need a community waste disposal system or enlargement or improvement in their present system. There are 156,250 households involved, with a total estimated cost of $306,865,000.

SUMMARY OF SURVEY:

	No. of Communities Where Improvements Needed	Households Involved	People Involved (3.5)	Estimated Cost
Water	787	120,284	411,080	$150,804,000
Waste Disposal	682	156,250	546,875	306,865,000
TOTAL	1,469	276,534	957,965	$457,669,000

approximately $6,000,000 (State Budget) Comm. Loans.
approximately $30,000,000 for rural housing loans (Sec. 504 Housing)

UNITED STATES DEPARTMENT OF AGRICULTURE
FARMERS HOME ADMINISTRATION
Morgantown, West Virginia
March 12, 1970

Dependable water facilities and safe sanitary sewer systems rank high among needs in rural West Virginia.

By an expenditure of about $457,670,000 rural West Virginia families could have modern water and waste disposal facilities. The annual investment in these basic facilities is thought to be in the range of $40 to $50 million dollars.

The magnitude of the problem was brought into sharp focus yesterday in a report issued by J. Kenton Lambert, state director of the Farmers Home Administration.

An investigation conducted by the FHA revealed that out of the state rural population, figured to be 1,232,130, over 411,000 people are forced to rely on unsuitable drinking water and approximately 546,800 people have inadequate sewer service. The total cost of supplying these basic facilities in proper quality and quantity is estimated at $457,670,000.

"The facts are documented and laid on the table," said Lambert. "Nearly 1 out of 2 rural people have moderate to severe water and sewer problems. This unhealthful situation cannot be continued. It is not only dangerous to lives but a major roadblock to the success of rural areas."

"Answers are available. They call for a sizeable outlay of cash, citizens sincere and concerned about future conditions, and a government responsive to the attitudes of the people."

2

The state-wide investigation into the water and sewer service needs of individual families was initiated by the FHA, according to Lambert, to help the agency develop immediate and long-range planning for financing water and waste disposal systems. With the actual compilation of the facts and figures, now, it can be readily seen that water and sewer development must be in the forefront of any comprehensive program to devise a satisfying human environment in the Mountain State.

"Although considerable progress has already been noted in the installation of community facilities," commented Lambert, "the need is still acute and remains a prerequisite to the survival and growth of a large part of the State. Families are no longer willing to settle for outmoded water systems and sewer systems that pollute the soil and air and degrade living conditions. However, the desired development won't happen overnight, nor did the ravaging pollution and water shortages occur just yesterday."

Efforts to place fresh, pure water within reach of every family and corresponding modern treatment of waste are in for intensification. Public interest has been aroused. Once more families are turning to the countryside and towns in search of living space. Local leaders and government have an unusual opportunity at this time to plan and work in partnership for the orderly development of rural-based communities. It is better to plan subdivisions and town enlargement than to follow the growth with remedial programs.

3

In arriving at the State's rural population of 1,232,130, for the study, the 27 municipalities exceeding 5,500 people were classified urban. These municipalities embrace 571,174 people and added to that number was an additional 10 percent to cover the fringe areas of the cities. Rural West Virginia, under this definition, houses 66 percent of the State's population.

Some 787 communities--245 towns and villages and 542 unincorporated areas--were found to need a central water system or enlargement or improvement in their present system. There are 120,284 households involved and the cost of meeting water needs was calculated at $150,804,0

Turning to the sewer problem, 682 communities split between 235 towns and villages and 447 unincorporated communities either need new waste disposal systems or a major improvement to present facilities. To supply acceptable service to the 156,250 households would cost an estimated $306,865,000.

Farmers Home Administration county supervisors carried out the water and sewer needs investigation under the coordination of William A. Jones, chief of the agency's community services program.

In addition to county supervisors' own knowledge of the areas, helpful information and assistance were obtained from: studies made by universities, utility companies, health department, and state agencies; local planning groups; comprehensive countywide water and sewer plans which have been prepared in most counties under FHA financing; and in consultation with local sanitarians and governing officials.

At this time nearly 100 towns, public service district, or nonprofit organizations have applications filed with the Farmers Home Administration for financial aid and technical supervision in securing water and sewer plants.

"It is incumbent upon the Farmers Home Administration, an instrument of the tax-paying public, to operate as fairly and efficiently as possible in processing all loan and grant applications," declared Lambert. "We will strive to meet the challenge, but ask for the patience and cooperation of everyone."

GENERAL INFORMATION

Three Counties in West Virginia

	West Va.	Marion	Monongalia	Preston
Population 1950[1]	2,005,552	71,521	60,797	31,399
1960[1]	1,860,421	63,717	55,617	27,233
1970[2]	1,744,237	61,356	63,714	25,455
Percent Change				
50-60	-7.2	-10.9	-8.5	-13.3
60-70	-6.7	- 3.7	+14.6	- 6.5
Size (Sq. miles)[3]	24,282	314	369	654
County Seat		Fairmont	Morgantown	Kingwood
County Seat Population(1970)[4]		24,405	29,074	2,494
Birth Rate, 1969[5]	16.8	16.3	15.9	17.0
Crude Death Rate, 1969[5]	11.6	12.5	9.1	10.9
Infant Mortality Rate, 1969[5]	23.3	18.3	13.1	4.8*

* 2 infant deaths reported.

ECONOMIC INFORMATION

Three Counties in West Virginia

	West Va.	Marion	Monongalia	Preston
Income				
Per capita personal income(1965)[6]	2033	2502	1974	1271
Median Family Income, 1960[7]	4572	5153	4515	3214
Percent Families < 3000, 1960[7]	32.6	25.3	29.6	46.4
Percent Families > 10,000, 1960[7]	8.4	10.2	8.7	3.6
Socioeconomic Ranking				
On Occupation, Education and Income (Among 55 West Va. Counties)[8]		15	8	41
Economic Activities				
Top activities 1965[6]				
(Thousands of dollars)(Wages&Salaries)				
Mining	320,800	25532	15427	6275
Government	370,041	10024	15448	4113
Manufacturing	829,500	35867	13297	3588
Transport, Communication, and Public Utilities	256,001	10085	3742	3146
Wholesale and Retail Trade	331,200	11527	9356	2373
County Labor Force, 1970[9]				
Total Work Force		24750	27060	7360
Unemployment		870	1300	510
Rate		3.5	4.8	6.9
County Court Budget, 58-59[10]		14300	7850	5400

SCHOOLS

3 Counties in West Virginia

	W. Va.	Marion	Monongalia	Preston
Superintendent of Schools[3]		T.L. Pearse	L.G. Derthick	L. Losh
Number of Schools[3]				
Elementary 68-69	1,149	43	40	21
Secondary 68-69	352	13	12	10
School Enrollment[3]				
Elementary 68-69	235,627	,689	5,939	3,628
Secondary 68-69	184,720	5,724	5,278	2,890
Estimated Revenue Receipts[11] from State and Local Sources/Enrolled Pupil 1969-70	530	540	591	519
Estimated Current[11] Expenditures per Enrolled Pupil 1969-70	527	544	584	531

PUBLIC ASSISTANCE AWARD EXPENDITURES BY CATEGORY
FISCAL YEAR ENDED JUNE 30, 1969[12]

Category of Assistance	Marion	Monongalia	Preston
Old Age Assistance Total	222,468	199,530	75,917
Average Number of Cases	247	171	128
Average Monthly Awards	75.05	97.24	49.42
Aid to the Blind Total	3,942	8,584	4,239
Average Number of Cases	7	10	9
Average Monthly Awards	47.00	71.50	39.22
Aid to the Disabled Total	79,658	62,869	43,662
Average Number of Cases	114	74	85
Average Monthly Awards	58.23	70.80	42.81

FOOD STAMP PROGRAM
SUMMARY OF PARTICIPATION BY COUNTY
FISCAL YEAR ENDING JUNE 30, 1969[12]

	Marion	Monongalia	Preston
Average No. of Households Participating Monthly	558	384	436
Total Cash Paid for Stamps During Year	245,810.25	158,550.00	200,037.00
Bonus Coupons (Increased Purchasing Power)	157,229.75	111,161.75	142,553.00
Total Value Food Stamps Issued	403,040.00	269,712.00	342,590.00

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Marion, Monongalia and Preston County Hospitals

	Marion		Monongalia			Preston	
Name & Location	Fairmont Emergency Hospital	Fairmont General Hospital	Monongalia General Hospital	St. Vincent Pallotti Hospital	W.V.U. Hospital	Hopemont State Hospital	Preston Memorial Hospital
Administrator	J. C. Morgan	O. B. Ayers	W.B. Rhodes	Sr. M. Pia	E.L. Staples	H.C. Rocha	I. Allsopp
Control	12	14	13	23	12	12	13
Service	10	10	10	10	10	48	10
Stay	S	S	S	S	S	L	S
Beds	58	207	116	90	434	300	56
Admissions	993	8,468	3,780	3,043	11,721	195	1,564
Census	30	186	76	67	319	196	30
% Occupancy	51.2	89.8	72.6	75.0	81.1	65.2	54.2
Newborn Data							
Bassinets	10	30	16	12	20	—	17
Births	63	1,078	415	186	820	—	204
Expense							
Total	335	2,780	1,093	1,023	7,140	1,380	492
Payroll	—	1,756	621	740	—	1,004	309
Personnel	61	384	175	161	949	329	82

Source: Hospital Guide Issue, August, 1970

LOCAL HEALTH DEPARTMENT BUDGETS

1970 FISCAL YEAR*

	Marion	Monongalia	Preston
Total Budget	125,036	702,167	33,580
State & Federal Funds	27,333	470,672	14,841
Percent State&Federal	28%	67%	44%
LOCAL APPROPRIATIONS			
County Court	33,212	94,850	12,739
Municipality	11,703	8,934	
Board of Education	22,000	16,500	6,000
Home Health	25,959	111,211	
Other	4,829		
TOTAL Local Funds	97,703	231,495	18,739
Percent Local	72%	33%	56%
Population, 1970 Census	61,356	63,714	25,455
Per capita expense	2.04	11.02	1.32

*West Virginia Department of Health Annual Budget, Fiscal Year 1970.

LICENSED PHYSICIANS BY COUNTY OF PRACTICE
LOSS OR GAIN 1959-69

County	Loss or Gain between 1959-1969
Marion	-18
Monongalia	+91
Preston	-4

From The Medical Licensing Board of West Virginia

Figures do not include osteopaths.

LICENSED PHYSICIANS LIVING IN MARION, MONONGALIA AND PRESTON COUNTIES BY AGE GROUP

County	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+	Total
Marion		4	3	3	11	9	8	2	3	2	1	1	2	49
Monongalia	19	24	24	20	19	10	16	6	6	2	1			147
Preston	2		1		2	3	2		3					13

From The Medical Licensing Board of West Virginia, February 4, 1970

NUMBER OF REGISTERED NURSES LIVING IN
MARION, MONONGALIA, AND PRESTON COUNTIES

	1960	1965	Active - 1969	Total
Marion	188	252	224	293
Monongalia	151	387	432	498
Preston	36	37	35	44

Data presented in this table are based upon information supplied by the Board of Examiners for Registered Nurses, Marjorie E. Dumez, RN, Executive Secretary (1967) and Margaret Wyatt (1970). Nurses reported from cities occupying area in more than one county were credited to the county in which the major portion of that city's population was located.

REGISTERED NURSES LIVING IN MARION, MONONGALIA
AND PRESTON COUNTIES BY AGE GROUP

Area 5--Jan. 1 - Dec. 31, 1969

	20-29	30-39	40-49	50-59	60+	Unknown	Total
Marion	87	69	82	38	14	3	293
Monongalia	276	80	78	43	17	4	498
Preston	6	9	12	8	8	1	37

From: Board of Examiners for Registered Nurses, Charleston, Margaret A. Wyatt, RN, Executive Secretary

STATEMENT BY

LORIN E. KERR, M.D., M.P.H.

ON

THE HEALTH CRISIS IN AMERICA

TO THE

SUBCOMMITTEE ON HEALTH

SENATE COMMITTEE ON LABOR AND PUBLIC WELFARE

My name is Lorin E. Kerr, M.D. I am Director, Department of Occupational Health, United Mine Workers of America and Visiting Professor of Public Health, Howard University College of Medicine.

Previous testimony which I have presented before both the Senate and the House of Representatives has been concerned with the occupational dust diseases afflicting the nation's coal miners. While the problem became one of my major concerns and focus of interest after joining the United Mine Workers of America Welfare and Retirement Fund in 1948, it has, since August 1, 1969, become my prime responsibility. This is due in part to the enactment on December 30, 1969 of the historic Federal Coal Mine Health and Safety Act of 1969. More important was the unanimous decision of the International Executive Board of the union, six months earlier, to establish the UMWA Department of Occupational Health. This action, unprecedented in the annals of organized labor in the United States, was primarily designed to hasten the eradication of

all occupational diseases occurring among coal miners. At the same time it was acknowledged that such action would at best be desultory unless combined with a comprehensive endeavor to resolve all the health problems confronting the miners.

Limitation of the new Department to the traditional concern for job-related illness usually exemplified by occupational health programs was immediately recognized as restrictive and counter-productive. This union mandate to improve the health status of its members and dependents provides me with a unique opportunity to share with you the knowledge of medical care administration which I have acquired during my 35-year professional career in the hope it will prove helpful in the formulation of legislation intended to assist in resolving the health crisis confronting the nation today.

My initial exposure to medical care administration antedates the initiation of this specialty as a discipline. As Director of the Bureau of Medical Relief in a midwestern city health department, I was confronted with the urgent need to improve the quality of medical services being provided more than 100,000 welfare recipients in a city with a population of 300,000. Although this health department function was initiated about 1905, the problems in 1937 were much the same as we confront nationwide today -- lack of readily accessible high quality comprehensive health services at a reasonable cost and shortages of facilities, as well as personnel. The stresses created by the depression and the enormity of the task evoked cooperation by most hospitals and

doctors. The former were trying to dig out of mountains of red ink and physicians in some instances survived only as direct and indirect recipients of relief payments. There were no insurance programs and no one scorned government payments.

Subsequent training and experience in public health provided convincing evidence that the major health problem confronting the worker was his inability to pay doctor and hospital bills. The major capital asset possessed by the American worker was and still is his ability to work, so it was little wonder that he was worried about getting in and out of the hospital and back on the job as quickly as possible when he was sick. However, the financial barrier to the doctor and hospital not uncommonly proved insurmountable and the worker joined the host of other sick and disabled workers eking out a miserable existence on relief. Closely associated was the financial barrier to medical care encountered daily by the public health nurse. She was constantly frustrated in her efforts to resolve family concerns about nutrition, child care and school health because of her inability to resolve the more demanding and pervasive daily medical needs confronting families. Cuts, bruises, fractures, colds, burns and diarrhea can be very frightening, particularly when there is no medical care available. These problems took a high priority over the health department's usual stock in trade which, by edict of organized medicine, excluded diagnostic and therapeutic services for the worker and his family. This proscription, in many instances, also excluded health department

immunization of children. It was disheartening to observe a mother who, when finally convinced of the value of such services, found that this could only be done by a private practitioner whose fee was ten dollars for each of four children. Her husband was only earning twenty-five dollars per week. Little wonder that in today's parlance many families turned off on the health department and in far too many instances there has been little change in programs and attitudes.

Wartime production demands forced the Federal government to provide medical care programs for both the domestic migratory and imported agricultural workers. Although the U.S. Public Health Service had been providing such services for merchant seaman since 1798, this was the first time the USPHS expanded its program to include other workers. Throughout the nation there were more than one million farm workers, the vast majority of whom were imported under international agreements from the British West Indies and Mexico. These workers were scattered in numerous isolated areas. The U.S. Public Health Service successfully built upon earlier programs initially developed within the framework of the Farm Security Administration program for low-income family farmers and migratory workers. These endeavors were historic in their content and achievement. There was active consumer participation, prepayment, medical and dental service, delegation of responsibility to nurses, drugs, hospitalization and monitoring of services. All of this was done for a mobile population with little loss of continuity of services. The providers of service were paid directly by the government with a minimum of paper

work and only a trace of red tape. Following the termination of hostilities national concern about the health of people, particularly those in low-income and minority groups, became almost nonexistant and the program was financially axed into oblivion.

In 1944 organized labor, in lieu of prohibited wage increases, was able to initiate the inclusion of medical care provisions in jointly negotiated wage agreements for which management would be granted a tax deduction up to 5% of gross payroll. This was a manifestation of the worker's long existant concern, mentioned earlier, about his inability to pay doctor and hospital bills. More importantly, it was a recognition that for the forseeable future this was going to be a responsibility of organized labor. The Federal government was in 1944 again abdicating to the pressures of organized medicine which it had been doing since 1920. Prior to that time the widsom of medical statesmen prevailed and even though organized medicine supported national health insurance in 1915 the morticians dug the grave for the bill that year. Since then the entrepeneur leadership of medicine, characterized as the last of the cottage industries, has spent millions of dollars in a prolonged delaying action to stem the increasing tempo of the demand for a national health insurance program.

While the worker's demands for a portion of wartime profits gave the major impetus to the concept of fringe benefits it was the long history of fear and frustation engendered by disease and disability

and the lack of financial security when retirement was inevitable which dictated the course to pursue. Unfortunately the limited earlier experiences in providing medical services on an organized basis had not been well publicized. The same was true of studies, reports and Congressional hearings which combined presented a veritable mountain of evidence clearly indicating the need and the directions for a rational organization of the system of delivering health services. The inordinate pressures to provide benefits immediately did not allow time to seek guidance from past experiences. Health insurance, a blatant misnomer with its limitation to hospitalized illness, rapidly materialized. Hospitals began to thrive, insurance companies expanded into a new field and organized medicine began to realize this bill paying mechanism was no economic threat. They soon joined Blue Shield with Blue Cross and the voluntary health program, with a few notable exceptions, became the wave of the future.

The exceptions were those union-sponsored health centers such as the Labor Health Institute in St. Louis; the Sidney Hillman Health Centers in New York, Philadelphia and Chicago; the Union Health Center in Chicago and the I.L.G.W.U. Health Center in New York which began operation in 1914. Although some of these provided nearly comprehensive services, most primarily provided only diagnostic care.

I have taken the time to relate these historical, and in a sense philosophical, developments which are well known to you, because once again we are confronted with legislative proposals which are singularly restricted to a primary concern about paying doctor and hospital bills. In fact, the President's recent health statement basically calls for a Federal partnership with insurance companies. Organized labor, after more than a quarter of a century of experience with a multitude of voluntary health programs is skeptical of this method of paying doctor and hospital bills. It has become abundantly clear that health insurance has done nothing to disturb the patterns of the past. In fact, it has reinforced the status quo and thereby obstructed resolution of the problems concerned with quality controls, use of manpower and the organization and distribution of medical care services.

The overwhelming desire of organized labor - the largest single organized body of consumers - is the ready accessibility of comprehensive health services - preventive, diagnostic, therapeutic, and rehabilitative at a cost the economy can afford to pay. This is the only solution to the many problems encountered by union health programs which today are contained in nearly every jointly negotiated wage agreement. This is also the answer to a question posed in 1939 by the dean emeritus of medical care administration, Dr. Nathan Sinai. He opined that if the national health insurance bill introduced that year by Senator Wagner did not pass Congress, each labor union might develop it's own medical care program. Were that to happen,

Dr. Sinai asked the seminar to consider the impact of such action on the eventual passage of a national law. While some students ventured that the unions would develop such a vested interest in their own programs that they would be unalterably opposed to national legislation, others stated categorically the opposite point of view. Thirty-two years later the answer is in. Experience has shown that no labor union can provide its membership with the full range of health services. This is the reason for the unanimity of support by organized labor for national health security.

I would now like to share with you from a personally biased point of view the major experiences and contributions of the United Mine Workers of America Welfare and Retirement Fund which, when founded in 1946, was one of a handful of negotiated medical-care programs. Today, 25 years later, the Fund still remains the only uniform industry-wide self-insured program. My reason for focusing on the Fund is my belief that the Fund program is a mini-national program which has encountered and resolved most of the problems confronting a comprehensive nationwide program. In microcosm it contains many of the answers to problems now confronting this subcommittee.

Nearly 25 years ago the Fund vividly demonstrated what has recently been repeated on a national scale by Medicare. The Fund medical care program at the start paid all bills submitted by hospitals, physicians, dentists, pharmacists, optometrists, podiatrists and nurses.

All equipment, supplies and appliances, including glasses, dentures and drugs were also provided. Nine months of experience, however, was sufficient to clearly document that in the absence of quality and cost controls there would never be sufficient money to underwrite the practices encountered. Painfully, the Fund proved that more than money was needed to formulate a sound program. This experience is equally applicable to a national program. It is my belief it will undoubtedly be repeated on a national basis should the Administration proposal become law. Quality and cost safeguards must be included to assure the non-repetition of this wasteful experience. When any medical care program is limited to the provision of money for doctor, hospital, dental and drug bills, costs inevitably escalate and there will never be enough money to meet the rapidly mounting charges.

The major health problem confronting the nation is the distribution of medical services. This is the reason the UMWA is pleased to see every conceivable effort being made to resolve this problem, while at the same time developing the fiscal aspects of the program. It is my belief that a better organization and utilization of services is the key to containing or moderating the rising costs of medical care. I seriously doubt it is possible to lower these costs without impairing quality.

The miners' Fund, from its inception, has endeavored to provide a program of comprehensive medical care, including preventive, diagnostic, therapeutic and rehabilitative services for all eligible

beneficiaries. Their number has decreased from the initial 1,750,000 to about 500,000 where it has remained for the last decade. The Fund has spent well over one billion dollars for all the medical services received by nearly five million beneficiaries. These services included about 25 million days of hospitalization and nearly 23 million visits by physicians caring for those hospitalized. In addition, there were more than 26 million consultative, diagnostic and therapeutic services provided by group practice clinics and specialists in private offices, outpatient and emergency facilities. The annual expenditure for medical care has risen in the last two years from the almost constant average of 50 million dollars to 65 million. Payments are made each year to about 1200 hospitals and 8000 physicians located in all 50 states and the District of Columbia. In providing this care the Fund has the responsibility and freedom to seek out and use the best talent and facilities available without limitations or restrictions. The Fund is not an indemnity program. Hospitals and physicians, including specialists, are paid directly by the Fund, not indirectly by reimbursement of the beneficiaries. Unlike Blue Cross-Blue Shield the Fund pays the total cost of all medically indicated services and maintains quality and cost controls. Beneficiaries make no payment to the Fund or vendors of services. It is totally supported by a tonnage royalty of 40 cents, paid by the operators in accordance with the National Bituminous Coal Wage Agreement, for each ton of bituminous coal mined for sale or use. The administrative costs have consistently been maintained at slightly more than 3% of total expenditures.

The first medical task confronting the Fund was to find and then arrange for the rehabilitation of the long-neglected, severly injured miners. In less than 5 months more than 500 men paralyzed by broken backs, some bedfast for nearly 12 years, were finally located, usually in the last house or windowless shack at the end of a hollow in the hills. In one instance 12 miners took turns carrying their friend nearly 3 miles to the closest spot an ambulance could be driven. Nearly half of these men were transported by rail, 12 at a time to a California rehabilitation center. Early successes there encouraged three Eastern centers to also provide services. All the physicians directing these centers were experienced physiatrists familiar with the destructive force of disability even when produced by wartime gun fire. None, however, were prepared for the appearance of these miners. Ulcers and sores the size of dinner plates and larger had eaten away the buttock tissues leaving all of the bones of the hip completely exposed. Smaller ulcers on the heel also extended down to the bone. Bladder and bowel control had often been lost with the injury and the men were unable to care for their simplest needs. Many of the miners also had massive stones in their kidneys and bladders. Not one specialist but a team of specialists was necessary to reclaim bodies deteriorated to a degree few physicians in this country had ever seen before. Determinations of individual aptitudes and capabilities as well as appropriate job training were coordinated with physical restoration. All of this took two to four years with most of the men able to return home completely rehabilitated in slightly more

than two years. The knowledge and experience gained from this program was immediately woven into the total program for all other disabled beneficiaries. By 1958 it was widely acknowledged that the Fund, in ten years had advanced rehabilitation further and faster than had occurred in the previous 25 years. Today, paraplegic miners rarely require more than 9 months for complete rehabilitation which begins in less than 36 hours following injury. The savings in money and human suffering are incalcuable.

The Fund, in the Appalachian Mountain coal mining areas of West Virginia, Kentucky, and Virginia--where modern medical facilities and adequate numbers of highly competent medical and hospital personnel were almost non-existant - took the initiative and created new facilities primarily for its own beneficiaries. Ten hospitals with a total capacity of slightly more than 1,000 beds were built and operated as a coordinated regional network by the Miners' Memorial Hospital Association, a non-profit corporation separate from, though closely related to the Fund. The hospitals were dedicated in 1955 and open to everyone, but most of the patients were Fund beneficiaries because most of the poeple who lived in the area were coal miners and their dependents. The Fund paid the MMHA a per diem rate based on cost for each beneficiary hospitalized in any of the ten hospitals. These hospitals provided the area with a quality of medical care never before seen in those communities. The more than 2,000 individuals employed provided a ratio of 2.1 per bed which was higher than the 1956 national average of 1.6.

Residency training programs were approved by the AMA in the three largest hospitals at Harlan and Williamson, Kentucky and Beckley, West Virginia. These three hospitals were also quickly approved for the training of graduate nurses, licensed practical nurses and laboratory and x-ray technicians. Decreasing coal production and increasing unemployment forced the Fund to sell five of the hospitals in 1963 and the remaining five the next year to a non-profit organization, the Appalachian Regional Hospitals, Inc., to continue the operation of the hospitals. All ten hospitals are extremely viable today, and the Fund continues to purchase services provided Fund beneficiaries. A significantly large number of physicians and other MMHA employees still remain with the hospitals which have expanded both the facilities and programs.

Based on the early rehabilitation program and supplemented by the hospital experience the Fund has developed three major techniques for providing medical care of high quality at a reasonable cost. The first was the control of quality which was an important element in controlling costs. An early study of rapidly increasing hospital admission rates revealed that surgery was the major cause and that much of this was of a somewhat questionable nature. Quality criteria developed by organized medicine itself were utilized by the Fund and since 1955 payment has been made for surgery only when performed by an appropriately Board certified physician, as far as this is possible. Surgical rates dropped precipitously within 90 days of the implementation

of this provision. The rates have since remained at a much lower level than previously prevailed.

Moreover, in many instances the Fund has required consultation by a Board certified physician before hospital admission of patients who do not require an operation. Closely associated with these provisions was the need to pay for specialists' office care to assure that beneficiaries were not being hospitalized for services that could be provided on an ambulatory basis. These procedures, although based on quality, have enabled the Fund to maintain a hospital admission rate over the years considerably lower than previously and thereby effect a major cost control.

Fund experiences provide your subcommittee, Mr. Chairman, with ample documentation to support the inclusion of Board requirements for payments for surgery and non-surgical hospital admissions in any national health security legislation.

Control of quality is also the reason the Fund has never established a fee schedule. Fee schedules rarely allow for differences in physicians' training and ability. Neither do they recognize differences among patients and the conditions for which they are seeking care. Moreover, no recorded experience clearly indicates that fee schedules control charges. Parenthetically, the rather marked similarity of fee schedules and capitation has led the Fund to shun the latter for essentially the same reasons it avoids the former. Medical ethics not only should be a code of professional ethics among doctors but also should serve as a code of fundamental morality and justice between medicine and the people.

The Fund's 23-year principle has been to pay reasonable fees with determinations of reasonableness made by physicians and expert medical care administrators. The Fund has been guided by fees paid by others in the same geographic area, and it has never hesitated to seek disciplinary restraint to the extent it is available in the ranks of organized medicine. Action has not always been helpful, even when services of questionable quality have been provided by an unqualified physician. In the Fund's considerable experience it is naive to expect more. It is equally naive to expect a hospital utilization committee always to discipline an erring colleague effectively - particularly if he has a large referral practice.

Finally, the Fund has observed that respect of human rights and personal dignity usually is a key element in the provision of high-quality medical services. The manner of providing medical services cannot be deleted from evaluations of the quality of the services. Adequate provision for this type of evaluation should be an integral part of national legislation.

The second technique in total patient care involves a single physician, the managing physician, who must be responsible for all medical care a patient receives. The managing physician usually is an internest or a capable general practitioner who, by training and experience, is thoroughly familiar with the value of providing comprehensive medical care on an ambulatory basis. He also has no vested interest in surgery and is thus able to assess the need for hospitalization more objectively. Hospitals are not "...the answer to all our medical needs."

This was the considered opinion of the late Dr. Warren F. Draper one of the nation's outstanding health officials and for 22 years the Executive Medical officers of the Miners' Fund. Use of the managing physician has been one of the most effective techniques in assuring hospitalization only when it is medically indicated.

A study of 2,845 hospitalized Fund beneficiaries revealed that 18 had been admitted an average of 28 times in one 4-year period - one patient had been admitted 83 times. There had been little communication between the 17 physicians responsible for admitting these patients and generally the physicians were unable to devote the time necessary for the beneficiary to fully understand the diagnosis and therapeutic regimen. Immediate arrangements were made for a managing physician, who with ready access to all the necessary specialty personnel and resources, could provide a continuity of ambulatory medical care. Thus have hospital admissions and length of stay been controlled. In contrast to the limited medical care previously provided, the managing physician is concerned with the prevention and early detection of disease and disability, as well as the diagnosis and treatment of illness and injury and rehabilitation of the beneficiary.

A large element of the success the Fund has encountered in developing the managing physician technique is due to recognition of the difference in time and manpower required to provide the full spectrum of medical services. It takes far more time to guide a patient successfully through the maze of medical technology and develop an understanding of all that is involved than it does to treat episodic illness.

Billing on a fee-for-service basis then becomes difficult if not intellectually and fiscally dishonest.

The Fund has developed a fee-for-time or a retainer method of payment which is used for paying about 70 percent of the participating physicians. The method is based on the amount of physicians' time devoted to beneficiaries and includes an equivalent percentage payment of the physicians' overhead costs. A surgeon paid on this basis is fully cognizant of the fact that his income is no longer geared to the outmoded "piecework" fee-for-service method of reimbursement. He knows that the Fund is equally concerned about his clinical judgment and his technical skill and willing to pay him for both.

Likewise, an internist is freed from the usual economic constraints of fee-for-service and is paid for his knowledge and ability. This method of payment has appreciably improved the quality of medical care provided beneficiaries, increased the number of qualified physicians available in mining communities, and reduced the amount of paperwork because the physician is paid a mutually agreed upon sum, either monthly or semimonthly.

Mr. Chairman, the Fund's high level of success with the managing physician and in particular the fee-for-time method of payments leads me to urge you and the other members of the subcommittee to give more opportunity for the use of these quality and cost control techniques.

A third Fund technique stems from recognition of the concept that a physician can no longer operate as effectively or as efficiently

on a solo basis. He needs ready access to all the allied health services. The managing physician is more effective and efficient when he is part of a multidiscipline group practice unit.

Before continuing, I would like to state three personal caveats which may be of help to the subcommittee in evaluating the testimony you will hear about prepaid group practice and Health Maintenance Organizations. First, group practice, regardless of the method of paying for the services, will not lower significantly the costs of medical care. It does have the potential, however, for containing or moderating the costs, particularly when it is a multi-specialty group combined with prepayment. The development of this potential is largely dependent on the adequate utilization of health manpower and medical technology, and the provision of an improved quality of medical care. Second, the designation of an aggregation of physicians as group practice does not necessarily assure that they are providing a good quality of medical care. Such an assumption is as fallacious as stating categorically that all fee-for-service solo practitioners provide a poor quality of medical care. The real reason for concern about solo practice is that today a physician is no longer able to operate as effectively or as efficiently on a solo basis. The vast store of accumulated knowledge, the increasing tempo of specialization and the rapid advent of technical developments are forcing us to improve the methods of organizing and distributing health services. Third, joining together with other physicians in a group practice setting is unpalatable to some physicians albeit this number is decreasing. The competit

of the solo practitioner with group practice is not too tough at this time but the life expectancy of solo practice fee-for service medicine is not too bright.

The miner's Fund has been instrumental in stimulating the development and expansion of 37 group practice clinics in coal-mining communities. The central clinics with from 10 to 30 physicians have been developed on a regional basis with one to three small outlying offices staffed with from two to four physicians. Physicians in the clinics are board certified in the more frequently used specialties such as pediatrics, internal medicine, obstetrics and gynecology, surgery, radiology and pathology. Other specialists are readily available from nearby teaching facilities. In each facility there are also general practitioners who are an integral part of the group.

In some clinics psychiatric teams consisting of psychiatrists, psychologists, and psychiatric social workers are available on a regularly scheduled basis. The health team also includes nurses, technicians, and family and rehabilitation counselors. Cooperative arrangements with other community agencies assure the availability of such additional health personnel and resources as may be necessary.

The Fund does not own or operate group practice clinics but purchases services from them as from other physicians or groups. The clinics are owned and operated by community nonprofit organizations, the membership of which, in many instances, consists largely of miners.

The Fund pays the organization monthly for that percentage of the total costs necessary to provide beneficiaries with services.

The physicians, in turn, also have formed their own nonprofit organizations and the Fund pays them a single monthly retainer for that percentage of their time in the clinic or hospital devoted to the provision of medical care for beneficiaries. Although payment is made for services after they are provided, this procedure is in fact prepaid group practice in that the two monthly Fund payments are the equivalent of the total monthly membership payment which the beneficiaries would have to make to the organization owning and operating the clinics.

About one-third of the clinics are hospital based. Although none of the rest are so situated, the physicians do have privileges in nearby hospitals.

Prepaid group practice with strong consumer participation has proved to be the most effective and efficient manner of providing beneficiaries with high-quality, comprehensive ambulatory medical care. Only in this manner has the Fund been able to control adequately hospital admissions which in some locations are at least 25 percent lower than previously prevailed. Group practice has also enabled the Fund to benefit from the economies effected by centrally located and jointly used equipment and supplies - an economy which does not usually prevail among solo practitioners.

The beneficiaries who have had long experience with company physicians deeply appreciate the savings of their time and energy resulting from group practice. Beneficiaries also accept and approve the Fund's efforts to maintain them in a healthy ambulatory state.

Although there is a physician shortage, recruiting physicians

for group practice is easier now that it was a few years ago. Apparently the providers of service also are convinced of the values of group practice. Just as the patient has much to gain from prepaid group practice, so do the doctors. Experience indicates that prepayment avoids the competitive financial tensions which have frequently proved disruptive of fee-for-service groups. Surplus earnings in prepayment are used to expand patient and staff benefits which effectively avoid the problems involved in limiting the distribution of these earnings among doctors. Prepayment usually eliminates the economic incentive for each physician to be a money producer. Fee schedules are unnecessary with prepayment which enables these groups to avoid economic barriers and paperwork. Also avoided is the fee-for-service incentive to promote the unnecessary use of services.

Of greatest importance to both the patient and doctor, as well as to the entire nation is the undisputed advantage which prepaid group practice enjoys over all other plans in lowering hospital utilization rates. This is an amply demonstrated characteristic of prepaid group practice wherever it is located. To date, insurance companies and the Blues have been unable to implement the comprehensive ambulatory medical care necessary to achieve this saving but recent developments are forcing them in this direction. Frankly, I fail to perceive the incentive essential for this cost control in the fee-for-service group or solo practice. Comprehensive ambulatory care, with its concomitant quality controls and inherent cost control, exists only when the costs are prepaid either by or for the patient.

Today the cost of medical care is of vital concern to everyone but it is with prepaid group practice that the consumer has taken the leadership role in developing and maintaining programs designed to provide high quality medical care at a reasonable cost. Most prepaid group practice is sponsored either by consumer-community or union-employer groups.

A group that is organized on the basis of meeting both the financial and medical needs of the patient is committed to serving the best interests of the sponsors, be they cooperatives, the community, or organized labor. With this commitment a synthesis of care is provided by the personal or managing physician who, covering the whole field of medical care, draws on other medical personnel as needed. When organized according to doctor's needs, a medical care system is primarily a scheme for a division of labor. It is the producers rather than the consumers who seem to benefit more from fee-for-service group practice. A consumer-owned-and-operated facility is more patient-oriented than a facility operating on a fee-for-service basis.

The United Mine Workers of America endorses the provisions implementing prepaid group practice. Our experience clearly indicates that this is the most effective technique yet devised for providing the continuing ambulatory services essential for maintaining people in a vertical rather than a horizontal position. When combined with the full spectrum of services, preventive, diagnostic, therapeutic and rehabilitative, hospitalization which is the most costly medical care item is then only necessary when all else has failed. The wide acceptance and

implementation of this concept is truly essential for the solution of the nation's health crisis. A major step in this direction is the earmarking of funds for a three-year "tooling up" period in the national health security legislation. For the first time this will make available on a national basis the capital money necessary for the development of group practice facilities. Heretofore, in the absence of such money, we have witnessed a painfully slow growth of these facilities.

When the Fund implemented each of the three major procedures which I have presented it encountered opposition - sometimes violent - from every level of organized medicine. Adroit endeavors seeking cooperative relationships were declared "null and void, terminated and ended." Violations of the time worn shibboleths of "free choice of physician" and "fee-for-service" were hurled at the Fund in a continuing effort to discredit the program. Fund physicians as well as those participating in the program were ostracized, ridiculed and on occasion threatened. It was covertly admitted that most of these activities stemmed from those physicians who viewed quality controls as an economic threat. This opposition made inoperable all attempts to establish peer review within the structure of organized medicine. While few attitudes have changed the overt manifestations markedly diminished with a decrease in the number of eligible Fund beneficiaries during the latter years of the 1950 decade. Mr. Chairman, essentially the same experience can be anticipated before and after the passage of national health security legislation and I might add for the same reasons.

Proposed national health security legislation wisely makes funds available for the training of all health personnel, all of whom are toda in distressingly short supply. Regardless of the discipline or specialt there is a dangerous shortage of health manpower throughout the entire nation. Undoubtedly, there will be some who will maintain that the education and training of personnel should precede the passage of the bill. This is nonsense! At the rate a resolution to this particular problem has been sought in the past, we might well never achieve nationa health security were the subcommittee to heed further Cassandra cries fo delay.

The provision of preventive services should be specified as an underlying theme pervading national health security legislation. It wil be the most important feature of this legislation if properly implemente In the absence of this concept the legislation would be just a bill-payi mechanism. The implementation of this concept is more than the provisio of specified preventive services. It is impossible to achieve without those sections devoted to improving quality mentioned earlier. Unless prevention becomes meaningful we will never reduce morbidity and disabil ity rates and our health standing will continue to compare unfavorably with other countries. This will be particularly true of those countries where prevention has become a way of life. I am deeply concerned about the fragmentation of the worker's health needs which occurs with the usu attempt to separate occupational illness and injury from those not job-related. These are inseparable because of the impact of one upon the ot I would hope that as your hearings continue the need to amalgamate these

services would become clear and that the prevention as well as diagnosis, treatment and rehabilitation of job-related illness and injury would be a recognized service provided by group practice facilities. This would be a major step in resolving the problem of providing these services in the vast majority of work places throughout the country where they are presently non-existent.

The United Mine Workers of America disagrees with the method of financing proposed in the national health security legislation. We are in favor of health services being totally financed out of the general tax revenue. It is our opinion that a method of financing can be developed which will avoid the pitfalls of annual appropriations and yet will tax all the people on their declared ability to pay rather than further decreasing their sorely burdened resources needed to meet the daily costs of living. Today regressive taxation should be an anathema among those who have labored so long to develop the otherwise forward-looking features of the national health security bill.

Mr. Chairman, to summarize, we can no longer ignore the health crisis confronting us today. All of its ugly and brutalizing manifestations have been documented many times over during the last several decades. However, each time Congress has looked anew at the nation's worsening health status the inordinate pressures of organized medicine and other vested interests have successfully staved off the passage of essential legislation. Congress dare not countenance further delay. Rhetoric is no longer a substitute for an adequate therapeutic regime.

Past experiences with a multitude of health care programs - past and present, foreign and domestic - provide ample information on which to base a comprehensive nationwide program. The enormity of the task prohibits isolated fragmented desultory efforts. Services must be readily accessible in the ghetto and rural areas as well as affluent suburbia and the place of work. All barriers to service - economic, geographic and racial - must be eliminated!

During the last quarter of a century the United Mine Workers of America Welfare and Retirement Fund developed a medical care program widely acclaimed for its pioneering contributions. It has clearly demonstrated those major quality and cost controls essential for the provision of a nationwide program.

Thank you for this opportunity to express the views of the United Mine Workers of America on national health care legislation and to reiterate our long-standing support of national health services as voiced by our membership in numerous resolutions in the past.

Senator KENNEDY. The subcommittee stands in recess.

(Whereupon, at 5 p.m. the subcommittee recessed, to reconvene subject to the call of the Chair.)

HEALTH CARE CRISIS IN AMERICA, 1971

TUESDAY, APRIL 20, 1971

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Nashville, Tenn.

The subcommittee met at 2 p.m. at the Vanderbilt University School of Law Building, 21st Avenue South, Nashville, Tenn., Hon. Edward M. Kennedy (chairman of the subcommittee) presiding.

Present: Senator Edward M. Kennedy.

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

Senator KENNEDY. The subcommittee will come to order.

This afternoon the Senate Health Subcommittee resumes its field hearings into America's health care crisis.

For the past 2 months the subcommittee has held hearings in Washington. And that hearing record documents the existence of a massive health crisis.

Health care is America's fastest growing, failing business. It is a $70 billion cottage industry. In the last two decades Americans have been forced to increase their expenditures for health care almost sixfold—from $12 billion a year to $70 billion. And much of that huge increase buys nothing. It is nothing more than inflation. For example, last year health-care costs increased twice as fast as the consumer price index. If we are to have national policies to control construction costs, why can't we have a program to control skyrocketing health costs.

Our hearings have also demonstrated that the method by which we finance health care is totally inadequate. For more than 30 years the American consumer has had to look to the private insurance industry. By and large the insurance industry has failed. After three decades of experience (and profit) private insurance only covers about one-third of health costs. It is biased in favor of sickness, not health. Most private insurance policies do not cover preventive health or health maintenance programs. Moreover, the insurance industry is essentially unregulated. Even the administration, which now looks to the insurance industry for solutions to the health crisis, has recommended that there be tight regulation of the industry.

We also know we have a serious health manpower problem. We do not have enough health manpower. And the manpower we do have is inequitably distributed. Why is it that the wealthiest nation on earth is an importer of health manpower? Why is it that America wins Nobel prizes for research and yet is unable to translate the benefits of that

research into decent health care for its citizens? Why is it that America ranks so low in terms of infant mortality? Why is it that there is virtually no quality control or peer review for the solo practitioner? Why is it that Blue Cross has become the agent of hospital and Blue Shield the agent of the doctor rather than both of them being the agent of those whom they purport to serve—the consumer? Why is it that most hospital emergency rooms have in fact become inefficient outpatient departments? Why is it that America has twice as many surgeons as Great Britain and does twice as much surgery? Why is it that doctors and hospital administrators privately admit the need for basic system reform and yet are reluctant to testify to that need? Why is it that consumers are afraid to testify about their difficulties in attempts to get health care?

To fully develop the answers to these questions the subcommittee has begun a series of field hearings. Last week the subcommittee visited New York City and its suburbs. Yesterday the subcommittee spent the entire day in rural West Virginia investigating the tremendous problems that rural people have in trying to receive health care. For them, the health system too frequently has nothing to offer. Today, we are in Nashville, and we have come to let the people speak.

Over the next month the subcommittee plans to visit at least seven more cities in all parts of the country. And in each of these field hearings I want you to know that we are biased. We are biased in favor of the consumer. The time has long since passed that his voice should be heard. The time has come to open up the health care system and let the people in. Now is the time for reform, not rhetoric or retrenchment.

First of all I want to express my appreciation to Chancellor Heard and Dean Wade and the members of the faculty of Vanderbilt for their kindness and hospitality and the reception they have given to us and the staff of the subcommittee in our hearing today.

During the period of the last 8 weeks the Senate Subcommittee on Health has been having extensive hearings on the health crisis. Some 7 weeks has been spent listening to the representatives of the health industry in Washington, D.C., and last week we began our initial hearings in the field. The Senate Health Subcommittee visited New York City, which in many respects reflects in microcosm the health problems we have in many of our urban areas; after a day and a half there we traveled to the more affluent suburban areas in Nassau and Westchester Counties and talked about the problems in suburbia, in the middle and upper income groups. Saturday we traveled to West Virginia. We spent a complete day trying to get a better understanding and feeling for rural health problems.

It is my belief that in spite of the extraordinary problems we have in terms of urban health crisis, that rural health is equally, if not a more difficult problem that we're facing in this Nation of ours. In the course of the field hearings, we're trying to spend as much time as we possibly can listening to consumers. We try in the course of the hearings to try and see the best and poorest facilities providing health delivery services, but we are primarily interested in listening to the consumers, those who have had some contact with the health system, or perhaps have had some contact and little else with the health system.

For the next two and a half hours we hope to listen to the consumers and then we'll open it up to any comments from the floor. If any of you would like to make any comments, give us your name up at the desk and we'll call on as many people as possible depending on the amount of time we have. For any of those who want to make a comment, we'll try and give you that opportunity. If time does not permit, you may send us your statements and they will be included as part of the record which will be printed and hopefully will be reviewed by the members of the subcommittee.

That is the procedure we'll follow here this afternoon. Now we'll begin with our witnesses. We know there are a number of people on the outside. I don't know the fire laws around here, but as far as I'm concerned they can come in and fill up whatever space is available. There are some seats in the middle of the third row, aren't there?

Our first witness this afternoon is Mary Lynn Fletcher from Knoxville, a student of the University of Tennessee. She's on a committee at the university to study the problems of the handicapped. Mary Lynn, we welcome you before the subcommittee.

STATEMENT OF MISS MARY LYNN FLETCHER, KNOXVILLE, TENN., A STUDENT OF THE UNIVERSITY OF TENNESSEE

Miss FLETCHER. Senator Kennedy, approximately 2 weeks ago the AMA testified before your subcommittee, I believe it was a Dr. Roth and a Dr. Parrott. They testified that the health crisis was not across the board. I'm here to refute that because they stated it was restricted to the slums and the rural poor. From my own personal experience and my family's personal experience, I want to come before this committee and say that it is across the board.

My own family, four members out of five had catastrophic illness, two of them chronic and two cancer which were fatal. In my own case, I was struck with polio in 1950, and it has required 20 years and 25 operations to come from a total paraplegic to a partial paraplegic.

My oldest brother had Hodgkins disease which required 4 years going from Knoxville to Atlanta on bimonthly or weekly trips. In 1965 my father was diagnosed as having bronchial carcinoma and died 3 months later. My younger brother, Charles, 11 months younger than I, 1 month after my father collapsed, was involved in a head-on collision, August 3, 1965, which crushed bones all over his body.

The effect of all of this financially is what I'd like to talk about. My parents were just starting in business when I was five, and they felt like it couldn't happen to them. Anything as catastrophic as polio couldn't happen to them. It was a question of either eating or paying insurance premiums, so they didn't have any insurance. My mother estimated approximately 2 weeks ago that from the time I was 5 years old until I was 19 they paid as an outlay of approximately $65,000 for my illness alone. She received no help with the exception of the Polio Foundation two times.

My parents' business was doing extremely well until about 1958 when there was a general business slump. Then Jack was diagnosed as having Hodgkins Disease. We had insurance on Jack but it paid only one-third of the total cost. They had Blue Cross and Blue Shield,

but the trips from Lenoir City to Atlanta and back to Lenoir City and the medicine needed was extremely expensive, and we had two people ill at this time, myself and my brother.

Another example occurred in the summer of 1958 when Jack and I both were in Atlanta, Ga., in Georgia Baptist Hospital. He was on the sixth floor and I on the third for an entire summer. My parents paid out of their pocket $4,400. This is only a sample of what they had to pay.

My father's business suffered reverses, and a lot of things happened in 1965. Finally they put it in the hands of a receiver in July. The Sunday after that Friday he collapsed and on Monday they said he had cancer. The following October he died. When he closed that plant it automatically canceled the health insurance for all employees and all members of the family, so he had no insurance. The doctors said he needed a private room but the hospital told my mother she could not afford a private room and made her pay an additional $300 as a deposit so we wouldn't run off and not pay.

Charles, the younger brother was under the same insurance plan, and when he was in the head-on collision he had no health insurance. He had car insurance, and finally when the automobile insurance companies settled with him, it took a year, his medical expenses were paid.

Now the American Medical Association and the Nixon administration say if we go under private health insurance everything is going to be all right. I know from bitter experience this is not the case, because in my later life when I was on my own, it has become me, Mary Lynn Fletcher versus the insurance companies. I cannot get insurance, I can only come under group insurance plans, and I am being forced to enroll in the mass enrollment firms that advertise in the papers and they are frauds of the worst kind, because I cannot get the insurance.

For instance, this summer I was going to school and I fell, necessitating surgery, back surgery, a spinal fusion, and the University of Tennessee medical insurance, Zurich Insurance, refused to pay on the basis it was a preexisting condition, because preexisting conditions are not covered. It took a friend of mine who was a lawyer and 9 months to force them to pay this. At present I am going to the University of Tennessee on an OEO grant, which in an academic year cost $1,200.

Senator KENNEDY. Why did the insurance company say that was a preexisting condition if it was after you fell? How did they know this?

Miss FLETCHER. Because I had had back trouble before. The surgeon's report definitely stated after he operated that it was because of a recent fall and two discs had been cracked and had not been calcified.

Senator KENNEDY. But the insurance company said it was preexisting?

Miss FLETCHER. Yes.

Senator KENNEDY. They required you to go to an attorney at least to try and realize what you felt were your own rights, and ultimately shown to be your rights, and they assumed that particular burden.

Miss FLETCHER. On most major claims I have had to have an attorney to force most insurance companies.

Senator KENNEDY. Who pays for those attorneys?

Miss FLETCHER. Well, I am very lucky in having some very nice friends who are attorneys or else I could not afford it.

Senator KENNEDY. Some of your best friends were attorneys. [Laughter.]

Miss FLETCHER. Even if I have group insurance, as I say, the problem of making them pay is tantamount to impossibility. I had an ulcer attack, and I have yet to see what polio has to do with an ulcer, and they have used this as an excuse. I have riders, I have two insurance policies and both of them have riders on them. It says anything relating to the lower extremities is not covered.

Senator KENNEDY. Who do you think the insurance companies represent if they don't represent the consumer?

Miss FLETCHER. They represent themselves.

There are more ramifications to insurance than just health insurance. I have been denied three specific jobs because they will not cover me. They say to the company, "You keep down your risks, and we'll keep down your rates." They can go in and say your rates go up because last month you had five accidents, so the companies won't take that chance.

Senator KENNEDY. That would be true if the companies were to employ you, they'd always be threatened with the insurance company saying if you take this party there's a possibility that your rates will go up correspondingly. Has that happened to you, do you think?

Miss FLETCHER. You mean do my rates go up?

Senator KENNEDY. No, the company's rates would go up if they hired you. Do you feel the fact that you have obviously had a tragic experience with polio and other health ailments, that when you go in to gain any employment, it has been manifested to you than an employer is a lot less willing to hire you because you are going to affect his insurance rates?

Miss FLETCHER. It is not that obvious. The reason I know specifically is because of these three job instances. People I became friendly with later have told me that they could not hire me because they had to keep down people with chronic illnesses. A vocational rehabilitation worker told a friend of mine if I were a handicapped person and it was not visible, he would not put it on an employment record because right there they'd throw it in the trash can.

My family has had more illnesses than usual. I realize this, but it is not that we are the great exception because we are not. I have worked in hospitals where you have to have insurance to get in and I've worked with handicapped children since I was 15 or 16. I've worked with veterans, I have seen diseases and expensive diseases going from black to white to polka dot, from rich, middle, and poor, and I just frankly dare anyone to say that mine is an exception. On my street alone there are three chronically ill people, and I've seen families destroyed when one person of that family is ill. I've seen them miss opportunities, go into bankruptcy, innumerable things.

The Nixon administration says we're supposed to use the same vehicle that has brought us to this crisis to take us out of it. To me this is totally irrational.

Senator KENNEDY. Let me ask you, Mary Lynn, what do you estimate were the total medical bills just for yourself?

Miss FLETCHER. $65,000.

Senator KENNEDY. $65,000. And in addition your brother was in the auto accident and your other brother had Hodgkins disease and

lung cancer when your father's business went on the rocks. I imagine it was partially due to the health expenses.

Miss FLETCHER. Partially, yes.

Senator KENNEDY. Have you ever throught about what these total medical bills were?

Miss FLETCHER. We tried to put them together in some type of assemblage and it would be somewhere between $80,000 and $100,000.

Senator KENNEDY. As I understood, you mentioned that one summer when you and your brother were both in the hospital, your family had about $4,000 that your father paid. What do you estimate that your family paid for the entire, the total amount of illnesses.

Miss FLETCHER. That was the $80,000 to $100,000.

Senator KENNEDY. That your family paid?

Miss FLETCHER. That the family paid. Mother estimated $65,000 for me and the rest for the rest of the family.

Senator KENNEDY. Are they still paying any of that?

Miss FLETCHER. I am, and I will be for many, many years to come.

Senator KENNEDY. You are still paying medical bills?

Miss FLETCHER. Yes.

Senator KENNEDY. Since when?

Miss FLETCHER. 1967.

Senator KENNEDY. And you're required to pay them. I suppose you feel morally obligated to pay those bills?

Miss FLETCHER. Of course, but when you do the best that you can and they still write these nasty little notes and ask you to accelerate your payments, you get to the point you say you're doing the best you can and that's all I can do. I've just about reached that point.

Senator KENNEDY. Under the administration's program they cover up to $50,000 for a family, so actually they'd be woefully inadequate. They pay a percentage of the first $5,000 and then up to $50,000 and that's the cut off.

Miss FLETCHER. I have no idea what my medical expenses will be. They will be continuous until the day I die. Fifty thousand dollars can be spent in a period of 2 or 3 years at the rate it is now, so I don't see how that can cover catastrophic illness.

Senator KENNEDY. I suppose the point which must trouble you, as well as us is the fact that you've had one of the most extraordinary types of tragedies in your families, and besides the personal tragedies you've had the financial tragedies as well. I suppose we have to ask ourselves as Americans if this is a part of the health system. We say your case is extraordinary, but is it really? We had testimony just last week up in Nassau County in New York, a young boy playing in the 150 pound football field last fall tackled another boy and separated his spinal column. Now the father, one of the most successful salesmen for a major insurance company has had medical expenses going up to $50,000. It appears that they will have to care for this boy as long they live and have continuing medical expenses of probably $50,000 to $60,000 a year. He is at the Rusk Center in New York City.

I think you made the point of the attitude of the insurance companies to the payment of various medical expenses to date and their attitude toward you which is a continuing attitude in terms of discouraging job employment for yourself. A part of the administration's

program is this cost consciousness. I don't know whether you are aware of that feature. That's the deductible, every time you go down to the hospital you have to pay out the first $100, or the first 2 days you spend in the hospital, and the first $100 of medical expense. That's supposed to make people cost conscious, so they don't use the facility. I would think you are about as cost conscious as anyone, and tragically so.

Miss FLETCHER. Senator, something has to be done now for people like "middle" Americans. It's so tragic and it is so urgent, that I am just afraid if we don't have something pretty soon many of us are going to be in dire bankruptcy for the rest of our lives.

Senator KENNEDY. I think the other point your situation demonstrates is that the health crisis isn't just for the rural poor of this country. It affects middle America, and it affects them in the most extraordinary ways. It can affect them in the kind of ways illustrated in your case, in the extraordinary financial obligations as well as in the health care they are receiving. There doesn't appear to me to be any reason why we can't have the concept of insurance in its total sense, where healthy people are paying through a progressive tax measure as we try to do in the National Health Insurance, which would help those people who have this kind of sickness or this kind of tragedy, where the burden is presented in the most progressive means possible on the whole society rather than on a particular individual or particular family. That is the essence of our National Health Insurance program.

Miss FLETCHER. Senator, there are times I would never have gone to the hospital because I was unable to afford continual care. Until it became a tragedy or an emergency, I would not go to the hospital, but I could not afford that weekly in-and-out hospital and medical care, and we didn't have it in a small town.

Senator KENNEDY. I want to thank you very much, Mary Lynn. We appreciate your testimony. It is about as strong an indictment of the present system as we have heard, and we appreciate very much your willingness to come and share this experience, which I know is not a pleasant one, with us.

Our next witnesses are Mr. Herbert Anderson and Mrs. Frances Lutz. Unfortunately, Mr. Anderson was taken ill and Mr. Don Vogen, a representative of the Steelworkers will tell his story.

STATEMENT OF DON VOGEN REPRESENTING HERBERT ANDERSON, STEELWORKERS REPRESENTATIVE

Mr. VOGEN. First of all, Mr. Anderson was supposed to be here today, he is a member of the Steelworkers and has had pretty serious illnesses. At the last minute today he notified me he couldn't be here so I thought I'd relate what I could. He had a serious heart condition several years ago, high blood pressure, and diabetes. As a result he has become disabled. He is drawing some VA pension and social security, a little over $200. He ended up with a considerable out-of-pocket expense over and above what his insurance would pay. As a result of that the hospitals demand a pretty high payment out of him for his hospital and doctor bills. They demand at least $50 a month.

He is unable to pay this. He has been paying about $5 or $10 a month for some time now. He felt like if he had been working or able to work anyway at all, the doctors and hospitals would have had his wage garnisheed and put an additional burden on him. He was admitted to the VA hospital.

Senator KENNEDY. What is this where hospitals garnishee a worker's wages?

Mr. VOGEN. I haven't had any personal experience with hospitals, but I have had with doctors.

Senator KENNEDY. We had one yesterday. It often appears that the hospitals are better at chasing patients than they are at treating them.

[Applause.]

Mr. VOGEN. May I add that most of these employers will not stand for but about two or three garnishments and then they'll terminate.

Senator KENNEDY. Tell us about that. If they have had people who do have these extraordinary kinds of hospital expenses and they're turned over to one of these collection agencies, which I understand is one of the fastest growing businesses in the country, they go out and get a judgment against the wages. We had an instance yesterday in West Virginia where they actually fired this employee because he was paying $15 instead of $25, and he went on unemployment. Does this happen?

Mr. VOGEN. It certainly does. I got involved a few weeks ago in a similar case. One of our ladies was in a car wreck. She was out of work for a very long time, 6 or 8 months, and her husband is disabled and can't get a job. She had a doctor bill of $300 or $400 that she couldn't pay. Some fly-by-night collection agency got control of the bill, sent a notice, got a garnishment in court, sent it to the employer. The employer called me because they sympathized with her, and I immediately began trying to make arrangements for her to pay some kind of money to the collection agency.

The attorney, which evidently was another friendly attorney, represented her and went to the collection agency and offered a sizable amount, I don't know what.

Senator KENNEDY. I understand these collection agencies are known in Nashville as Professional Adjustment Companies.

[Laughter.]

Mr. VOGEN. I've heard that; yes. They would not let her pay a partial payment and withdraw the garnishment. They insisted on full payment. She wound up with a garnishment and two more she may lose her job. Mr. Anderson related yesterday this is one of the things he'd be faced with. He went to a VA hospital and felt he was getting fine treatment there. They were running several tests for the heart condition and the diabetic condition and high blood pressure, and for some reason they would not treat him any more. They released him and sent him to General Hospital in Nashville, which I understand is a Metro hospital.

He goes there early in the morning, stays all day, about once a week and all they do is give him a bag of pills and check his blood pressure.

Senator KENNEDY. Why does it take all day?

Mr. VOGEN. He doesn't know. He just sits there and waits until they call him. He went out last week at 11 o'clock in the morning and stayed until 5 before they got to him.

Senator KENNEDY. Is that because of crowded conditions?

Mr. VOGEN. I don't know, but he feels he is not getting proper care. Of course like most of us he's not in a position to determine whether he's getting proper care or not, but it's going out there knowing he has conditions other than high blood pressure and they don't seem to be concerned with his heart condition or with his diabetic condition, they just take his blood pressure.

Senator KENNEDY. He felt he was getting better care at the VA hospital, did he?

Mr. VOGEN. Absolutely.

Senator KENNEDY. That's the Government hospital.

Mr. VOGEN. Yes.

Senator KENNEDY. Miss Lutz, you are Mrs. Frances Lutz.

STATEMENT OF MRS. FRANCIS LUTZ, NASHVILLE RESIDENT

Mrs. LUTZ. Yes. I have had three heart surgeries within a year and a half and the last one was a month ago, open heart surgery, and I am drawing social security right now of $209 a month for my son and I. When he graduates from school his part will be dropped.

Senator KENNEDY. What will you receive then, Mrs. Lutz?

Mrs. LUTZ. Well, I'm receiving $70 for him, right now, unless he goes to college.

Senator KENNEDY. It would be $130 then.

Mrs. LUTZ. Yes, and my first operation I still owe $1,200 for the hospital. This includes the doctor in the hospital, above that which my insurance paid.

Senator KENNEDY. This is $1,000 in excess of what your insurance paid?

Mrs. LUTZ. Yes, for the first operation.

Senator KENNEDY. How long ago was that?

Mrs. LUTZ. That was in 1970, yes, January of 1970.

Senator KENNEDY. January of 1970.

Mrs. LUTZ. My second operation was in December of 1970, open heart surgery, and then I had the last one this March; the 10th.

Senator KENNEDY. Do you get blood tests every day now?

Mrs. LUTZ. Yes; I have to every other day since I was out of the hospital. That's to my own private physician and, of course, this isn't covered by insurance, the insurance I have at work. It covers some but it doesn't cover all, it doesn't cover my private doctor.

Senator KENNEDY. So how much medical bill do you owe now?

Mrs. LUTZ. Well, I would say over $1,000.

Senator KENNEDY. That's part of the hospital bill?

Mrs. LUTZ. That was the first operation.

Senator KENNEDY. Do you owe some of that to the heart surgeon?

Mrs. LUTZ. Yes, and the hospital.

Senator KENNEDY. Do you owe some to a cardiologist, radiologist, some for drugs?

Mrs. LUTZ. Yes.

Senator KENNEDY. Anesthesia.

Mrs. LUTZ. Yes.

Senator KENNEDY. So that's somewhere over a thousand dollars not covered by any kind of insurance program you had, and you're trying to pay that off at what, $10 a month?

Mrs. LUTZ. Well, sometimes if I don't have it, I just pay as I can because of the three operations.

Senator KENNEDY. You're still trying to pay that even after your income is reduced, after your son finishes school?

Mrs. LUTZ. Yes, and medicine.

Senator KENNEDY. I suppose you're running up bills now?

Mrs. LUTZ. Yes.

Senator KENNEDY. So that's going to mean you're going to have even more medical bills?

Mrs. LUTZ. Yes.

Senator KENNEDY. Can you tell us a little more about yourself? You live here in this community?

Mrs. LUTZ. Yes, I've lived here about 20 years. I worked up until I had this heart condition which left me disabled, totally disabled.

Senator KENNEDY. You worked before the time you were disabled?

Mrs. LUTZ. Yes.

Senator KENNEDY. How many years did you work?

Mrs. LUTZ. Thirteen years.

Senator KENNEDY. Then you were disabled by this heart condition?

Mrs. LUTZ. Yes.

Senator KENNEDY. And because of that it would certainly appear that you have a very serious indebtedness and will have for a long time to come.

Mrs. LUTZ. Yes, I'm totally disabled and will be probably the rest of my life.

Senator KENNEDY. We have to recognize that heart disease is the biggest killer in this country, yet even though we know that and understand that, all the statistics show it, and the Heart Association points this out to Americans all the time, yet we're still unable to develop a health care system that will cope with it, or deal with it effectively in terms of someone like yourself who has been a working persons and is tremendously disadvantaged because of it. Thank you very much.

Mr. VOGEN. I'd like to add if we had had a little more time, there wouldn't have been any room here for the spectators, there'd be so many witnesses. This is just a small example of what is happening throughout the area here. Representing the Union, if we don't have a crisis now, I'd hate to see one. There's got to be a better system than what there is now.

STATEMENT OF MRS. MARY YOUNG, EMPLOYEE OF GENERAL HOSPITAL, NASHVILLE, TENN.

Senator KENNEDY. Our next witness is Mrs. Mary Young.

Mrs. Young, your name is Mrs. Mary Young?

Mrs. YOUNG. That's right.

Senator KENNEDY. And you work at General Hospital?

Mrs. YOUNG. Yes. in 1967 I became a victim of cancer, carcinoma of the cervix for which I had insurance and they paid over 80 percent of the bill. Of course, the total amount of the hospital bill was $1,234.04. That was just for the hysterectomy that I had in 1967, that's when they found out I had cancer. Then I became a patient at Vanderbilt and I had a radium implant and then cobalt therapy which amounted to $908.64. Out of that the insurance company paid a quarter of it. The

rest I paid out of my pocket and at the present time the balance of my whole hospital bill is $345.66. Of course, I'm paying on that now.

Senator KENNEDY. How much do you pay on that bill of $345.66?

Mrs. YOUNG. $25 a month.

Senator KENNEDY. $25 a month; that will take you 4 years to pay that off, is that right?

Mrs. YOUNG. Well, it's according to my salary.

Senator KENNEDY. You feel like you're going to pay that, you're going to make every effort to do that?

Mrs. YOUNG. Yes.

Senator KENNEDY. What is your take-home pay a month?

Mrs. YOUNG. My weekly take-home pay, without the insurance taken out is $92 a week. With the insurance taken out it's $86.

Senator KENNEDY. So you're going to pay at least 5 or 6 dollars, about 6 dollars a week out of that, even out of the $86?

Mrs. YOUNG. Right.

Senator KENNEDY. Which is almost 10 percent which you will be paying for the next 4 years.

Mrs. YOUNG. That's right.

Senator KENNEDY. This in spite of the fact that we know that in this country of 200 million people that 50 million people will contract cancer; of the people living now, one out of four will contract cancer and two out of three of those will die of cancer. Thirty-five million people alive today will die of cancer. In spite of the fact we know this is going to happen, it brings about the kind of extraordinary medical expenses you have had and a great deal more in some cases. We are still not providing this country assistance with those extraordinary kinds of expenditures.

Mrs. YOUNG. You still have to go through the clinic as a followup and of course that costs too.

Senator KENNEDY. So you are probably going to have future medical expenses?

Mrs. YOUNG. Sure, I'll have them until they dismiss me, which I don't know when that will be.

Senator KENNEDY. If you have the drug treatment, won't that be expensive too?

Mrs. YOUNG. Which drug?

Senator KENNEDY. The cobalt.

Mrs. YOUNG. I don't take that any more. The doctor just follows me up now. I come in about once every 3 or 4 months.

Senator KENNEDY. Don't you think there's a better way of trying to finance this kind of medical expense than the way you have at the present time?

Mrs. YOUNG. Well, I wish there would be.

Senator KENNEDY. I would imagine so. You have a health insurance plan now with a private insurance company?

Mrs. YOUNG. Yes; we are compelled at Metro General to have New York Life.

Senator KENNEDY. What does that cover? Does that have a deductible? Does that mean every time you go into the hospital you have to pay out something before you go in?

Mrs. YOUNG. No; all you need is your insurance card.

Senator KENNEDY. I see. OK, thank you very much. We appreciate it.

STATEMENT OF MRS. PATRICIA LONG, TELEPHONE OPERATOR

Our next witnesses are Mrs. Patricia Long and Mr. James Parsons.

Mrs. Long, Mrs. Patricia Long, is that right?

Mrs. LONG. Yes, sir.

Senator KENNEDY. And you are a telephone operator?

Mrs. LONG. Yes, sir.

Senator KENNEDY. Will you tell us a little about yourself?

Mrs. LONG. I have been employed with the telephone company for about 19 years. Over the period of years until I came to Nashville about 4 years ago I didn't have much trouble. It first started in 1967 when I went to see a company doctor, and he took me off work for a week. After I got back to work he sent me a bill for $30 and then sent me a nasty note because I thought it had been taken care of by the insurance. Then on top of that my company inserted in the record an entry over this illness the next time I was out sick I'd be fired.

Then in 1968 I was involved in an automobile accident with a tractor-trailer, which it was not my fault, it was the tractor-trailer's fault and at the time of the accident I was taken to a motel in Grifton, Ga., about 5 miles away from the hospital. The insurance adjustor dropped me there with no place to eat or anything. He didn't come back and check to see if I needed medical help. The investigators of the accident came back the next day and took me to the hospital because they felt I did need medical help and at the time the doctor happened to be there? But all he did was look at me and tell me to come back the next day and we'll X-ray you and see what's wrong.

So I did, I went back the next day and stayed an hour. After my hour he asked me then to come to his office. By that time the X-rays were ready and it showed I had a sprained neck. He didn't tell me at the time that my back was cracked. I found this out about a month later.

Senator KENNEDY. You had a sprained neck?

Mrs. LONG. And a cracked back. So I came back to Nashville where I have been treated now by my physician, and he has told me now that probably I will have to have surgery on my back. He has given me an estimate of what it's going to run. So far my bills which aren't paid yet have run in the neighborhood of $600 out of my pocket if I were to pay them, but he has consented to wait and see what the insurance company is going to do after he has released me. Then whatever they pay he'll send me a bill.

Senator KENNEDY. Do you feel you're getting adequate health care?

Mrs. LONG. Not for the amount of money I'm paying.

Senator KENNEDY. For any amount of money you're paying, the way you told us you were treated after your accident.

Mrs. LONG. Even now when I go to the doctor's office I go and sit about an hour and a half, then I go into the patient's room and sit 15 or 20 minutes and he sees me about 5 minutes and charges $15.

Senator KENNEDY. Is that typical in your experience? Talking with your friends, other telephone operators, is there this kind of feeling too that you have to wait a good deal of time in doctor's offices?

Mrs. LONG. Yes; that we're actually not getting what we should get.

Senator KENNEDY. Are some reluctant, say that you work with, are

they reluctant to go to doctors because of the long waits in line or because of the expense?

Mrs. LONG. Well, because of the long waits in line, because of the expense, because of the pressure the company puts on them, if they have to go to the doctor and if they have to be out for any amount of time they are either threatened with being suspended or being fired.

Senator KENNEDY. They really wait until they are really sick before going to a doctor?

Mrs. LONG. That's right, and then they might stand a chance of being fired even if they are sick.

STATEMENT OF JAMES PARSONS, EMPLOYEE OF NASHVILLE BRIDGE CO.

Senator KENNEDY. Mr. Parsons, you're Mr. James Parsons and you work for the Bridge Co.?

Mr. PARSONS. Nashville Bridge Co.

Senator KENNEDY. Could you tell us a little bit about some of your problems?

Mr. PARSONS. Well, it started in 1964 when my wife went to the hospital for childbirth. The hospital bill was about $600 and the doctor bill $250. Three months later she went back to the hospital for an operation for tubal pregnancy. She came out of the hospital 3 days before she was supposed to because we didn't have money to pay the hospital bills, because we didn't have insurance. The doctor told her he'd have to take her out of the hospital.

Senator KENNEDY. What happened to your insurance?

Mr. PARSONS. I was working at Wedgewood Corp. at the time and they went out of business. I had insurance with Wedgewood Corp. and they went out of business and they told us our policy was good for 90 days after the company went out of business, so I was out of work a month and a half and that's when my wife went to the hospital and then we found out we didn't have any insurance.

Senator KENNEDY. How long did you work for that company?

Mr. PARSONS. Three years.

Senator KENNEDY. Then they went out of business and your wife had this additional difficulty or complication, and do I understand that she went to the hospital and the doctor or someone in the hospital said she'd have to leave?

Mr. PARSONS. Yes, the doctor, Crafton and Stroad.

Senator KENNEDY. He's going to have a nice surprise on the 6 o'clock news. [Laughter.]

This is after your wife had been admitted, she had some complications and the doctor told you you'd have to take her out of the hospital. What did you do?

Mr. PARSONS. Well, they checked her out of the hospital.

Senator KENNEDY. You mean you took her out of the hospital?

Mr. PARSONS. Yes, sir, because we didn't have any money to keep her in any longer so we took her home and then she had a setback.

Senator KENNEDY. What do you mean a setback?

Mr. PARSONS. She started hemorrhaging, and the doctor wouldn't put her back in the hospital, he treated her at home.

Senator KENNEDY. Why wouldn't he put her back in the hospital?

Mr. PARSONS. Because we couldn't pay the hospital bill.

Senator KENNEDY. All right, go ahead.

Mr. PARSONS. And then 7 months later she went back to the hospital for another operation for a tubal pregnancy and she couldn't stay in the full length of time. They had to send her home again because we didn't have insurance.

Senator KENNEDY. Now did she go back to the hospital again?

Mr. PARSONS. Yes, sir, the Baptist Hospital, that is where Dr. Crafton and Stroad——

Senator KENNEDY. Tell us what happened them.

Mr. PARSONS. For the second operation?

Senator KENNEDY. Yes.

Mr. PARSONS. Well, the doctors put her in the hospital. They didn't know what was wrong with her the second time. She had been to his office that Friday morning and she went back home and started being faint, so she called me at work and told me about it.

Senator KENNEDY. You are working now?

Mr. PARSONS. Yes, sir; so I told her to get the girl across the hall to stay with her until I could come home. In the meantime she got so bad the girl across the hall called the doctor and he said for her to elevate her feet and then the girl called the ambulance so she could go to the hospital, and she went to the hospital and stayed in there, it was 4 days, and then they dismissed her because we didn't have the money.

Senator KENNEDY. Did they find out what was wrong?

Mr. PARSONS. A little intern found out what was wrong with her. [Laughter.]

Senator KENNEDY. And we talk about the need for quality control. What did he find?

Mr. PARSONS. He examined her before the doctor got there and found out what the trouble was, tubal pregnancy, and she had very little blood left in her system because she was bleeding inside, it had already ruptured.

Senator KENNEDY. Was this the first time they found it was a tubal pregnancy?

Mr. PARSONS. No, that was the second time.

Senator KENNEDY. Were they able to discover this the first time? Did they understand this the first time?

Mr. PARSONS. Yes, sir.

Senator KENNEDY. But they didn't find it out the second time. So then what happened after that. You had some rather extraordinary medical bills?

Mr. PARSONS. Yes, sir; I had about $3,200 worth of medical bills.

Senator KENNEDY. Not covered by insurance?

Mr. PARSONS. Not covered by insurance. That was hospital bills and doctor bills and drugs, and they pressured me so bad.

Senator KENNEDY. Who is they?

Mr. PARSONS. The doctors and hospitals and collection agencies pressured me so bad.

Senator KENNEDY. What do you mean by pressure?

Mr. PARSONS. Well, I was paying $20 a month and I was making $70 a week.

Senator KENNEDY. You were making $70 a week?

Mr. PARSONS. Yes, sir; and I dropped down. I was not paying anything because I couldn't afford it, and then they turned it over to the collectors, and they garnisheed my wages. They threatened us on the telephone, sent us letters.

Senator KENNEDY. What sort of things would they say when they called up and threatened?

Mr. PARSONS. That the bill was past due, and they wanted payment in full.

Senator KENNEDY. You were trying to pay at least something whenever you could, is that right?

Mr. PARSONS. Yes; whenever I could. At the time they were calling on the telephone I couldn't pay anything at all and that's when they started pressuring.

Senator KENNEDY. So what finally happened?

Mr. PARSONS. I had to take bankruptcy in order to get out from under the pressure of the doctors and the collectors.

Senator KENNEDY. You had to go into bankruptcy?

Mr. PARSONS. Yes, sir.

Senator KENNEDY. So where are you now, Mr. Parsons, what kind of shape are you in now?

Mr. PARSONS. I'm in fairly good shape now. That was in 1967 when I had taken bankruptcy.

Senator KENNEDY. How many years have you been a working man?

Mr. PARSONS. I have been working since I was 15 years old.

Senator KENNEDY. And you worked all the time you could?

Mr. PARSONS. Yes, sir.

Senator KENNEDY. What sort of employment do you do?

Mr. PARSONS. I'm a spray painter at Nashville Bridge.

Senator KENNEDY. And you left school to work?

Mr. PARSONS. Yes, sir; I left school when I was at home to go to work, and I worked in a veneer mill for a year and a half and I worked two shifts.

Senator KENNEDY. You worked two shifts?

Mr. PARSONS. Yes, sir; because I didn't have a father, so I was forced to make a living.

Senator KENNEDY. How many members in your family?

Mr. PARSONS. Three.

Senator KENNEDY. Well, when you were growing up, did you have some brothers and sisters yourself?

Mr. PARSONS. Yes; two brothers.

Senator KENNEDY. Older or younger?

Mr. PARSONS. I have a twin brother and a younger brother.

Senator KENNEDY. And they had to work too?

Mr. PARSONS. Yes.

Senator KENNEDY. Do you have children now?

Mr. PARSONS. A little girl 6, and she goes to the doctor now, probably once a month and they won't let her in to see the doctor unless we have money to pay them in advance.

Senator KENNEDY. Who won't let them in to see the doctor?

Mr. PARSONS. Miller's Clinic. It costs $11 for her to get in to see the doctor and you have to sit out there about 3 hours and he's with her about 5 minutes.

Senator KENNEDY. That's about a hundred dollars an hour. That's no matter how sick the child is?

Mr. PARSONS. No matter how sick.

Senator KENNEDY. You have to get up the $11?

Mr. PARSONS. Yes, sir.

Senator KENNEDY. There couldn't be a question in anybody's mind whether this is how the richest society in the world ought to be caring for the health of the people. Some people say the fact that you have to pay the $11 for your child to go down and see a doctor is cost consciousness. They say that's going to make you a lot more cost conscious. This cost conscious concept is written into the administration's program as it is in the AMA as well. They think someone like yourself who has been working all your life ought to be able to have to pay because they think you'll overutilize the facility otherwise. They think you want to give up your hours of work and get your wife sitting in a doctor's office because it's fun. I don't understand that particular argument of the administration, but they feel as strong as the AMA does about it.

Mr. PARSONS. It's rather embarrasing. She goes out there and sits out there almost an hour and then they'll call her up to the desk and remind here that she has to have the money before she can get in. Yesterday I got a bill from Miller's Clinic and I called them because I knew I didn't owe them anything. Back in November I fell at work and cut my leg. I had to have it sewed up and that was under Workmen's Compensation, but they didn't charge it to Workmen's Compensation, they charged it to me. So I asked her to check about it and she checked and said we're sorry about this mistake, the balance of your bill is $4. The rest we'll charge to Workmen's Compensation.

Senator KENNEDY. Well, I want to thank both of you very much. You really performed a very important public service here today. You really have. There's no doubt it's one of the most tragic comments that I have heard about our whole system. We appreciate very much your appearance here.

Mr. Parsons, are you working now?

Mr. PARSONS. Yes, sir.

Senator KENNEDY. Where are you working?

Mr. PARSONS. Nashville Bridge.

Senator KENNEDY. Did they give you some time off today?

Mr. PARSONS. Yes, sir.

Senator KENNEDY. I want to thank your supervisor for letting you come down. It has been very helpful.

STATEMENTS OF MRS. MARY SMITH, PUBLIC HEALTH NURSE, AND MRS. BERNA LOU KAISER, COUNTY RESIDENT

Our next witnesses are Mrs. Mary Smith and Mrs. Berna Lou Kaiser. Mrs. Smith is a public health nurse in Houston County, and Mrs. Kaiser is a resident in the county.

Mrs. Kaiser, we're very appreciative of your being here. Could you give us your full name?

Mrs. KAISER. Berna Kaiser, Erin, Tenn.

Senator KENNEDY. Could you tell us a little about yourself?

Mrs. KAISER. I'll start with my parents. My father is not yet retired from the railroad, but he became ill working on the railroad. During this time it took him some years to get his social security and in trying to get this the Health Department helped my mother get welfare for the kids. I come from a family of 13.

Senator KENNEDY. There's nothing wrong with large families. [Laughter.]

Mrs. KAISER. In 1966 my mother got welfare and it helped them up until about 2 or three years ago. My father was able to get a little money from social security. When I was going to school there were a lot of things we couldn't get, like medical help and then I lost a brother about 4 months ago. He was in the service. Mother was on medicare, they had medicare cards. I have a brother who has to have allergy shots every 2 weeks. My mother was getting these shots for him off her medicare card. They took that away after my other brother got killed, so this caused a problem even though she got a small sum of money with the medical bills and hospital bills. After they took her off welfare we felt the medicare card would be a big help because if one of them got ill there was no other way for them to pay the bills.

After I got married in 1968 I have had four children. In 1969 I had a child that had to have a blood transfusion. I was in Crossville Hospital. My child had to be sent from Crossville to Vanderbilt and I had no insurance and no money. They took the child in thinking my insurance would cover it but at the time I hadn't been in it long enough for the insurance to cover it. I had to pay off $554 for this.

I also have a little boy who has been back and forth to Junior League Hospital for his feet, and another little boy 10 months old is back and forth to the Junior League Hospital to Vanderbilt Hospital for convulsions. He has had these convulsions for some time but without the money we could not afford to take him to the doctor every 2 weeks, so they couldn't help him because we didn't have the money.

During this time my mother contacted the health nurse and talked to her about the condition I was in and I've got him coming up here now. The problem now is my mother doesn't have any help whatsoever with medicare and, my brother has to have these shots and he doesn't have any way of getting them.

I wanted to know why did they take my mother off medicare since my brother got killed? And this is the thing, my baby brother would have to have these shots and she can't afford the medical bills.

Mrs. SMITH. The son that died was in the service and the mother is getting a Government pension, and this is the reason she was taken off welfare and medicare.

Senator KENNEDY. Was he lost or killed?

Mrs. SMITH. He had a civilian accident.

Mrs. KAISER. The type of insurance I have, I have hospitalization through my job. We have to take Blue Cross, Blue Shield. The company pays half. For medical bills it does not help. You know, if you have to go to the hospital, yes, you can get in on your card, but if you have to go to your family doctor, it is no good, you have to have the money. It's just the thing where if you don't have the money to pay for your medicine there's no use to go to a doctor, because he can't help you if you can't get your prescription filled.

Senator KENNEDY. You're saying hospitalization in some instances is covered, but any kind of outpatient business is not covered and the doctors prescribe medicine and the people have to have the money to pay for those prescriptions. So why bother going to the doctor?

Mrs. KAISER. I don't worry about myself, but when I take the kids to the doctor I'd like to have money to pay for the prescriptions.

Senator KENNEDY. Why does it appear to you that money has to come first before health? Does that bother you?

Mrs. KAISER. It may be the way the businesses are run.

Senator KENNEDY. It doesn't appear to me to be the right way. Does it to you?

Mrs. KAISER. No; it's not the right way, but it's the way it's done.

Senator KENNEDY. Do you think we ought to be able to find a better way?

Mrs. KAISER. There ought to be a way.

Senator KENNEDY. We ought to put health first and let people get quality health care and then work out the fairest and best way of trying to finance it. Does that appear better for you and your family?

Mrs. KAISER. Yes.

Senator KENNEDY. Now Mrs. Smith.

Mrs. SMITH. Senator, I represent a low-income rural community, a very small community.

Senator KENNEDY. You're a public health nurse in Houston County and a resident of the county?

Mrs. SMITH. Yes, sir; our county is one of the smallest counties in the State. We have approximately in round figures 6,000 people.

Senator KENNEDY. Do you have a doctor there?

Mrs. SMITH. We have had four. We have two leaving now, so we will only have two. We have a new hospital that we worked very hard to get.

Senator KENNEDY. I imagine with a good deal of local contributions.

Mrs. SMITH. No, sir; this was I'm sorry to say——

Senator KENNEDY. That's not known as a leading question. [Laughter.]

Mrs. SMITH. I think it has taken a lot of sweat and blood but not money out of the citizens to get this hospital there because Small Business Administration didn't think it was feasible. We kept working and pulling until we found somebody who did think it feasible, and it is working pretty satisfactorily now, but this doesn't present the real problem we have in the county.

Mrs. Kaiser gave you her story and she and her family are a typical example of the problems we have. We have a major transportation problem because the specialists are all centered in Nashville and we're 70 miles away from there. It takes a taxi $20 to bring one patient from Houston County up here to the medical facilities.

Mrs. KAISER. $21. I come twice a month.

Mrs. SMITH. $21.

Senator KENNEDY. Who pays for that?

Mrs. SMITH. The family themselves. The service provides the doctor bill and medication if the child is accepted into the service, but here again this is a small matter compared to transportation costs.

Senator KENNEDY. Isn't that one of the key problems in getting good rural health care, transportation?

Mrs. SMITH. That's right. We have grown from a very small public health department up into a pretty big one, not in personnel size, but we still have more work than we can do down there in trying to help with the preventive side.

Senator KENNEDY. Why do you think preventive care is important?

Mrs. SMITH. Well, I think it's important to keep people well so they don't have to go in for all these medical bills, if we can do it. There's a lot more to preventive medicine than keeping people well. In our older people we have to keep them from getting worse. A lot of times we can't get them better, but we can keep them from getting worse.

Senator KENNEDY. I'm interested in that. Some people think we have a policy and act only for sick people, only take care of people who are sick, and I think it's your testimony we ought to have a health policy too so if they have health they can maintain it.

Mrs. SMITH. Let me go through the types of things we do in a week. One day we call our visitation day, Monday we spend consulting and visiting patients, going to see doctors and getting prescribed medicine for patients and visiting chronic illness cases. Tuesday, is our diabetes and cancer detection clinic. Wednesday we have our baby clinic. We see sick babies, give them iron supplements to bring their iron up, observe the child for any defects and give them immunization shots. It used to be that people thought prevention was shots alone. This is just the smallest part of the day's activity. Thursday we have the tuberculosis clinic and Friday we try to round up chronic illness.

Last Monday we were on a time study and for the first time we were allowed to tell how much time we spent doing our job. I found out I spent 31 hours overtime which I wasn't getting paid for and I didn't really get the month's work done. There is a need for more personnel, we need more private doctors, we need bigger buildings. We have outgrown our public health department twice, and now we are outgrowing it again.

I'm a provider of services, but I'm a pretty good consumer too. In this past year my drug bill was $547. That's just to maintain me so I could work as a public health nurse.

Senator KENNEDY. Who pays for that?

Mrs. SMITH. I do. In addition to my health insurance I paid $250 to doctors. The health nurses get better pay than when I started out, but we're still not the best paid profession in the world.

Senator KENNEDY. Do you agree with me that solo practice in these rural areas is virtually unable to do the job? The individual practitioner, the individual doctor working alone is as really devoted and as hard working as he might be.

Mrs. SMITH. Not unless we want to kill them off. We have one doctor in our community who is 90 years old, who has been a devoted servant of the people in Houston County. He is still at the present time of 90 years of age making house calls, and this is a rare thing.

Senator KENNEDY. That's right. As I gather from your study of health needs in a rural community, it could be much more favorably and effectively done if done in a group effort. If you're going to provide the greatest degree of health service to a community, you're going to need supplementary health personnel and we have to find ways of attracting them into those areas and provide a medical atmosphere in which they can practice good medicine.

Mrs. SMITH. One other need I see now that we have a facility giving quality care in our community. We still have to send them 70 miles with an untold cost to the family when we could get the identical service in our community. We don't have the money to break down the service into smaller areas. They have to prove their worth, and this hospital is only 2 years old and it hasn't been able to prove its worth yet, so this is what I would like to see.

Senator KENNEDY. I want to thank you, Mrs. Kaiser, and Mrs. Smith. I understand that Reverend Nelson brought you down here today. Is he here?

Mrs. SMITH. He's right in the front row.

Senator KENNEDY. I don't know if there's anything you'd like to add from the floor. We have had good comments and enormously valuable ones.

Reverend NELSON. I can only think of one thing, Senator. There needs to be some type of incentive for the doctors that are graduating to go out into the rural areas. It may be that a health insurance that could cover all the people might be that incentive.

Senator KENNEDY. Well, I agree with you. We have to try to provide something so doctors who practice in rural areas aren't isolated medically, that they are given support with personnel and facilities to practice quality medicine, and that they're given help to meet the problems which exist in the rural areas. That's really what we have to be able to do to attract people out there. There are other features needed to upgrading schools and a wide variety of other things. We try in our national health program to do just that. That's what we're trying to do.

Mrs. SMITH. I want to say one more thing, Senator Kennedy, about retired assistance. We have these retired people living on small pensions. These are the ones I have in my chronic illness program. I go out and see these patients. When they go to the hospital they have medicare to take care of their bills. This is fine, because the doctor's bill, and in the clinic the outpatient care is taken care of. But the bills for the drugs for these patients take up almost 50 percent of their retirement check and they have to have these drugs in order to live.

There's a lot of people throwing slander at the doctors. I'd like to hit the drug people.

Senator KENNEDY. Thank you Mary Smith and Mrs. Kaiser. We appreciate your efforts in being here and your comments have been very helpful. We have two more witnesses before we go into the other part of our program.

Mrs. Mary Jones. Where do you live, Mary?

STATEMENT OF MRS. MARY JONES, EMPLOYEE OF CENTRAL STATE HOSPITAL, NASHVILLE, TENN.

Mrs. JONES. I live in Nashville on Gernecker Road, I work at Central State Hospital.

Senator KENNEDY. I understand that's a large mental hospital.

Mrs. JONES. Yes. When I first moved here about 3½ years ago I was working at one hospital and I was sent to the hospital with asthma, at which time I was in for quite awhile with asthma attacks. I had

to be readmitted several times after this. Due to the fact of me being sick I lost my job, so I went to another hospital and was bothered with asthma quite a while, and I lost my job there too because I was sick. At this time they found out I had ulcers. My blood count kept dropping and the insurance I had was Blue Cross and Blue Shield which paid only part of the bill.

When the doctor found out I had ulcers, he suggested I go into psychiatric treatment. So I was out of work for 6 months this time, and I lived on $14 a month from the welfare department. The doctors and the hospital still wanted me to pay part of their bill from the welfare check, at which time I couldn't. I was making no payments at either place. So I had been working there for about a week when I got sick. At this time I was terminated because of being sick. This is when I went to work at Central State.

Senator KENNEDY. What do you mean you were terminated because you were sick?

Mrs. JONES. Well, they just let me go because of being sick and I hadn't been working there very long.

Senator KENNEDY. Your employer let you go?

Mrs. JONES. Yes, so in May of 1969——

Senator KENNEDY. And as I understand from Mr. Parsons when his company closed down he lost his insurance, and was your insurance threatened after you were terminated?

Mrs. JONES. Yes.

Senator KENNEDY. You're so sick you're terminated, and after you are terminated your insurances goes.

Mrs. JONES. Yes, sir. So in May of 1969 I was put into the hospital with asthma. I had part of my stomach removed, my gall bladder, hiatal repair and an appendix removal, which caused me to be out of work. I also had phlebitis. I went into the hosptial the 10th of May to the 20th of June, and I was off work until the middle of September. At this time I was living on $75 a month from welfare because I couldn't work. The doctor still wanted me to pay for the treatment I received, and the doctor that did the surgery had said that I couldn't come back to him until I had paid at least some of the money on the bills.

Senator KENNEDY. You mean the one under whose treatment you were?

Mrs. JONES. Yes, sir.

Senator KENNEDY. Did he call you?

Mrs. JONES. No; I had to go for a checkup.

Senator KENNEDY. And when you went back for a checkup, what happened?

Mrs. JONES. The manager of the clinic said this.

Senator KENNEDY. This is what the manager of the clinic said, you'd better not come back until you pay your bill, something like that?

Mrs. JONES. Yes, and there was no way possible. Then I went back to work in the middle of September.

Senator KENNEDY. How much was the bill now?

Mrs. JONES. $3,900, and my insurance paid $2,800. This was the hospital bill, not the doctor bills or anything.

Senator KENNEDY. Who is supposed to pay the other thousand?

Mrs. JONES. Well, I went through bankruptcy because of the other.

Senator KENNEDY. What would happen if you went back to see the doctor now after you filed bankruptcy?

Mrs. JONES. I don't know. So now when I do go to a doctor with asthma—I have it quite a bit—and when I do go to a doctor they either want the money right then or they won't see me.

Senator KENNEDY. Have you had a circumstance where the doctor wouldn't see you until you got up the money?

Mrs. JONES. Yes. Or if they find out you filed bankruptcy they check your credit.

Senator KENNEDY. Who checks your credit?

Mrs. JONES. The doctor's office. They have signs that say credit applications checked through the credit bureau.

Senator KENNEDY. What does that mean?

Mrs. JONES. I guess it means they check your credit. I'm sure that's what it means.

Senator KENNEDY. They find out your credit and if you have been through bankruptcy, and what happens then?

Mrs. JONES. Then they won't see you.

Senator KENNEDY. Has that happened to you?

Mrs. JONES. Yes.

Senator KENNEDY. So it's difficult for you to win in any way. If you go through bankruptcy to get out from under these extraordinary kinds of medical bills, then they won't treat you or let you into these clinics. Is that pretty widespread, the idea of having this credit evaluation?

Mrs. JONES. Oh, yes; you can even go into a dentists office and see the signs, credit applications checked with the credit bureau.

Senator KENNEDY. Thank you very much. We appreciate very much your coming here and telling us your story.

Our final witness representing the people, Mrs. Jean T. May. So far we have heard directly from people. Mrs. May is here to tell us about the experience of two of her friends whose situations are so symbolic of the health crisis. She has coauthored a study of the health needs in lower income areas in Nashville. I'd like to make this study a part of the hearing record. We'll make it a part of the file.

Mrs. May, we're very glad you're here.

STATEMENT OF MRS. JEAN T. MAY, RESIDENT, NASHVILLE, TENN.

Mrs. MAY. Thank you very much. During the course of about 3½ years that we worked on a health survey in the lower income areas of Nashvile, we heard many, many stories of hardship and deprivation as far as health care was concerned. When I heard these hearings were going to be held here, I tried to find some examples at each end of the socioeconomic spectrum that would give you an idea to corroborate what one of the earlier witnesses said about the fact that catastrophic illness can have catastrophic effects on anyone in our society.

I selected two examples, both of which were struck by catastrophic illness and wiped out financially, and both have many similarities and many differences. The first case is a woman who was working 5 days a week as a domestic worker. Her husband was a taxi driver. They had

three children who were not their own that they raised. The oldest at that time was about 16, and they had been taking care of these children. They had very minimal insurance which covered only him, through his employer, and they had savings of about $200.

She went into the hospital for minor surgery. Before she was admitted, however, she was required to go and take out the savings account of $200 which wiped out their entire reserve and deposit it at the hospital to prove she'd be able to pay her bills, but she was not declared an indigent. After she entered the hospital, during a routine checkup, they found a shadow on the lung which resulted in a final diagnosis of tuberculosis. This is a case of what I call instant indigence. At the time they entered the hospital they were not indigent, they both had jobs and a little reserve, but after 4 weeks in the hospital the reserve was wiped out. The department of public health went to the family and found all five members had tuberculosis. The husband was no longer able to work, he was hospitalized for a year and a half. However, on the hospital records, the family still had the status of being able to pay.

So here, too, we have a story of bills being turned over to a collection agency to the tune of $1,100. While the husband was in the hospital, for the first 3 months of that time, she lived on welfare payments of $28 a month, which had to support herself and the children. At the some time she was being dunned by the bill collectors.

Senator KENNEDY. She was being chased by the bill collectors besides?

Mrs. MAY. Yes. At that point she was so desperate we began to use many resources in the community to try to help this particular family. The reason I'm citing this case is because it was such a complex case of having to work our way through a whole complex of legal services, welfare services and health services in order to be able to untangle all the different parts of it so she could some how come out and get rid of this bill and be able to get some payment for the children, who were then declared foster children and wards of the state so she could have help for them.

We helped her find a home that would be in the service area of the Mathew Walker Health Service which most people in the community are familiar with, but for any person who has this type of problem and does not live in the designated area, even though they might be eligible due to financial circumstances, would not be eligible because of geographical area.

Now the family recovered from the tuberculosis, and she has had additional catastrophic illness of cancer, but at this point she seems to be able to handle this complexity simply because she has a place like Mathew Walker Health Center with legal aid service that can work out those problems and a social worker, all in one place, so she doesn't have to go all through the community to find these services.

The second instance I selected is the wife of a university professor who was a consultant on our study. During the course of the time we were consulting him, he became ill with what eventually was diagnosed as cancer of the brain. The man died at the age of 46 leaving his widow with staggering bills. Her estimate was that the total bills amounted to about $20,000. He was a Ph. D., she has a master's degree, they were

people who had status in the community, who had every reason to feel very secure because they were covered by what they thought was an adequate insurance plan until such time as catastrophic illness hit them.

There is an additional irony in this story. About 6 months before he died the professor was offered a position in Israel, which was their original home, and the widow feels most strongly about this. Had they lived in the country of their origin, which has a completely different system of medical care, this entire tragic event would have had no financial consequences for her whatsoever, because under the system of medical care in Israel all medical bills would have been paid.

And this was the reason I chose these two instances, of a colleague of ours who had a catastrophic illness as well as one of the people who served as a case history in the poverty area we were serving.

Senator KENNEDY. These cases, are they typical; do they happen every day in every other city in this country, based on your experience?

Mrs. MAY. Well, certainly we surveyed an area that covered 65,000 people. We had a large field staff. There wasn't a day I wasn't hearing instances similar to the first one. The thing that struck us so amazingly is it happened to one of our colleagues. We people sit around and study health care problems. We think we're immune and one of our colleagues suffered the same kind of problem, and his wife feels as though she has mortgaged her future because she's going to have to pay for years and years in order to pay these bills.

Senator KENNEDY. It's really playing roulette with the whole health care system in this country. It can happen to anybody, rich or poor, black or white, north or south, urban or rural. It can drop in any kind of slot and effectively wipe out their security.

Mrs. MAY. Yes; that's right.

Senator KENNEDY. Thank you very much for coming here and testifying. We have three additional witnesses, then we'll try to get into open session until about 5 o'clock.

Dr. Tom Nesbitt, immediate past president of the Tennessee Medical Association and president elect of the American Association of Clinical Urologists and Delegate to House of Delegates of American Medical Association.

STATEMENT OF TOM NESBITT, M.D., PRESIDENT-ELECT, AMERICAN MEDICAL ASSOCIATION AND PAST PRESIDENT, TENNESSEE MEDICAL ASSOCIATION

Dr. NESBITT. Senator, I welcome this opportunity as immediate past president of the Tennessee Medical Association to appear before you this afternoon. We have some 3,500 doctors in the State of Tennessee. I happen to be the immediate past president as of 3 days ago, having just completed our annual meeting.

I appreciated receiving your telegram this morning inviting me to appear and testify before your committee, and you and the other members of your committee. I assume there are other members of your committee present today to transmit this information to our friends in Congress.

I also had the opportunity of hearing from our Fifth District Congressman this morning, the Honorable Richard Fulton, who is a rank-

ing member of the House Ways and Means Committee, and as such has the responsibility of hearing and making decisions on any and all health care plans presented to the Congress which the committee of which you are chairman I believe has no authority and is not conducting hearings today, sir.

Senator KENNEDY. Well, Dr. Nesbitt, you'd better stick to your medical testimony and I hope you know more about that than you do about the jurisdiction of the Health Subcommittee.

Dr. NESBITT. Thank you, Senator, I shall proceed to do that. I call this to your attention, sir, only because the Honorable Congressman from the Fifth District of Tennessee who is a sponsor of uniform health insurance reminded me of that this morning. You asked me to express my views in 7 or 8 minutes, on the nature and magnitude of the health care crisis in this country today, and what resolutions to these problems I might be able to offer you in some manner that could be considered as you consider the health care needs.

I was also asked if I thought there was a crisis. This morning at breakfast, I happen to have four teenagers. My 17-year-old daughter asked me what I was to do today and I mentioned I was invited to appear before you. She said what are you going to talk on. I said the health care crisis. She said, is that what they call a crisis? I said I don't know, what do you call a crisis. She said, "I think the Cuban missile was a crisis. This concerns most of the people in this country."

So I had an opportunity to read a definition of crisis and I'm not certain it precisely applies to what we're discussing today. I do feel strongly, as do most physicians in this country today, we are faced with a magnitude of problems as relates to health care in this country and they are related to four primary areas. They are related to problems of manpower, problems of distribution of this manpower, to the spiraling cost of medical care, and to socioeconomic educational factors that inevitably intertwine.

In the manpower problem, we have a shortage of physicians and nurses, technicians, medical assistants, which we all acknowledge. However, in that area there are some solutions developing in this area and I'm sure, Senator, you are well aware of these. In 1967 there were some 89 medical schools in this country with 9,000 freshmen each year. In 1971 we have 103 medical schools with a potential output of 12,000. They are taking in 12,000 students this year. By 1976 we will have 11 new schools with an anticipated output of 15,000 each year. This is doubling the physicians in this decade and I would submit that is some progress.

As to the distribution of the individuals in this country who are rendering medical care to the people not receiving optimum medical care, I am the first to acknowledge we do have a significant number of people not receiving optimum medical care. We have had the areas of rural America, the core city areas who do not receive medical care properly because of maldistribution of physicians, technicians, and medical facilities. There are steps being taken in this regard.

The administration has recently authorized the development of some 1,500 health maintenance organizations that will be aimed toward providing medical care in these areas. Medical foundations are being developed. You today toured one of the finest institutions that has

been developed in our area to help resolve some of the problems, the Mathew Walker Health Center, which has been doing a magnificent job. It has been through some trying times. They handle from 500 to 600 patients daily and I am told that the patients feel they are receiving adequate medical care in this area.

This is the type of program we hope will be expanded to help resolve some of the problems of maldistribution of medical care in this country. However, these problems do not become resolved in a day, and you and I both know this, Senator.

The third problem is spiraling costs of medical care. We are well aware this is the main topic of discussion. This is what disturbs all of us. We don't like to see medical care costs rising. A good bit of the blame is directed at the physicians. I believe Senator Kennedy himself expressed the belief that he did not feel physicians' incomes were larger than could be expected according to the amount of time they spent in training and education and the amount of time spent in pursuit of their practice.

One of the contributing factors to the spiraling costs is the increased demand for medical care on the part of American people. Part of this has been engenered by the development of Federal health programs, medicare and medicaid programs. Everyone knows these have far increased the demand for services. We have had inflation in this country. Labor has contributed to this, increased cost of materials, increased cost of doing business, and some of the other factors even more important are those of socioeconomic and educational in their origin.

We do have poor housing in many areas. We have poverty and malnutrition, and the thing, the number one cause of death in this country, automobile accidents and heart disease, can scarcely be solved by a program of uniform health insurance without educating people that our social behavior in allowing ourselves to over indulge in excessive eating, drinking, smoking of cigarettes, lack of exercise, driving cars too fast, all contribute to this immense cost of medical care which we are encountering in this country today.

These are not medical care problems. They are educational in their nature and they become socioeconomic in their contruction. Building a hospital every 50 miles down a highway is not going to resolve the problems of the 55,000 people that die on the highways every year.

How do we resolve these problems? I have alluded to two steps being taken by the profession of medicine, the increase in manpower, the increase in output of physicians, the increase in programs of nursing and technicians I have alluded to programs that has already begun and are under way to help solve the problems of maldistribution of medical care and these need to be given a trial opportunity. Where they have had such an opportunity they have been successful, and noteworthy in this success.

The position of the American Medical Association is one that we believe is a form of universal health insurance for this country on a voluntary basis. Medicine's position has always been that the inability to pay should not be a deterrent to medical care, and that it is the right of the American people to expect to have adequate health care available to them. As I alluded to previously, most of the health care problems in this country today are generated by the habits and socio-

economics of our people, and for these we need programs other than complete total socialization of the medical care of this country.

A bill providing for a voluntary universal health program which has been presented by Congressman Fulton from the Fifth District of Tennessee, in conjunction with a provision that will cover catastrophic illness has been presented in Congress. It has 131 cosponsors. It seems to most of us this will provide a reasonable solution to the situation that exists today. It will cost by estimate roughly $12 to $15 billion and some other programs are estimated to cost some $45 to $70 billion.

S. 3 alluded to today, for which we are given information on the blackboard, would cost the American people for every $100 of taxes they now pay an additional $35 to $37 per $100 of taxes.

Senator KENNEDY. What is your authority on that?

Dr. NESBITT. I'm quoting Senator Bill Brock, sir.

Congressman Fulton alluded today in our discussion to the fact that the Nixon administration has estimated a budget deficit in the range of $11 billion for 1971. Many say this will go far beyond that estimate. He questioned whether the country could well afford another program estimated to cost between $45 and $70 billion at this time on top of the taxload now being carried by the Federal Government, and the Federal Government is not the taxpayer. It is we who are the citizens of this country and we are being asked to share an additional tax burden.

I appreciate this opportunity. I feel I may have gone beyond my 7 minutes. Thank you very much for the opportunity of appearing.

Senator KENNEDY. Thank you, Dr. Nesbitt. If the figures that have been worked out in terms of national health do reach the approximately $45 billion figure, we believe quite frankly that that's old money that's already in the system that is being used for inadequacies and inefficiencies already in existence. Do you think we can afford not to provide quality health care in this country?

Dr. NESBITT. I didn't say that. I believe it can be done for a figure less than that that has been planned for a program that would not provide total Federal Government control of the health care industries. We have seen, for example, that the Federal Government has had total Federal control for the postal industry for a number of years and we have found that has failed to be successful and have found another manner in which to handle that.

Senator KENNEDY. The Federal Government has total Federal control of the social security system too, has it not?

Dr. NESBITT. And today the obligation of the social security system I am told is in the neighborhood of some $3 trillion to the citizens of this country for which there is very little to back it up in the coffers.

Senator KENNEDY. Are your questioning the financial soundness of the social security funds?

Dr. NESBITT. I didn't say that.

Senator KENNEDY. What are you trying to say? We have capital assets. Do you feel social security is a good thing? Maybe we had better start with that.

Dr. NESBITT. I'll be happy to start with that. I have no question that social security as initially conceived——

Senator KENNEDY. What about medicare; was that a mistake?

Dr. NESBITT. May I elaborate? Medicare was a program of health care to older citizens. The American Medical Association had such a program and believe it should be instituted. I would like to point out medicare as it was conceived and passed by the Congress of the United States was the first and only program of its nature in the history of this country that has ever provided funds to a group of people whether they wanted it, whether they needed it, or whether they could afford to pay for it themselves.

Senator KENNEDY. Are you for repealing it?

Dr. NESBITT. I feel the program should be modified; I really do.

Senator KENNEDY. Do you think it should be cut back?

Dr. NESBITT. I didn't say that.

Senator KENNEDY. What part would you cut back? Modified could mean expanded. Which way do you want to go?

Dr. NESBITT. I think it should be related to the ability of the individual to pay. For those people without the ability to pay for their medical care, I think it should be provided. I think the millionaires in this country and the many, many people who are perfectly capable of paying for their own medical care should not have the privilege of receiving benefits of tax-supported funds from the citizens of this country.

Senator KENNEDY. Let me ask a question which is asked me often. With the concept of fee-for-service built into our present system, which in effect makes the doctors richer the sicker people get, how do you really think we can get a handle in terms of cost control?

Dr. NESBITT. I'd be happy to discuss this on cost control. This has to do a great deal with the quality of medical care and has to do with review of what physicians are doing and how physicians conduct themselves in the practice of medicine. I would like to point out to the Senator and the audience I know of no other profession that completely screens who it chooses to serve the people than does the medical profession. People interested in becoming physicians are screened from the day they leave high school. They eliminate a large number before they get to medical school based on their integrity, moral character, and so on. Further large numbers are eliminated in medical school. They are examined when they go through internship and residency. They pass examinations for basic sciences and they are further screened by a board of professionals in their specialization.

There are existing utilization and grievance committees operating in every major medical society in this country and they operate efficiently and with success, and situations arise annually where steps are taken by physicians, who are the only ones qualified to review the work other physicians perform. I might also add there's a great deal of talk these days about reviewing physicians' office work. I would like to point out, sir, a man's hospital work is nothing more than a reflection of his office work, and this is how physicians' practices and offices are reviewed.

These are the manners in which cost control are contained within the profession. It has been shown on studies of existing group prepayment plans, and I might add we have never been able to get a handle on what these figures amount to from any of the existing foundations that have been in existence for over 20 years. These plans have

been available for 25 years and today less than, I think, 6 percent of the population belong to these. We have never been able to get reliable statistics to tell us what the cost control of these is. They do provide incentive in terms of available funds to provide the service in the event they don't put people in the hospital and don't take care of hernias and gall bladders. This is cost control. I'm sure it's not quality control.

Senator KENNEDY. Let's get back to fee-for-service again. That's what I asked.

Dr. NESBITT. This relates to fee-for-service as opposed to prepayment plans.

Senator KENNEDY. Don't you think the present system with all the kinds of protection that have been built into it, and all the various reviews and so on, when it still results in this kind of extraordinary increase in doctors' fees, hospital costs, additional charges, don't you think there's something wrong with it. Isn't it reflected in the kind of medical bills that these consumers have talked about here today. You can talk about all the statistics and we can shuffle those statistics around all afternoon, but nonetheless you see the kind of extraordinary increases we're having. People ask why this is so. And they ask why this country has twice as many surgeons as Great Britain and does twice as much surgery. And why, for example, in California they do four times as many tonsillectomies.

Dr. NESBITT. Is that really germane? Perhaps the people in California have four times as many polio injections.

Senator KENNEDY. Well, take California, why do you think there are four times as many tonsillectomies?

Dr. NESBITT. I don't know that they do.

Senator KENNEDY. Don't you think the Medical Association ought to know that?

Dr. NESBITT. I think we could explain if these were valid statistics. Can you show me the source?

Senator KENNEDY. They are in the President of the United States' message to Congress. [Applause.]

Dr. NESBITT. I don't believe you take everything the President says as being valid. I don't believe you agreed with him in regard to the statements he made with regard to Vietnam, and welfare reform.

Senator KENNEDY. Don't you think if it's in the President's message it's up to the medical societies and associations to try and find out why this is taking place or if there is too much surgery? Doesn't the American Medical Association have a responsibility in that?

Dr. NESBITT. The medical society does have a responsibility in that and exercises it constantly through its system of utilization of review.

Senator KENNEDY. Well, do you want to leave it with that?

Dr. NESBITT. Who would you like to leave it with, Senator?

Senator KENNEDY. It's interesting to hear about how the society endorses neighborhood health centers. That idea never came out of AMA. I can remember as the sponsor of that amendment when they opposed it. [Applause.]

I think what has to concern these consumers as it concerns the American people is why the medical societies are always responding at the last moment. The President talked 18 months ago about a health

crisis and then we put in a hard hitting bill and then you hear them respond. You're talking today about all the things being done in terms of holding down costs and so on, it just makes some of us wonder who's looking out for who.

Dr. NESBITT. I feel you have a perfect right to wonder. We also realize that you are intimately concerned with matters other than health care. You deal with this in short periods of your day and we deal with it constantly.

Senator KENNEDY. There's been a mistaken belief that the only people who know about war are generals and the only people who know about medicine are doctors. That's what has been wrong. We've been leaving it in the medical profession too long. I think that's precisely what has happened.

Dr. NESBITT. I'm glad we got to hear your opinion. I'd like to hear from some of the other members of your committee.

Senator KENNEDY. You've been listening to Senator Brock.

Dr. NESBITT. Is he a member of your committee?

Senator KENNEDY. No, he's not. [Laughter.]

You've been kind and generous with your time and made yourself available to us here. We have heard a series of consumers this afternoon and they haven't been people who have been involved in excessive eating or excessive drinking or all the other kinds of indulgences. You heard the problems of Mr. Parson's wife in terms of childbirth, you heard the problems of Mary Fletcher and all the problems her family had. When we just scratch at bedrock on this and leaving out all the other vestures, mini credit and all the other things, what are you prepared to tell them this afternoon?

They are living in this community here, they're working people. All they want is a crack at some decent health. They are prepared to pay their bills, but they have some of the most extraordinary expenses. These aren't untypical. What are we supposed to say. We're interested, I'm sure you are interested in trying to do something about this. What do you say we ought to do?

Dr. NESBITT. Thank you. I would say this——

Senator KENNEDY. What would you say to their problems?

Dr. NESBITT. I'm waiting for the opportunity.

Senator KENNEDY. Let's hear you speak.

Dr. NESBITT. I've been waiting for this opportunity. I admit I have listened to this testimony with great concern this afternoon. I realize fully that conditions like this exist in every community. I view them with the utmost compassion and sympathy, and I wish there was a solution that the medical profession or the U.S. Government could find for the catastrophic situations that arise in daily living. These are not easy solutions, or they would have been found by our profession and the Government of the United States long before now.

There are situations that arise in daily life that are a result of catastrophic situations for which there has never been a solution in the history of mankind. I would like to find such a solution, sir. We feel a beginning is embodied in the Universal Health Insurance Act that has been promoted by Senator Fulton, embodied in the AMA's bill which is up before Congress at this time. The President feels like

we should include some mechanism to begin to take care of the problems of catastrophic illness. Medicine never has been able, nor has anyone, to resolve these situations that we encounter almost daily.

A day does not go by that I don't see one or two situations that defy solution under our present system of free enterprise as we know it today. But the solutions are underway. They are in Congress. It is up to Congress to decide which of these can best be handled within the economic feasibility that this Nation can afford to handle such problems.

Senator KENNEDY. It is the catastrophic problems that are created that are obviously the greatest problems, but we're also talking about the wife of someone who had childbirth, who had an $800 bill. That's catastrophic in their lives. We're talking about two or three hundred dollars of savings taken away and bills that are going to take away 8, 10, 15 percent of these people's take-home pay for several years.

Dr. NESBITT. Yes, I'm fully aware of this. I do not have the solution nor has anyone presented a solution that has been found to be totally acceptable by the American people or by Congress. I think there are solutions available. We hope this will be forthcoming from the 92d Congress. There are opportunities available for us to resolve some of the problems and No. 1 is the inclusion of some form of catastrophic health insurance.

Senator KENNEDY. Thank you very much.

Dr. NESBITT. Thank you very much. We appreciate the opportunity of being here.

Senator KENNEDY. Our next witness is Dr. Lloyd Elam, president of the Meharry Medical College. Dr. Elam is a member of the National Medical Association, American Medical Association, American Psychiatric Association, and we're extremely glad to have you here.

STATEMENT OF LLOYD ELAM, M.D., PRESIDENT OF MEHARRY MEDICAL COLLEGE

Dr. ELAM. Senator, as you said, I am president of Meharry Medical College and what I am saying today really grows out of my work at Meharry Medical College despite the fact that I am a member of some of these other organizations you mentioned.

Meharry has been concerned with health care for the poor and with educating doctors to practice in urban ghettos and rural areas. Almost half of the practicing black doctors graduated from Meharry, although this is a fully integrated institution with 20 percent of our students being white.

As we have moved into the community, we find three areas of serious deficit in health care. The first is the large number of persons who are employed full time but with incomes that are too low to meet the cost of health care. In our hospital 21 percent of the patients are in this category. Residents in the community are fortunate because there are ambulatory comprehensive health programs which can care for the poor and the near-poor, if hospitalization is not necessary.

In preparation for the institution of a neighborhood health center in this area a study was made by the center of community studies of the health of the community of 64,500 persons. I would like to cite

some of the findings. The median income was $4,000, or about half that needed to live in Nashville at a moderate level.

Sixty-one percent of the 2,057 persons contacted reported current mental, dental, and physical health problems.

Fifty-eight percent of the poorest households reported one or more problems which lasted for 3 months or more.

Twenty-three percent of the population reported a major disability during the year—an illness which required hospitalization or a 7-day loss from work.

One-third of the population had never received such preventative services as chest X-ray, tetanus shot, polio vaccine, and 25 percent of the children had no baby shots.

The most frequently reported specific disorders were hypertension, arthritis, heart disease, anxiety, and headache.

Persons in the 25 to 44 age group reported most frequently that nothing had been done about their current health problems.

These are only a few of the findings but they indicate that even in a community where there is no doctor shortage, the health of the poor and the near-poor is far from acceptable.

A second major deficit involves the limited scope of personal health care. In the past, acute illness care has been of concern while chronic illness, malnutrition, the need for eyeglasses, hearing aids, or dental and mental care have been available only to those with money. In a study by our Health Service Research Center, 65 percent of the black residents and 26 percent of the white residents spent less than 85 cents per person on food each day. From this population 44 percent of the pregnant women went into labor with significantly less hemoglobin in their blood than normal, which reflects malnutrition. In the same population 14 percent of the citizens had physical impairments for which they were receiving no service. There are many other statistics which show that while care for the acutely ill is less than adequate, care for the chronically ill is often completely lacking for people in all but the top economic levels.

A third major deficit relates to the separation of medical education from health service. While it is necessary to assign costs to the appropriate area, the provision of health service is so dependent upon the availability of adequate manpower, the two must go hand in hand. Recent financing programs for health seem to discriminate against medical education by encouraging the exclusion of trainees from the health care arena. This has not affected Meharry greatly as an institution, but if the potential exists in the new legislation, it must be changed in order to insure an increased flow of doctors and other health personnel.

Another crucial factor regarding manpower relates to the need to have new manpower resources precede new demands on that manpower. Despite the calculations by some that allied health professionals can provide the additional care or that redistribution of existing doctors would solve the health crisis, the fact is that these measures will require time as well as the education of additional doctors. Only if manpower training support is coordinated with health service support, will it be possible to provide expanded health services without serious inflation.

The fourth deficit is the lack of incentives to provide the kind of health system which best serves all the people. The right to adequate health care can be protected by governmental activity as other rights are guaranteed. It is not possible to guarantee a right on a voluntary basis—the Government must have a major role in it.

The continued support of comprehensive health programs is a step in this direction. These programs, such as the Neighborhood Health Center, are extremely important in areas of greatest need. However, these centers will not cover all populations and in addition to these, legislation is needed to provide a system which will insure that everyone in the population has access to health care and that providers have an incentive to cover all persons in the population.

Although Meharry has provided health care for the black and the poor in Nashville, Mount Bayou, Miss., Tuskegee, and other communities, we do not believe that there should be a different kind of care for different segments of the population. Despite these models which give excellent care, in general, history shows that if there are different levels of health care, the poor, the black and the disenfranchised will receive the worst kind of care.

When faced with a crisis, there are many areas which need attention. I have limited myself to four major deficits. These are:

(1) There is a large number of persons who are employed full time but with incomes too low to meet the cost of health care through their purchase of services or through third party support available to them.

(2) There is a need to greatly expand the scope of health care to include not only acute and chronic disease care, but also systematic preventive services, including adequate nutrition, housing and sanitation.

(3) The education of physicians, dentists, and allied health workers must be supported in coordination with the provision of health services.

(4) There must be legislative incentives to provide the kind of health system which serves all the people, or stated differently, the Government must guarantee this right. [Applause.]

Senator KENNEDY. Do you think the health crisis is just a crisis for the poor or do you think it's a health crisis for middle-income people as well?

Dr. ELAM. The health crisis is a crisis for everyone. We are noticing it more among the poor, it is certainly much worse among the poor, partly because as the level of living decreases the health care needs increase. But more and more we are finding that the working people do not have access to adequate health care, and more and more we are finding people who a few years ago, just in the 1930's, a family at a certain income level would have access to health care they no longer have access to it. We think it is a crisis for everyone and probably to some degree to people who don't consider themselves middle income.

Senator KENNEDY. What about the quality question? Do you think there is a real question about the adequacy of quality, not only for the poor people but also for the middle-income people?

Dr. ELAM. Quality must be looked at in many ways. One of the ways in which you look at quality involves the kind of service a person gets when he gets service, and by and large for the middle-income group if

he gets service, it is service of the highest quality in the world, and if you get into one of our better hospitals, you can't beat that kind of service. But other kinds of things that must be involved in quality include the availability, whether or not the care is available, the continuity of care and so on. If you look at all of these elements of quality, the quality is not as good as it should be even for middle class people.

Senator KENNEDY. How are you really going to know? Is it just a matter of paying the bills, or the ability to pay? You find a lot of people paying their bills without any assurance that they are getting quality care.

Dr. ELAM. There are two ways of assessing quality. One is a kind of process evaluation. This can best be done by doctors. Process evaluation, looking at the process that the doctor went through to provide the care. I think maybe peer review is all right for that.

Senator KENNEDY. Is that being done systematically in this country?

Dr. ELAM. Not outside of the hospitals. One of the great contributions of Medicare to this country is that many hospitals do a better job of peer review than they were doing before medicare. But the other kind of assessment of quality is just as important I think, and that's assessment of the results of the process, and of course you don't have to be a doctor to assess that.

Senator KENNEDY. What is your feeling about the independence of Blue Cross from the hospitals. Are they really independent?

Dr. ELAM. I don't think I can answer that.

Senator KENNEDY. Do you think they ought to be more independent? We heard last week in Nassau that half the board in Blue Cross were representatives of the hospital personnel and they didn't describe what the other half were. Do you think that in fixing hospital rates or perhaps even reimbursement rates, there ought to be a stronger consumer voice on the board?

Dr. ELAM. I don't really think that would get at it. I think the cost of health care cannot be controlled by Blue Cross, and of course the people who get involved in Blue Cross are more than likely people who for one reason or another are very concerned with health care. So you're likely to have people involved in health delivery or who are with unions or some way have a stake in it. Even if it were completely separate, if you had the same kind of situation that you have where you can only have many procedures done if the person goes into the hospital, you're not going to be able to cut down or control the rising cost. So I don't think you can get at what you're trying to get at by anything you can do to Blue Cross.

Senator KENNEDY. Let me ask this. They purchased 15 open heart surgery units in New York City. I don't know if they need that many, yet Blue Cross is prepared to fund that program. I think that's because they are to a great extent captured by the Hospital Association as Blue Shield is captured by the Medical Association. I would suppose if you had consumer interest they'd make these studies and find out what is needed in terms of heart surgery.

Dr. ELAM. That's a very interesting idea. One of the things we have to ask ourselves is why does the hospital purchase this piece of equipment if it does not need it for community care.

Senator KENNEDY. Does prestige have anything to do with it?

Dr. ELAM. It is absolutely the reason. It is necessary to have a certain amount of prestige, hospitals feel, in order to attract the

doctors and the patients they want. If it is necessary to buy an additional piece of equipment that costs $50,000 in order to staff your hospital, you're likely to buy that piece of equipment.

I think you can only get at that by having a system which makes available an adequate amount of health manpower in which case the hospital doesn't have to do all these special things like staffing up for something they really don't need to do in order to attract personnel, but that's what goes on here. It isn't the hospital is just doing this to make additional money or anything like that.

Senator KENNEDY. Thank you very much, Doctor. You were extremely kind to be with us today. When we visited the Meharry College and we had a good conference with your students over there, sort of a give and take session. We met with the students and asked each other questions, and they were extremely helpful in their comments. I want to thank you very much for your courtesy in coming here.

Our next witness is Dr. Joseph M. Bistowish, the director of health for Metropolitan Nashville and Davidson County. He assumed this position in November 1964, after serving for 15 years as health officer of Leon County Health Department, Tallahassee, Fla.

STATEMENT OF DR. JOSEPH M. BISTOWISH, DIRECTOR OF HEALTH FOR METROPOLITAN NASHVILLE AND DAVIDSON COUNTY

Dr. BISTOWISH. Senator Kennedy, members of the subcommittee, ladies and gentlemen, I was asked to comment regarding emergency medical care for Metropolitan Nashville and Davidson County. I am not a clinical physician and I do not practice clinical medicine, neither am I an expert in the field of emergency medical services. However, I an familiar with the emergency medical services in Metropolitan Nashville and Davidson County.

In my opinion, emergency medical services for this county are completely inadequate. In fact, I am convinced that this inadequacy results in several deaths each year. I am told this by knowledgeable physicians in this community, and from my own observation I am in agreement with them, that we do not have in this county a real first-rate emergency medical service room in any of our hospitals. At least three of our hospitals are planning in the near future to improve their facilities and services. This will be a great help to the community.

All of our ambulance service is furnished by funeral directors. Attendants on these ambulances have, for the most part, little or no training for their work. Equipment carried on the ambulances is inadequate. There is no provision for exchange of equipment between ambulances and emergency rooms so that ambulances will not be unduly delayed at hospitals. There are no standing orders as to where certain types of injuries will be taken for emergency room service. In fact, ambulances sometimes pass a hospital perfectly capable of taking care of a particular injury to go to another hospital farther away of their own choosing.

Senator KENNEDY. What do you think is the reason?

Dr. BISTOWISH. I have heard some rumors on this, but I'm not able really——

Senator KENNEDY. What do you think the reason is?

Dr. BISTOWISH. Obviously they must have some reason for having a choice of one hospital over another. What the reason is or what the connection is I do not know.

Senator KENNEDY. Do you think economics is the reason?

Dr. BISTOWISH. It could possibly be, but then I cannot conceive of any of our hospitals in town making any arrangement like that. It is inconceivable knowing the men in charge of these hospitals.

Senator KENNEDY. What do you think the reason is if that's inconceivable?

Dr. BISTOWISH. Well, as I indicated I could not comment.

Senator KENNEDY. All right.

Dr. BISTOWISH. Ambulances travel at high rates of speed on busy streets and jeopardize the lives of everyone in their paths as well as the patients within the ambulance. Most medical authorities are in agreement that high speeds by ambulances are, in most cases, unnecessary. There is no system of radio communication between ambulances and emergency rooms so there could be advance warning given to the emergency room to get certain equipment ready. There is no dispatch service available to avoid two or three ambulances showing up at the same time.

Senator KENNEDY. Suppose you had radio equipment, would it make a difference in terms of saving lives?

Dr. BISTOWISH. Yes, it would. It would even make it possible for a physician on duty in the hospital to give information to the attendant on the scene for a particular type of injury.

Senator KENNEDY. I suppose it's resources that prohibits the kind of equipment the ambulances carry.

Dr. BISTOWISH. I think it's more than that. A public hearing was held at our metropolitan council a few years ago when we had an ambulance service before the ordinance was repealed, and at that time indications from the funeral directors was that they did not want the type of equipment we were requiring on the ambulances. They did not want their people using it. They were afraid apparently of the liability involved. The more you do, the more you are likely to be sued.

There was a newspaper account some time ago in which two ambulances arrived at the scene of an accident and the drivers argued over which one would take the corpse while leaving the injured person unattended on the ground. Approximately 2 years ago a group of teenagers had an automobile accident almost in the front yard of a local physician. Because of the type of injury to one of the teenagers, this physician recommended to the ambulance driver that the patient be taken to a particular hospital. The driver let the physician know in no uncertain terms that he made the decision as to where the patient would be taken.

Approximately four and a half years ago, our local funeral directors announced publicly and to the metropolitan council that effective a certain date they were getting out of the ambulance business, and they informed the metropolitan council that other arrangements must be made for ambulances service. Members of the metropolitan council, along with the director of health, visited other cities to study their ambulance service. The council considered at length whether to operate an ambulance service as a part of one of the existing departments or let

private enterprise furnish this service with regulations and a subsidy from the metropolitan government in the form of payment for service to indigent patients. The decision was made to let private enterprise furnish the service. Actually an ordinance was passed which gave the metropolitan health department responsibility for formulating regulations and supervising ambulance service.

Adequate regulations were formulated which provided for the training of attendants and the carrying of essential lifesaving equipment. A privately operated ambulance service, as well as a few funeral directors, applied for ambulance permits. Temporary permits were issued in order to give these companies time to comply with the regulations. At the expiration of the temporary permits no ambulance company had complied with the provisions of the ordinance, and the city was faced with the decision to either close the ambulance companies and lose all ambulance service or organize an ambulance service within the metropolitan government.

About that time, several funeral directors appeared before the metropolitan council and stated that they wanted to again furnish ambulance service for the county. In support of their reentering the field of ambulance service, they stated that they had given very adequate service for many years at no expense to the government and were willing to continue this service. One funeral director stated that his company had always had high praise for its service. It was stated that a physician at the hospital had told his driver that if the patient had arrived at the hospital 4 minutes later he would have been dead.

Although I am not familiar with the details of the case, it is possible that what the physician should have said was that if the patient had been given adequate care before being put into the ambulance, the driver could have taken his time traveling to the hospital without risking the lives of other motorists and pedestrians, and the patient would have arrived in the hospital in better condition. The outcome of the funeral directors' appeal to the metropolitan council was that the ordinance and regulations were repealed, and Nashvillians still have the same inadequate emergency medical service that they had 15 years ago.

This community badly needs improved emergency medical service. Improved services have been urged by the metropolitan board of health, the Nashville Academy of Medicine, the Mid-Cumberland Comprehensive Health Planning Council and many other groups. The Nashville Urban Observatory and the Mid-Cumberland Comprehensive Health Planning Council are presently working on a plan for a first-rate regional emergency medical service. We certainly hope that their plans can be put into effect in the very near future.

Senator KENNEDY. Has the medical association taken a position?

Dr. BISTOWISH. Yes, the Academy of Medicine has.

Senator KENNEDY. Is that your local organization?

Dr. BISTOWISH. That's correct. Our local academy of medicine, Nashville Urban Observatory and the Mid-Cumberland Comprehensive Health Planning Council are now planning a good regional service and we do hope the plan will be acted upon favorably by all the groups.

Senator KENNEDY. When will that be up before the acting body?

Dr. BISTOWISH. I believe my last contact with the group indicates it would be within the next 2 or 3 months the plan should be pretty well

completed. The problem then will be to get the cooperation of 13 counties.

Senator KENNEDY. How long has the problem you have identified been going on?

Dr. BISTOWISH. I suppose for many, many years. This problem is not unique to Nashville.

Senator KENNEDY. Many communities have it, don't they? We were hearing about it in West Virginia yesterday.

Dr. BISTOWISH. We had the same kind of problem in Florida.

Senator KENNEDY. Thank you very much.

We have about 10 minutes here if there are individuals who would like to make comments, if they'd be kind enough to state their names and we'll try to limit it to a minute or two.

STATEMENT OF MISS GALE LEWIS, WITNESS FROM FLOOR

Miss LEWIS. There is an organization in east Tennessee called Project Concern which is a private organization which has been trying to fill the gap in areas where there is no medical care, in the Appalachian Mountains. These people secured funds in March. The average income of the people in this area is somewhere between $1,200 to $2,000 a year. In some parts there are no doctors at all, and the people in Project Concern travel around 200 miles a day to small communities and set up and provide medical care for these people and provide medication. The people are not able to pay anything and they do not. However, the doctors and dentists working with Project Concern provide this health care. This is an example of where the public is trying to help.

Senator KENNEDY. Thank you.

STATEMENT OF JAMES R. SMITH, WITNESS FROM FLOOR

Mr. SMITH. At a time when nurses are clamoring for higher wages, 600 to 800 doctors in this area whose duties are increasing constantly, how do you think this situation as well as providing Federal funds for education of nurses would be affected by your bill, with reference to article 6 in the bill S. 3?

Senator KENNEDY. There is separate manpower legislation in terms of nurses training which will expire in June of this year. We have been very much distressed by the reduction in total funding made available for nurses training over the last 3 or 4 years. There has been a $3 milion cut over the period of the last 3 years which distresses me. I think this is some indication unfortunately of the kind of priority placed upon the whole question of the supply of nurses and nurse training. In terms of the more sophisticated utilization of nurses we would hope that through the resource development fund, which would be a fund established under S. 3, there would be a mechanism by which more innovative, creative, imaginative ways of utilizing a nurse, practical nurse, paramedical personnel trained as nurses could be used.

We want to make it clear we're going to get into the whole question of licenses regarding these professional personnel because for too long we have seen the licensing mechanism used to exclude competent, qualified, committed, concerned individuals who do have talents and have been excluded from nursing and other technical areas. We are going to try and deal with it in this way.

STATEMENT OF MISS DIXIE TAYLOR, WITNESS FROM FLOOR

Miss TAYLOR. As I understand it a portion of your bill would affect impacts on nursing, would limit 120 days for a spell of illness for free standing facilities, whereas a hospital bed facility would give it unlimited days. What is the reason for this?

Senator KENNEDY. You are right, the distinction in our legislation is between nursing homes that have affiliation with hospitals and those that are independent. The reason for that is once again to get at cost control, where you can move from acute into ambulatory care with a great deal more efficiency and have a much greater handle in terms of control. This kind of association would be assured of continuing kinds of payments where if they were solely independent, there would be this 120 limitation. This would encourage quite obviously the development and utilization of the nursing homes within the general kind of total health complex, and we believe this is important and useful and from various observations we have seen up at Massachusetts General Hospital and some of the other complexes that have worked in this area, we think it will be useful.

This would encourage nursing homes to develop their relationship with the hospitals and you'd get a much more efficient utilization of the system and personnel within the system.

STATEMENT OF MRS. JEAN MAY, WITNESS FROM FLOOR

Mrs. MAY. What kind of timetable do you project for the passage of your bill?

Senator KENNEDY. I hope that the bill will be at the President's desk by fall of 1972. I think that's an ambitious program. We have 25-cosponsors in the Senate made up of Republicans and Democrats, and I think there is a strong sentiment for it and we hope we'll get some action on it. We'll get votes on this concept, I can guarantee that this year and next year, but to be able to implement it, it might take a while.

STATEMENT OF MR. ROB CARLEY, WITNESS FROM FLOOR

Mr. CARLEY. If your bill does pass, how long do you think it will be before you can get relief to these people like the people giving testimony? Is it going to be caught up in a lot of redtape or are these people going to get the relief they want?

Senator KENNEDY. It goes into effect 2 years after it passes. You're talking about escalating provisions of the legislation. We start off limiting dental care to 14 years of age and move on up. We have certain limitations in psychiartic and pharmaceutical aspects. These features will probably have to be expanded and enlarged, but we'll get at the kind of problem that has been outlined here this afternoon, and we'll get to that immediately.

In terms of resource development funds, we're trying to provide awards for innovative programs being developed in the whole health delivery system. That will take time and imagination. It took a long time before we got to neighborhood health centers. What we're trying

to do in S. 3 is build competition between the health delivery systems rather than just adding on to the cost as we do now, with all due respect to Dr. Nesbitt.

What we're trying to do, by encouragement of health maintenance organizations, neighborhood health services, various different kinds of delivery groups is to get them to compete for the right to provide comprehensive health services. There will be strict national standards on this. Let's make that very clear. They are going to have to meet these national standards. When one gets a contract they are going to have to live within a prefixed budget, which makes more sense in terms of the economics. They are going to be rewarded for keeping people healthy rather than making money when they get sicker. The reward will go for keeping people healthy rather than keeping them sicker.

Dr. ELAM. As a cosponsor of this national health insurance program, are you in a position at this time to submit a resolution to the Congress to call for a national referendum and see what the people of the United States have to say along about 1972?

Senator KENNEDY. Hopefully that's part of the purpose of these hearings: To engender a national political discussion and debate. This is going to be a controversial subject in the election. The candidates are going to have to take a position on this; the first year in the Senate medicare lost by four. The next year it carried by two and lost in the House. It is going to take sometime and much education. I'm hopeful we can really focus on that.

Let me just say the purpose of coming here today was to listen to the comments and the statements that were made. We will continue to try to listen to the consumers who have had some relationship with the health system or have had no relationship because of the way it treated them, and I think today we heard eloquent testimony. I firmly believe there is a health crisis, it exists in my own city of Boston and I believe it exists in Nashville. Dr. Nesbitt and I disagree on this. We can't get around the fact that AMA has a program that has been submitted to Congress; it has congressional support, but I think it can't do the job that has to be done.

What they are trying to do or doing in terms of their publications, and what we're attempting to do by public hearings is to try and ventilate this whole question about finding out the best means to meet this health crisis. We have more attention on this issue than we have ever had in the history of this country. The way we'll get the best system whether it is the AMA program or our program or industry's program is when we really get the people interested. You have been extremely kind and generous in your interest here today, and your attention in this program, and I want to express my appreciation for your demonstrated concern by spending 3 hours here. I also want to express my sincere appreciation to Dr. Nesbitt and the witnesses who testified.

It has been an extremely valuable and informative meeting for me and I'm sure for the other members of the subcommittee who will have a chance to review the record. The subcommittee stands in recess.

(Whereupon, at 5:10 p.m., the subcommittee hearing in Nashville, Tenn., was adjourned.)

HEALTH CARE CRISIS IN AMERICA, 1971

TUESDAY, MAY 4, 1971

U.S. SENATE,
SUBCOMMITTEE ON HEALTH
OF THE COMMITTEE ON LABOR AND PUBLIC WELFARE,
Cleveland, Ohio.

The subcommittee met, pursuant to call, at 1:15 p.m. in room B-1, Federal Office Building, Senator Edward M. Kennedy (chairman of the subcommittee) presiding.

Present: Senators Kennedy (presiding), and Packwood.

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

Senator KENNEDY. This is really as informal a meeting as we can have in terms of the Senate. We have an order of witnesses which we will go through, then we will open it up to anyone who wishes to speak.

Is Mr. James Rieger here by any chance? Mr. Rieger, would you be kind enough to fight your way up to the front. I know you have got an interesting but rather sad story. We would be very much interested in it. We realize at the onset that it's difficult for people to come up and tell their ills and problems. Nobody enjoys doing it; I think to a great extent, this is part of the reason we haven't developed the kind of health system in this country that we are capable of. People feel if they are sick or their wife is sick or their child, it is something personal. They want to keep it to themselves. But if we are going to provide a meaningful program, we have to learn about these everyday experiences. That is why we are so appreciative that you can be here telling us about your family and your tragedy.

If you could go ahead now?

STATEMENT OF JAMES RIEGER, CLEVELAND RESIDENT

Mr. RIEGER. Well, I have a wife who was about to have a baby——

Senator KENNEDY. We will need quiet now, so we can hear Mr. Rieger.

Mr. RIEGER. I had hospitalization insurance through my employer.

Senator KENNEDY. Let me ask you, do you work; were you working, and where?

Mr. RIEGER. Oh, yes, I work for Joseph Feiss & Co., a clothing manufacturer.

Senator KENNEDY. You are married?

Mr. RIEGER. I am married, and have one baby now; one just passed away.

And like I said, I had insurance through my employer, which was negotiated by my union.

Senator KENNEDY. Your union had, through collective bargaining, set up a program for hospitalization?

Mr. RIEGER. Right.

Senator KENNEDY. Fine, please continue.

Mr. RIEGER. All right. While giving birth, my wife had a cardiac arrest, her heart stopped and they had to perform a tracheotomy to assist her breathing and several electrical shock treatments to restart her heart. Then she caught pneumonia and her lungs collapsed.

She was in intensive care at the Cleveland Metropolitan Hospital for approximately 2 months and the child, who was 2 months premature, was in the infant intensive care unit for 2 months. And the total bill came out to about $20,000.

Senator KENNEDY. This is for the care that was being provided for your wife when she had these complications involved in childbirth and for your child in the children's intensive care ward?

Mr. RIEGER. Right. They had to put tubes in her chest, and quite a few other things. They put a leader into her heart to register the pressure caused by all the fluids they were giving her, because they had her on IV's for a long time.

And all my insurance paid was $350 of it. And there was no way I could pay the rest. We have only been married for a couple of years now, and this was our second child. And at the time, I had been laid off. There had been a trucking strike going on. There was nothing else I could do but go into bankruptcy.

Senator KENNEDY. Is your wife covered by an insurance program too?

Mr. RIEGER. No. See, my wife had been working at the same place I was, Joseph Feiss & Co., but when she became pregnant, she had to take a leave of absence.

Senator KENNEDY. So she wasn't covered?

Mr. RIEGER. No.

Senator KENNEDY. So you just had your program?

Mr. REIGER. Right, right.

Senator KENNEDY. And that allowed for $350?

Mr. RIEGER. Right. And that doesn't pay off $20,000.

Senator KENNEDY. And your child was in the intensive care for how long?

Mr. RIEGER. Well, she was 6 months old, she passed away a month ago. Out of the 6 months, she spent 5 months in intensive care.

Senator KENNEDY. You have this debt of some $20,000 to the hospital?

Mr. RIEGER. Right.

Senator KENNEDY. Now, did the hospital try and collect this money?

Mr. RIEGER. Yes, they called me up three times before I finally got to my lawyer, and wanted to know how I was going to pay it. I asked them if they wanted cash, check, or money order.

Senator KENNEDY. Did they ever get in touch with your employer, that you know of?

Mr. RIEGER. Not that I know of, no.

Senator KENNEDY. They just talked with you?

Mr. RIEGER. Right. I believe the credit department called and said, "Mr. Rieger, you owe us some money. When are you going to come up with it?"

Senator KENNEDY. What did you indicate to them?

Mr. RIEGER. I told them I couldn't get $20,000. And the lady on the phone said, "Why don't you go to a finance company and borrow $20,000?" You know, right.

Senator KENNEDY. What did you say when she said that?

Mr. RIEGER. I asked her which loan company would give me that much money. I doubt if any would.

Senator KENNEDY. You indicated that you tried at least to pay some of it off?

Mr. RIEGER. I told them if they would come down to a reasonable amount that I could possibly handle, I would be more than glad to handle it. Because like I said, they saved my wife's life and my baby's life.

Senator KENNEDY. And you felt an obligation to pay at least some, if you could?

Mr. RIEGER. Definitely.

Senator KENNEDY. What do you make a week?

Mr. RIEGER. Take-home pay?

Senator KENNEDY. What is your take-home pay?

Mr. RIEGER. My take-home pay is about $120.

Senator KENNEDY. And you have your wife and child you have to care for with that?

Mr. RIEGER. Right. At the time this child here was born that meant four, I had two little girls then and my wife and myself. She subsequently expired from pneumonia.

Senator KENNEDY. She caught pneumonia and passed away?

Mr. RIEGER. Right.

Senator KENNEDY. I understand you are going into bankruptcy now?

Mr. RIEGER. My bankruptcy petition is already filed. I lost everything, you know.

Senator KENNEDY. What do you mean, you lost everything?

Mr. RIEGER. Well, I had a car which was—well, it was stolen while she was in the hospital. And I lost the stove, refrigerator, television set, everything was taken from us since I filed bankruptcy.

Senator KENNEDY. Stove, refrigerator, and television?

Mr. RIEGER. Right. And my car, as soon as I filed bankruptcy, the things I had on credit at the time.

Senator KENNEDY. As soon as you went into bankruptcy, all the things you had on credit, and most people today, as I understand, are on credit?

Mr. RIEGER. Are on credit.

Senator KENNEDY. Once you go in, all these things were what, taken out of your home?

Mr. RIEGER. Yes. They came right away and took them. I tried calling Continental Bank, that is where I had the stove and refrigerator and TV through; I explained to them I would like to revive it, but they wouldn't talk to me. What can I do?

And the damage this has caused is something I will be feeling probably for quite a few years.

Senator KENNEDY. What do you mean by that, now?

Mr. RIEGER. Well, as it is, the only way I can buy anything I want or need, no matter how bad a necessity it might be, is by paying cash for it.

Senator KENNEDY. That will be hanging over your head probably the rest of your life.

Mr. RIEGER. Oh, yes, definitely. They look up your record through some firm, and they say, "He went bankrupt." And then nothing.

Senator KENNEDY. Has this had any impact on your employment?

Mr. RIEGER. I am extremely, extremely lucky that I worked for who I do work for. Because they knew of the trouble I was getting into, and they stood by me all the way, so I was very lucky.

Senator KENNEDY. What is the name of the company?

Mr. RIEGER. Joseph Feiss & Co.

Senator KENNEDY. So people know. It's good to hear the good side of the human concern, as well as the difficult.

Mr. RIEGER. They say in times of difficulty, true friends show their true colors, and boy I tell you, they came through with flying colors. They really did.

Senator KENNEDY. Mr. Rieger, this could happen to anyone—this kind of a problem. The complications of childbirth that were involved produced this extraordinary medical bill, $20,000 in 4 or 5 months. This could happen to anyone in this country. And of course, the questions I think we as Americans have to ask ourselves is why do we have to have a system which adds such a financial burden to the pain and trauma and sense of loss that you felt in terms of your infant, and the extraordinary kind of hardships that your wife has been confronted with. In fact, this system forced you into bankruptcy, which will be with you for many years.

What is it all about? What has happened to you could happen to anyone else. I think you should be asking us, "Why in this Nation of ours do we have a health system that is not more compassionate, more concerned, and more attentive to these kinds of needs."

That question is long, long overdue. [Applause.]

Senator PACKWOOD. Mr. Rieger, apart from the obvious financial burden, and this is certainly one of the things we are trying to alleviate, did your wife and your baby receive good medical service?

Mr. RIEGER. I have no complaints, really. As far as I am concerned, they were fantastic. Because when she had the cardiac arrest, her heart had stopped for a little over 3 minutes. They kept right on working without giving up, and pulled her through. All the complications arose, they didn't hesitate to do what had to be done, and they didn't keep me in the dark of what was going on. They came to me and explained to me in terms that I would understand what had occurred, what was going to happen, and all the things coming up.

Senator KENNEDY. Which hospital is that?

Mr. RIEGER. Cleveland Metropolitan. She was in the intensive care unit there. I don't know about the rest of the hospital, but as far as the intensive care unit is concerned, those people are really, really fabulous.

Senator PACKWOOD. Let me ask this, Mr. Rieger: Is it correct to say that what you really needed, and didn't have, was a catastrophic insurance plan to pay everything over $1,500 or $2,000?

Mr. RIEGER. Right, right.

Senator PACKWOOD. Would it make any difference to you how that insurance might be financed, that is whether it is financed by the Federal Government or paid by the employer so long as it's available.

Mr. RIEGER. As long as it's there, that is the main point.

Senator PACKWOOD. Thank you.

Senator KENNEDY. In terms of the catastrophic problems, I imagine even if you had a $2,000 medical bill with a take-home pay of $120 it would be catastrophic. If a senior citizen living on social security, for example, had a $800 or $900 health bill it would be catastrophic.

Mr. RIEGER. It would be a lot better than what I got, that is for sure.

Senator KENNEDY. A lot better than what you have, but it would still be pretty catastrophic.

Thank you very much, Mr. Rieger. We appreciate your kindness in coming here.We hope that your wife is well.

Mr. RIEGER. She is doing all right now.

Senator PACKWOOD. Thank you very much.

Mr. RIEGER. Thank you.

Senator KENNEDY. Our next witness will be Mr. John Dowden, and he has some associates with him. If he would be kind enough to come up here.

We have Miss Souliotis in the red dress here. Those who want to make a brief comment should give their names to her. She is right under the lights here. As I say, we will do our best to hear everyone in the time we have available to us.

We want to welcome you here, Mr. Dowden. I understand you are a member of the Mount Pleasant Community Council?

Mr. DOWDEN. Yes, I am.

Senator KENNEDY. Also a member of the Christian Social Relations Association of the Diocese of Ohio, and a member of the Eastern Ohio Council of Churches?

STATEMENT OF JOHN DOWDEN, MEMBER OF MOUNT PLEASANT COMMUNITY COUNCIL; ACCOMPANIED BY A PANEL COMPOSED OF CITIZENS OF CLEVELAND, OHIO

Mr. DOWDEN. Yes; I am appearing here this afternoon, not in any official capacity, but simply as a citizen interested in health care. And I am going to have as my first witness or speaker, Mrs. Betty Hawthorne, who will tell you of a personal experience in a hospital in the city of Cleveland.

Senator KENNEDY. Mrs. Hawthorne, where do you live?

Mrs. HAWTHORNE. My address is 3931 East 135th. This is something that happened several years ago. My mother became ill, and I rushed her to a hospital as an emergency patient. She wasn't taken care of. They didn't bother to look at her at all, but they said that she did have a heavy cold and to take her home. And I did this. And I used home remedies on her for about 13 days, and she progressively became worse.

I took her back to the same hospital, and they told me to call her worker. I had tried to explain to them that she wasn't on public assistance, but they wouldn't take care of her. And they asked me to take her home, which I refused to do. I called a friend who was on the board of trustees at another hospital, who came out immediately with an ambulance and took her to the hospital where he was on the board.

They told me there that if I had taken her back home, that I could have called the undertaker the next day. She had pneumonia for the third time, and had massive bleeding, she was hemorrhaging from the brain, but she was saved, thank goodness.

Senator KENNEDY. Now evidently she had gone to an emergency room the first time, and she didn't get any kind of treatment. They recommended that she go home with you, is that right?

Mrs. HAWTHORNE. Right.

Senator KENNEDY. Then she got sicker while she was at home. Did you get in touch with the emergency room? Or did you not want to go back because they wouldn't look after her?

Mrs. HAWTHORNE. Well, because they told me this was a heavy cold, I was using home remedies, which wasn't very helpful.

Senator KENNEDY. They told you at the emergency room it was a heavy cold, and still you could see her condition deteriorate?

Mrs. HAWTHORNE. Yes.

Senator KENNEDY. Finally she was just so sick that you took the other steps of going to ask a friend, that was a trustee of another hospital, to get her into another hospital?

Mrs. HAWTHORNE. Right.

Senator KENNEDY. Why don't you think your mother was treated in the emergency room of that hospital? Why don't you think that she was able to get better care? Do you have any feelings on that; was it crowded, did she have to wait a long time? Were they able to give her sufficient examination, do you remember?

Mrs. HAWTHORNE. No; it wasn't crowded, but we did wait a long time.

Senator KENNEDY. Was one of the reasons you didn't go back when you saw her getting sicker that you felt that they wouldn't care for her, or that you knew that it would be costly, or that you thought they might say the same thing, that she's got a bad cold?

What went on in your mind; did you feel the hospital was sort of a friend in need, or did you feel that it was something frightening?

Mrs. HAWTHORNE. Well, to me it was rather frightening.

Senator KENNEDY. Thank you very much.

Mr. DOWDEN. May I next introduce Mr. James Price, who has a personal experience.

Mr. PRICE. My name is James Price, I live at 13708 Melzer Avenue.

My mother was a diabetic. She had a diabetic arrest, and was taken to the hospital and through the outpatient clinic they let her sit there for a while. And finally after an hour and a half, someone finally saw her and she was treated and returned home.

Subsequently, she was hospitalized because her condition didn't improve. This, by the way, was in November of 1962.

In February of 1963, at about 7 o'clock in the morning, she suffered a cardiac seizure. She called my home and my wife was there and took

her to the hospital immediately. When she arrived, she told them the condition, the circumstances; and instead of doing anything for her, she sat for an hour and a half, and this time she expired.

Now, I am saying this because I had another experience about a month ago while I was working, one of the men on my route had a cardiac seizure and his wife asked me to drive him to the hospital. When I saw that the man was in such bad condition that he would never make it, so I took him to the Shaker Fire Station where they had a resuscitator. And subsequently we went to the hospital, I had to go with him because I was the one who brought him in. We took him to the hospital, and the hospital had been notified by radio that the man was going to come in. When we arrived, the hospital brought their resuscitator out to relieve the emergency vehicle's resuscitator. The man was hospitalized about 10 days ago, he is now home recuperating and doing fine. It's just a matter of attention, when and where and how.

Also, I was once scalded and the place where I was working sent me to that same hospital, and they told them that a certain doctor would take care of me. Well, I drove myself down there. When I walked into the emergency room, I said, "I am James Price." They said, "Oh, you are Dr. So-and-So's patient," and I got the red carpet rolled out for me.

And about 4 years later, I had a severe cold and indigestion, which I thought was a heart condition. And my friend was at the house visiting me. I walked in the same hospital, told them what the situation was. I laid down on an emergency table and it was about an hour and a half before I got any attention whatsoever. I had hospitalization, so it wasn't a matter of money.

Senator KENNEDY. You get a different kind of treatment, in terms of your ability to pay. Would you say this has something to do with it?

Mr. PRICE. No, not exactly. Now in the one case, in regards to my mother, she was on social security and the social security was taking care of her hospitalization. And they had some Blue Cross which was covering the better portion of her medical care through the outpatient department. And plus the fact that her sons had been contacted to subscribe to any deficit amount of money that might be due to the hospital.

Senator KENNEDY. Why do you think you were treated one time, and had to wait another time?

Mr. PRICE. Well, I hate to say it, but I think it was blatant prejudice in this particular hospital.

Senator KENNEDY. Do you think as well that some of these hospitals are operating on a tight budget so they can only take so many people who they assume might be poor. They know they can only recover so much in terms of medicaid, medicare, and therefore if they see someone that comes in there that looks like he's got the resources to pay, they might say they are a safe financial risk and treat him, but they have to screen the poorer patients, and they are not able to take as many of those. They would like to, but they haven't got the resources to do it. This may be part of the actual explanation, too.

Mr. PRICE. Is a man's life worth more than a dollar, or a dollar worth more than a man's life?

Senator KENNEDY. I agree with that, that is part of the problem, the nature of the crisis. Your situation is a good example of what health crisis means to you and to certain members of your family.

Senator PACKWOOD. Mr. Price, is it correct to say that your problem was not money?

Mr. PRICE. No, sir.

Senator PACKWOOD. You had insurance coverage, so the hospital wasn't worried about the possibility that you might not be able to pay?

Mr. PRICE. Right.

Senator PACKWOOD. So money wasn't the reason the hospital refused you service or made you wait for a long period of time?

Mr. PRICE. On one occasion, the place where I was scolded at, this particular doctor, who happens to be a famous heart surgeon represents this organization. They said I was his patient when I walked in and told his name, right away, it's taken care of.

A year later I went in on an emergency, gave them my hospitalization card and everything, and still had to wait an hour and a half before I was taken care of. This pain was really giving me the heebie jeebies, I didn't know if I was having a heart attack or what.

Senator PACKWOOD. Thank you.

Senator KENNEDY. I suppose it does show good organization when you are able to call down there and get immediate service. That is a good organization. But when you have to go down there and wait an hour, or an hour and a half when you are in agony, that is poor organization. I suppose to some extent it reflects on the compassion of the system.

We are interested in a system which is compassionate. Our system does permit the compassion of doctors and nurses and other health personnel to actually get through to the patient. You have given us examples of some of the difficulties. I want to thank you very much.

Mr. PRICE. Thank you, sir.

Mr. CHAPMAN. My name is Tom Chapman. I live at 109 Avon Avenue. I pastor the Avon Baptist Church, a small church.

It was in 1968 in August, about 10:30, 11 p.m., my wife, Marie, fell in our home. We helped her to the bed and discovered that the pain was so intense at that time that she would need medical attention. So we called the emergency crew, and they came out and they did take her to St. Luke's Hospital. We arrived there, I guess about 11:30 p.m.

About 12 or 12:30, she got to see a doctor there who immediately sent her to get some X-rays in the area of her back where she said she was hurting.

They returned about, oh, 20 minutes later and the doctor told me she was okay, that I could take her home. I went in to assist her, but she insisted that she couldn't move. And at this, I went back to the doctor and I related to him that Marie says that she can't move, the pain was that intense. So he went back into the room, and of course I stepped out, and when I went back again after he had left the room again where he was waiting on her, she was crying, of course, and she says "Chapman, the doctor wants me to go back home, but I can't hardly move, the pain is too much."

So I go back again and talk to the doctor and he says, "Well, listen, your wife has had a fall, she's got a pinched nerve in her back and she

is in pain and that is to be expected. Now I am the doctor and she is okay to take her home."

And I said, "Well, I know my wife. We have been married 15 years now, and I know she is not a pretender, she can take pain, she has been ill before." So I refused to take her home. I went out to the waiting room.

He and a nurse went back and it was about 15 minutes later that they were back there with her and they brought her out in a wheelchair, and what they had done was to dress her and basically lift her from the place she was lying, dressed her, sat her in a wheelchair, and brought her out to me, and said, "Now take her home."

Well, at this point, I don't believe that is the thing to do. So I told the doctor I am not going to take her home, because I believe she ought to be kept here and further attention or examination ought to be given.

He says, "It's your wife, you do what you want to do, I am through." So he goes back to the office, and I sat there and my wife sat there in a wheelchair. It was about, oh, 2 o'clock in the morning, now, and, of course, by this time all the other emergency traffic had been cleared away, and we were the only ones there.

The doctor goes back into another little room, and I guess that is where he sleeps, and about 3:30 he came out again and he saw that we were still there. He went back into the little room.

And he came back in about another hour and we were still there. So it was about 4:30, 5 o'clock that my wife wanted to go to the bathroom. And, of course, she couldn't get any help here because they had discharged her and I couldn't take her into the ladies' restroom nor the men's restroom. So she sat there until around 7 o'clock, 6 o'clock maybe.

I called the Academy of Medicine, it being Saturday morning and they were closed and I didn't get any answer. Of course, I did reach their answering service which is all a taped system.

Well, at this time I encouraged my wife just to release herself there. Her bladder was full, and I said, "Well, just go right where you are."

Well, she couldn't do that. Of course, by this time, I had no alternative but to try to get her to the bathroom at least to the door.

And as she did get to the door and finally into the bathroom and back to the chair again, I concluded that since she had been that mobile on her own account, that possibly I could take her home and do as the doctor had prescribed, which was to take sitz baths twice a day.

So finally I literally picked her up and carried her to the car. We drove home and I literally carried her into the house, put her in bed, and began her first sitz bath operation. And that kept on for the next few days and the pain did not subside.

So eventually we concluded that there had to be something wrong which X-rays maybe did not reveal. So we carried her then to the Lakeside Hospital, where she in fact was given extensive X-rays. And they did discover that there were several vertebrae broken in her back. And for weeks she had been laboring, going through those processes of sitz baths and up and down. And of course at this point I just felt that there was something that ought to be done. And I sought legal ad-

vice as to what we should do to find satisfaction for the kind of damage that I felt as a result of this terrible situation.

Senator KENNEDY. You mean that all the time they were prescribing remedies for a pinched nerve, she had these fractured or dislocated or broken vertebrae?

Mr. CHAPMAN. Broken vertebrae.

Senator KENNEDY. Their examination had failed to reveal that?

Mr. CHAPMAN. There was only one X-ray as I understand that was given, which was not quite as extensive as I think should have been at this time. I think there was neglect on the part of the hospital to really perform the kind of research or examination to discover this.

Senator KENNEDY. How does that make you feel about the kind of care that you received? I suppose other people are going to that same doctor today. How does it make you feel about the quality of care you received?

Mr. CHAPMAN. Well, in that particular case, I wouldn't want to say it here before these people about what kind of care, what I think about the care that was received, or the kind of an apathetic attitude that was displayed that night.

I think only the course of law and people who are concerned about changing these kinds of practices can do the things that are necessary to change the practice.

Senator PACKWOOD. May I ask you, Mr. Chapman, because Mrs. Hawthorne and Mr. Price raised this same question. Money, or financing, is not the source of the problems which have been related to us. Let me ask you what advice you would give to us to make the hospital or the system more compassionate?

Whether it's a public or private hospital doesn't seem to matter. Is there any guarantee that the Federal Government would operate hospitals they would be better.

What is the answer?

Mr. CHAPMAN. In a racist society where people become geared or colored by these kinds of attitudes that say they don't give a damn about people or really don't care, it doesn't matter if a person has money or doesn't have money because these kinds of patterns have set in, and they become as a part of that person's makeup. And this was the kind of thing, I think was happening that night. Because we had Blue Cross and I had presented a Blue Cross card.

But I saw the kind of apathy go on there that night with other people that I thought just ought to be brought to the attention of the public.

Senator PACKWOOD. You're pointing to a problem much bigger than medical care or medical costs. It's basically a problem of race relations, and all the money in the world isn't going to change it unless we change our hearts.

Mr. CHAPMAN. I am saying that because this kind of situation grows out of another situation where people have not had the money, and people have not had the time because people didn't have the money to give the people the time and the care that they needed at the time that they needed it, that this kind of attitude becomes ingrained in the system, in a society, in an individual so that he reacts to other situations that might not be even colored by that same kind of situation

that initially had his roles of development around. Yet, he exerts that kind of an attitude.

Senator PACKWOOD. Let me ask you again, what would you suggest to us to change it? We are talking about medical problems, medical care, medical coverage. What should we do to change it?

Mr. CHAPMAN. If everybody could get well and stay well, it would do one thing. But I suppose just to say publicly that we think society or the system ought to change is not enough.

But I do believe that people like yourself and people who are in authority are going to have to sit down, well, like you are doing now, and talk with the people who are being constantly confronted with these kinds of things and those people who are responsible for bringing about these kinds of conditions and presenting these kinds of attitudes and problems for other people as a result of their own carelessness and coarseness, that there will be a change in them.

Senator PACKWOOD. What should we do about these problems? What would you suggest to us when we go back to Congress to write new legislation?

Mr. CHAPMAN. Sir, I suppose I would be in your seat, maybe, I don't know at this moment if I could come up with the kind of answer.

But we could think about it, right. [Applause.]

Senator KENNEDY. Wouldn't at least a part of the answer be giving the community a greater voice on hospital policies? I mean if you have the voice of the consumer in your neighborhood, or your community, influencing the policies within the hospital, don't you think it would reflect more accurately the concerns of the community? Isn't that, at least, one of the additional features that is needed, opening up the system so representatives of the community are making these policies and listening to these kinds of complaints that we hear? Don't you think this would be useful and helpful in terms of adjusting and changing attitudes?

Mr. CHAPMAN. I certainly do.

Senator KENNEDY. Give a stronger voice to the consumer in terms of development of things of this kind. It's an enormously complex problem, but obviously this could be enormously useful in giving an idea of what the needs are in a community.

Mr. CHAPMAN. I think so.

Senator KENNEDY. Thank you very much.

Mr. DOWDEN. I would like to say something before I leave the table because of the fact that I have here a file of cases similar to the ones that have been presented. These are all documented, and I would just want to take but 2 minutes to bring them to your attention in this matter.

No. 1 is an automobile accident where four people are involved.

No. 2, and I am only going to give you 10 of them, No. 2 is a rape case where the person was taken to the hospital and refused examination as requested by the police.

No. 3 is a new person in the city that had no doctor at that time, and went to the hospital.

No. 4 is a child with a broken foot in two places, given no treatment and sent home.

No. 5 is a social worker who had burns on both legs, and advised to take two aspirins and see a doctor tomorrow.

No. 6 is a child put to sleep with some drugs because the child had stomach pains.

No. 7 is a pneumonia case where the man was sent to the hospital by his employer, the factory where he works. This factory has a contract with this hospital, and he had to be taken to another hospital instead.

No. 8 is a comment where the man said he was told, "Well, you have got to be cut or shot."

Now it's important to recognize that I am not a professional welfare worker, nor am I an agitator. I receive no Federal or State funds, and I am in the business of churchmanship rather than politics. And I therefore have different thoughts from the areas who appear before you on the issues of the National Health Plan. I am not going to cover all I had to say because you were asking Mr. Chapman, and I say I wish this committee would take into consideration the need for guidelines setting forth conditions for financial support to the providers of health and medical services that would eliminate some of the present areas of discriminatory practice engaged in by some hospitals and health centers who must develop by an independent health package.

It is my conviction that most of the citizens of America, and indeed the Members of Congress and the Senate, consider themselves to be active participating members of the religious community who sincerely want to enact just and equitable laws, and there are some in our society who are poor and unable to meet these high costs of being sick.

And therefore, I would support the health plan, or Senator Kennedy's bill, your bill, and I certainly say to you that I am not doing it on the basis of race, I am doing it on the basis of the fact that the people of Ohio need it. And I will be going to the Ohio Council of Churches as well as to the Department of Christian Social Relations where we have 17 denominations represented, five Roman Catholic dioceses represented; and I will be saying to them, as I am saying to you, that we should support this type of bill and this sort of thing, because as you have seen today, the people need it.

Thank you.

Senator KENNEDY. Thank you very much. That is a splendid statement.

Ralph Tresky?

Mr. TRESKY. My name is Ralph Tresky, and I live in Garfield Heights. I am here because in effect my wife came down with kidney trouble, kidney failure in 1969. As far as the doctor in the hospital, everything was fine, it's just that the cost was so great that my insurance didn't cover it all.

Being dialyzed in a hospital is very expensive and much of the cost is not covered by insurance. My insurance was what is called a Basic Blue Cross plan, and I had a $450 surgical benefit. Well, my wife had three operations, so the other two, I had to pay for those myself.

But right now, I still have an outstanding bill at the hospital for $5,200. Now with kidney patients that go home, you have to have a home dialysis machine. Well, the machine itself costs $3,685, an artificial kidney is another $800, you have a blood pump which costs $645, a Hepburn pump, $245. The cost is tremendous.

Now, the cost for the patient to be dialyzed at home would run you on the average of $200 a month for supplies, blood tubing, concentrate, and so forth.

If it wasn't for the man that I work for and the company that I work for, the men in the local had gone out to different locals and collected money, and sold raffle tickets, and they collected over $7,000 to help me purchase the machine so that I could take my wife home.

And I have had my wife home for about a year and a half, and I can say unfortunately my wife passed away on April 3 of a heart attack. We are in the process right now of setting up a community dialysis center in the city of Cleveland. And my machine will be donated to this community kidney dialysis center.

Now the reason we are trying to get this set up is for people who cannot afford to go to the hospitals to be dialyzed. To be dialyzed in the hospital it costs roughly $10,000 to $15,000 a year. Some insurance plans will cover you for 3 years in the hospital, but after that, what are you going to do, go home and die? They don't cover you any further, people cannot afford to go to the hospital to be dialyzed. That is the reason we are trying to get this center set up for people who cannot afford to go to the hospital and be dialyzed.

Senator KENNEDY. Where do you work?

Mr. TRESKY. Van Dorn Co.

Senator KENNEDY. And did you have a health program in your company?

Mr. TRESKY. Well, we have the insurance, yes; hospitalization insurance.

Senator KENNEDY. And how much did that cover?

Mr. TRESKY. It did not cover the doctor's fees. It covered the rooms and covers for meals and everything. But like I say, it did not cover for dialyzing.

Senator KENNEDY. You have a bill of $5,200?

Mr. TRESKY. Right.

Senator KENNEDY. There is no way in the world that you could have prevented your wife from having this difficulty?

Mr. TRESKY. No, sir; no way in the world.

Senator KENNEDY. Nothing that you could have possibly done in the world that you know about that could have possibly prevented that difficulty?

Mr. TRESKY. No.

Senator KENNEDY. It just hit your wife, really right out of the blue, didn't it?

Mr. TRESKY. Right. She had strep throat, and that is where the trouble settled.

Senator KENNEDY. How old was she when she had the strep throat?

Mr. TRESKY. Roughly 32 years old.

Senator KENNEDY. But there wasn't anything before that that led you to believe that she had any difficulty with this type of thing?

Mr. TRESKY. No, sir; not at all.

Senator KENNEDY. You are a workingman?

Mr. TRESKY. Yes, sir.

Senator KENNEDY. What is your take-home pay?

Mr. TRESKY. Roughly $140 a week.

Senator KENNEDY. Do you have other members in your family? Do you have children?

Mr. TRESKY. I have two children.

Senator KENNEDY. You are trying to provide for their care and their housing and their education and clothing and food and shelter, and also trying to meet these other health needs of your wife, is that right?

Mr. TRESKY. Yes, sir.

Senator KENNEDY. And you got to the point where you were dependent for your wife's existence on the goodwill of the people where you worked?

Mr. TRESKY. Right.

Senator KENNEDY. I suppose your colleagues, your friends, have families, don't they?

Mr. TRESKY. Yes, sir.

Senator KENNEDY. And for every few dollars that they give out of that take-home pay a week, that means less in terms of their own children or giving up some other kinds of satisfaction that they and their families might like to have. And you were really dependent on them for your own wife's existence?

Mr. TRESKY. Yes, sir.

Senator KENNEDY. And with all of this, on top of the heartache, the suffering, you have a bill now of $5,200?

Mr. TRESKY. Yes, sir.

Senator KENNEDY. And how do you think you are going to be able to pay that off?

Mr. TRESKY. Well, right now again, the union has come through, and they are out making a campaign to help.

Senator KENNEDY. Which union is this?

Mr. TRESKY. The United Auto Workers.

Senator KENNEDY. They are one of the stronger supporters of National Health Insurance.

Mr. TRESKY. Yes, sir; definitely.

Senator KENNEDY. I hope you will take an interest in this as well, because I think you have shown the reasons why we have to do something about this.

Senator PACKWOOD. Mr. Tresky, let me ask you, had you had a health plan similar to Kaiser, that would have taken care of your needs?

Mr. TRESKY. Yes, but it still wouldn't have purchased the machine.

Senator PACKWOOD. You are talking about the burden of doctor's fees and hospital costs. Your problem seems not unlike Mr. Rieger's in that you have been hit with catastrophic costs with no way to pay for it.

Would it be correct to say that what you need is catastrophic insurance that you know would take care of the costs?

Mr. TRESKY. Yes, sir.

Senator PACKWOOD. Could it be provided just as well by your employer as by the Federal Government?

Mr. TRESKY. Yes. But it still gets down to the point that your insurance companies, I say some of them, will not go over 3 years on dialysis inside the hospital.

Senator PACKWOOD. Some insurance companies will go pretty far if

they are faced with some minimum standards at the Federal level.

Senator KENNEDY. I will be amazed. [Laughter.]

Senator PACKWOOD. This happened with the automobile manufacturers and air pollution emissions. We found we could make them produce a clean car, and I think we can make insurance companies come up with good policies.

The key is how it will be funded.

The important thing is having the coverage; how it's financed is secondary.

Mr. TRESKY. Yes, sir.

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

Estella Rayford.

Mrs. RAYFORD. I am Estella Rayford, and I went to the hospital in 1960, I had heart failure. My hospital bill was about $3,500, which my husband paid. On last December, I went back to the hospital, I didn't have hospitalization——

Senator KENNEDY. Can I go back just a little bit, Estella, with you, and get a little information before we get into the health questions.

As I understand, you and your husband worked regularly for some time, did you not?

Mrs. RAYFORD. Yes.

Senator KENNEDY. You each were employed and you worked regularly?

Mrs. RAYFORD. Yes.

Senator KENNEDY. Then at some time or other, you came into a little money, is that right, or you——

Mrs. RAYFORD. No, we had a place of business, a little delicatessen.

Senator KENNEDY. You started your own business. As I understand, you were working fulltime, you and your husband, then you decided to start your own small business, is that right?

Mrs. RAYFORD. Yes.

Senator KENNEDY. And this was what, a delicatessen?

Mrs. RAYFORD. Yes.

Senator KENNEDY. So you quit your old jobs, and both of you tried to make a go of it in the delicatessen, is that right?

Mrs. RAYFORD. Yes.

Senator KENNEDY. You were well, your husband was well, is that right?

Mrs. RAYFORD. Surely.

Senator KENNEDY. You had the delicatessen, you were working for yourselves at the delicatessen. Now, tell us what happened.

Mrs. RAYFORD. Well, we both got ill in December.

Senator KENNEDY. December when?

Mrs. RAYFORD. Of last year. We both had to go to the hospital for an operation, and I had six operations on my legs.

Senator KENNEDY. The amputation?

Mrs. RAYFORD. No; the circulation in my legs, first. And they sent me back home to see if that would work. It didn't work, then I went back and I had five operations there.

My hospital bill is $11,000, the prosthesis will cost $1,500, the chair is $250 and my husband is still ill. We have no way of paying the hospital bill.

Senator KENNEDY. So you have $11,000 in hospital bills, and $1,500 for prosthesis, is that right?

Mrs. RAYFORD. Yes; it will cost $1,500 to get my prosthesis, and a wheelchair would cost around $250.

Senator KENNEDY. Do you have money for that?

Mrs. RAYFORD. No.

Senator KENNEDY. If you had the money, would you be able to get them?

Mrs. RAYFORD. Surely.

Senator KENNEDY. You would like to get them?

Mrs. RAYFORD. Yes.

Senator KENNEDY. And just because you haven't got the resources at the moment, you are unable to get them and you are stuck in the wheelchair?

Mrs. RAYFORD. Yes.

Senator KENNEDY. Now tell me, before you were working on your own, in your previous job, were you covered by Blue Cross?

Mrs. RAYFORD. Yes; my husband had worked for the city, and still worked for the city 3 months after he got the business, to help pay off the bills.

Senator KENNEDY. But you got sick after you went into your new business, is that right?

Mrs. RAYFORD. Yes.

Senator KENNEDY. Tell us, were you covered then by Blue Cross?

Mrs. RAYFORD. No.

Senator KENNEDY. As I understand, you were covered when you worked earlier, and if you had thought about it when you were working in the delicatessen, you would have wanted to be covered, but you overlooked it.

Mrs. RAYFORD. That's right.

Senator KENNEDY. And through that oversight, you find that Blue Cross didn't pay for any of your hospital bills, is that right?

Mrs. RAYFORD. No. Because we didn't have it.

Senator KENNEDY. You didn't have it even though you had it before, you paid on it before, it was a program you believed in, but you overlooked it when you got your own business going, trying to make a go of it on your own.

Now you have all these medical bills.

Mrs. RAYFORD. Yes.

Senator KENNEDY. Your husband is now very sick, as I understand it.

Mrs. RAYFORD. Yes.

Senator KENNEDY. What is he sick from?

Mrs. RAYFORD. Well, we don't exactly know. The doctors, they have given some injections in the vein, it's something wrong with the pancreas.

Senator KENNEDY. How long has he been hospitalized?

Mrs. RAYFORD. Oh, he is at home now.

Senator KENNEDY. Does he have hospital bills?

Mrs. RAYFORD. No, he goes to his doctor every 2 weeks. Today is the day for him to go to the doctor for the injection. And they won't know whether the injections worked until they go back and operate on him again.

Senator KENNEDY. Who is paying for his hospital bills?
Mrs. RAYFORD. No one is paying for them, they haven't been paid.
Senator KENNEDY. He has some bills, he might not have paid them, but he has some bills, hasn't he, if he hasn't paid them?
Mrs. RAYFORD. Yes.
Senator KENNEDY. So he has some hospital bills as well, doesn't he?
Mrs. RAYFORD. Yes.
Senator KENNEDY. And you have about $11,000 in hospital bills?
Mrs. RAYFORD. Yes.
Senator KENNEDY. How do you think he will ever be able to start paying those bills off?
Mrs. RAYFORD. Well, I haven't the faintest idea.
Senator KENNEDY. You would like to pay them though, wouldn't you?
Mrs. RAYFORD. We have a triple A credit rating.
Senator KENNEDY. You are proud of that fact, that you have a triple A credit rating?
Mrs. RAYFORD. Very much so.
Senator KENNEDY. You would like to maintain that credit rating and meet your responsibilities and obligations. You have maintained it all your life, have you not?
Mrs. RAYFORD. That's right.
Senator KENNEDY. Except now you have this $11,000 medical bill that you are faced with. I suppose it's difficult to get a job unless you have prosthetic devices.
Mrs. RAYFORD. Surely.
Senator KENNEDY. And still they expect you to pay for these devices?
Mrs. RAYFORD. Sure.
Senator KENNEDY. Had you been reasonably healthy before?
Mrs. RAYFORD. Yes. As a matter of fact the week before I went into the hospital, I had gone out to the store and worked. My husband's brother passed away, and I had to keep the place open, and I worked until the week before I went in the hospital.
Senator KENNEDY. Did you think about trying to get Blue Cross or Blue Shield after you were sick?
Mrs. RAYFORD. The doctor my husband is going to told him to call Blue Cross. I called, and they said they only have a certain time of year that they take in customers, and I would have to wait until the time.
Senator KENNEDY. What do you mean there is only a certain time of year that they take people?
Mrs. RAYFORD. It's not open year around, they have a certain time of year that they take in.
Senator KENNEDY. Have you tried to enlist at all?
Mrs. RAYFORD. That is what I called for, and they said it wasn't the time. And I called again, and it still wasn't the time.
Senator KENNEDY. When is the time?
Mrs. RAYFORD. They gave me no date.
Senator KENNEDY. Where is our friend from Blue Cross who has been following this committee around the country?
When is the time?
Mr. MOONEY. I don't know.
Mrs. RAYFORD. But they did tell me that.

Senator KENNEDY. Do you think Estella is going to be able to get into Blue Cross? What do you think?

Mr. MOONEY. What is her age?

Senator KENNEDY. That makes a difference.

Mrs. RAYFORD. 55.

Mr. MOONEY. She will be able to.

Senator KENNEDY. Will you make sure she's taken care of and give her a hand? That would be wonderful.

I want to thank you very much. Again, it's the problem that people face through no fault of their own, and leads to extraordinary kinds of personal tragedy and disaster. Certainly we ought to be able to devise a system to beat that. We can't solve all the health diseases and difficulties, but certainly we can go along way toward relieving the kind of financial pressures which so many people have to bear.

I want to thank you very much for coming down.

Mrs. RAYFORD. Thank you.

Senator KENNEDY. Mrs. Mansick, is Mrs. Mansick here?

Well, she is not here right now, we will have Mrs. Jasilionis.

You are Mrs. Carolyn Jasilionis?

Mrs. JASILIONIS. Right.

Senator KENNEDY. Where do you live?

Mrs. JASILIONIS. 3807 Whitman.

Senator KENNEDY. Very fine. You have five children, as I understand it?

Mrs. JASILIONIS. Yes, I do.

Senator KENNEDY. Would you tell us a little bit about some of your problems?

Mrs. JASILIONIS. Well, I was married at a very young age, I had a girl and four boys. Each one of my boys was born with a hernia problem and had to be operated on. We didn't have insurance which covered the doctor's fees, and the doctors would charge $250 for each one of them. And within a year and a half's time, one was in the hospital eight times, and the one time was for a period of 8 weeks. He had to have special medicine that Blue Cross did not cover that cost $15 a day, plus $10 a day for the doctor. Just with doctor bills and medicine bills for the one boy it was over $3,000 that my husband and I had to pay.

And it got to a point where we couldn't pay and keep up the bills either, so we were forced to file bankruptcy, which was real bad, you know. Like we lost everything over it, and it like put my husband down, made him feel like a nobody, which caused friction in the family. And when there is friction in the family, there is constant fighting, which caused a separation and which put me on welfare.

And, like, that is about it.

Senator KENNEDY. The doctor said no more money, no more treatments for your children?

Mrs. JASILIONIS. Right, right.

We are really in debt up to our ears, and we had no choice but to file bankruptcy. They wouldn't handle the case any more.

Senator KENNEDY. You couldn't get the kind of treatment that your children required without coming up with financial resources?

Mrs. JASILIONIS. Right.

Senator KENNEDY. You had to buy some special drugs for your son?

Mrs. JASILIONIS. Yes. My son had asthma and he had pneumonia eight times from the asthma, and he became immune to regular drugs. And there was a new type of drug, it was coming out, Blue Cross hadn't covered it yet; therefore, we had to pay for the medicine.

Senator KENNEDY. What did you pay for that per day?

Mrs. JASILIONIS. $15 per day.

Senator KENNEDY. For how long, over what period of time?

Mrs. JASILIONIS. Five weeks.

Senator KENNEDY. This reflects as much of a catastrophic problem as large bills would to someone with greater resources. How are you going to pay $15 a day for 5 weeks for your children while your total bill is amounting to several thousand dollars?

It's as much of a catastrophic debt to you as the $20,000 is to someone else.

Mrs. JASILIONIS. Actually, it was $25 a day, because the doctor charged $10 a day to come in, rub the boy's stomach, and take his temperature.

Senator KENNEDY. You wanted to get the best for your children, didn't you?

Mrs. JASILIONIS. Yes.

Senator KENNEDY. You would pay your last dollar to make sure they had it?

Mrs. JASILIONIS. We did, we did.

Senator KENNEDY. And you paid your last dollar, because of your concern for your children, and that wiped you out financially?

Mrs. JASILIONIS. Right.

Senator KENNEDY. And put a mortgage over your whole future, and caused enormous tensions in your family.

How are your children now?

Mrs. JASILIONIS. Well, now I am on welfare, what more can I say?

Senator KENNEDY. Are they healthy?

Mrs. JASILIONIS. They are healthy in the sense that they are not walking around passing out for food. But what are you going to do?

County welfare doesn't give you enough to live on. We eat, but it's not the proper food.

Senator KENNEDY. Do you use food stamps? Do you have a food stamp program?

Mrs. JASILIONIS. Yes, I get food stamps.

Senator KENNEDY. Are they helpful to you?

Mrs. JASILIONIS. They are helpful in a sense, yes. But I would like to get more of them.

Senator KENNEDY. You are just interested in providing some decent food to your children?

Mrs. JASILIONIS. Decent food, right. Because kids go to school; in order to function right in school, they have got to have proper foods. If they don't have proper foods, they can't function right. Therefore, they fail, they are dropouts.

Senator KENNEDY. Do they have a hot lunch program in school?

Mrs. JASILIONIS. No. Our school was something like about 4 percent under the standards, therefore, it doesn't qualify.

Senator KENNEDY. Thanks very much. I appreciate your coming in. Again, we see the problem that people are confronted with in terms of finances. The system has driven you to bankruptcy and driven you to the welfare rolls.

We have here a family trying to be good citizens, trying to meet their responsibilities, in terms of their community, in terms of their family, and the system has just driven them back against the wall. That is what we are interested in changing.

I appreciate your coming here and telling us about it.

Now, we have two professional witnesses. After they have testified, we will start on the open part of the hearing.

Dr. Milton Lambright is a past president of the Cleveland Academy of Medicine, Dr. Joseph L. Bilton is vice president of the Cleveland Academy of Medicine and past president of the Cleveland Academy.

Gentlemen, we appreciate your appearance here. Earlier in the day, we had a chance to meet with Dr. Bilton at another session on prepaid group practice programs. We had 15 or 18 people who were in prepaid programs, members of advisory councils, spokesmen for industry, and others. We talked about a variety of subjects for about an hour and a half. We are pleased to have you here with us this afternoon.

You have heard some of the concerns expressed here this afternoon. We have heard these concerns not only here, but in rural West Virginia, in the urban areas of other great metropolitan centers. We will be interested in whatever comments you would like to make on these concerns.

STATEMENT OF JOSEPH L. BILTON, M.D., VICE PRESIDENT, CLEVELAND ACADEMY OF MEDICINE; ACCOMPANIED BY MILTON LAMBRIGHT, M.D., PAST PRESIDENT, CLEVELAND ACADEMY OF MEDICINE

Dr. BILTON. First, thank you, very much, Mr. Chairman, for having us here and listening to our viewpoint. Certainly we are distressed to hear the cases that were related here this afternoon. And to the extent we are responsible, I feel badly.

I would like to read a statement setting out the position of the Cuyahoga Medical Society, because perhaps our position isn't clear, if I may, and the statement goes as follows:

The Cleveland Academy of Medicine and the Cuyahoga County Medical Society has no quarrel with anyone who is attempting to improve the quality and distribution of medical care and seeking methods of meeting its costs. We, therefore, are happy to participate in this hearing in a constructive manner with the hope that some benefit will accrue to all concerned.

We also are aware that the rapid growth of medical science requiring sophisticated and expensive equipment, along with the inflationary spiral and the adjustment of hospital wages, have raised the cost of medical care to the extent that many people are finding it difficult to meet. It goes without saying that to deny anyone the right to adequate medical care is like denying motherhood; and, we therefore, feel that every effort should be made to bring the maximum care to the largest number of people at the most reasonable possible cost.

Unfortunately, little can be done to reduce the costs of medical care, in spite of many allegations to the contrary. The above-mentioned

items that contribute to our present costs are those which most of us would loathe to change.

It is possible that some savings in costs could be effected by methods of health care delivery, such as various types of group practices; however, this will do little to stem the overwhelming cost of top quality sophisticated treatment that is being made available and improved month by month and year by year.

The Academy of Medicine is now engaged in an indepth study of review in the establishing of norms for medical practices. They are also studying the possibility of a foundation for the purpose of administrating various group approaches to the delivery of health care.

Thus, we look forward with hope that something will emerge from these and other hearings that will guide us in our future attempts to meet the tremendous responsibilities of medical care to our community.

Senator KENNEDY. Dr. Lambright?

Dr. LAMBRIGHT. Yes, I would like to take a little different tact here. I am a surgeon, I have practiced in this community many years, and I am not a wealthy doctor because about one-third of my patients are patients who are unable to pay for proper medical care. I have had a great deal of experience in knowing some of the problems that you have heard of people who have testified here today.

Most of these concern catastrophic illness, and they exhibit in some instances racism. Sometimes it is lack of compassion, sometimes it's purely lack of personnel and lack of time.

Now, I know that anywhere that you go in this country, you are going to find the same kind of problems, you will find the same kind of testimony that will be given. My concern is that we seem to be trying to find the answer to the problem through the wrong door.

I am not only concerned about catastrophic illness and acute illness, I am concerned about the illnesses that we still don't know anything about. How many people in this room are ill and don't know it? Well, we have used the survey for——

Senator KENNEDY. Don't look at me quite that way. [Laughter.]

Dr. LAMBRIGHT. We have used the survey for chest X-rays, and we have found a great deal of illness which has occurred in people and been present in people who have no knowledge of it.

We read daily, at least in the medical profession, about many of our patients who have just left for a complete checkup, had electrocardiograms, and everything done; the next day, the fellow dies of a heart attack.

We spend billions of dollars on space vehicles and things of that sort, but I have wondered how much money we are really prepared to spend on finding the answer to our health problem.

Now I would like to put this in a perspective that I think everybody might understand, so if we try to imagine this whole problem as being a circle, it depends on where we start to find the answer to it. Now if we start somewhere along the circle and we are concerned with the problems of illness that we already know about, we will go around that circle, we will try to finance, and we will try to solve the problems, but we will come upon the first part of the circle that we didn't

touch. And these type of people who are ill now and have no knowledge of it.

Now there must be some way for us to reach a solution to this.

Senator KENNEDY. I'd like to refer you to Dr. Weed, who is a professor of medicine at the University of Vermont.

Dr. LAMBRIGHT. And he has a real good knowledge, and has this much experience about this kind of diagnostic computerized medicine that we have. I am surprised to find that in none of the plans, your plans, President Nixon's plans, and the American Medical Association's plan, the American Hospital Association plan, Senator Javits' plan, nobody is talking about this.

And I think that if we were able to include in this one of these plans, we would possibly find part of the solution. Of course it's not the total solution, but as a member of the board of trustees of Cleveland State University, I would like to give another idea about this.

Now we have here, as part of our team to explore these possibilities, Dr. John Knowles, and also Dr. Bob Eber, along with a large group of medical specialists throughout the country. And they certainly felt that our approach should be a little bit different.

Now the question is will we ever be able to develop enough physicians to handle the problems and avoid the difficulties that we have been listening to here today. And it seems that possibly we can't do that, at least not in the coming decade. But there is a possibility to develop a much greater health care approach by developing paramedical personnel.

I also think it would be of great interest for somebody in the Federal Government to try to bring back some semblance of the plan that was used during World War II in which we had the Cadet Corps for nursing. At that time we used to have nursing classes which were three to four times the size they are now. And I think some of these things could be explored as a positive input to try to solve these problems.

Senator KENNEDY. Thank you very much, sir. You have made some very interesting and worthwhile comments. We are flexible on the whole question of computerization and using computers to assure quality care. That is why we had Dr. Weed down to testify, before the subcommittee.

There is nothing inconsistent with that program and S. 3. We are able to translate it into legislative form. We welcome it in terms of providing some meaningful quality standards. But you mentioned something earlier, which is a cause of concern to me. You mentioned how many people are in this room that are sick and don't know it. How many people are sick in this room and know it and can't pay for it? [Applause.]

I am also interested in the questions of preventive medicine. That is an important feature of S. 3 and the various kinds of prepared group practice plans that it encourages.

Nevertheless, the fundamental problem is often one of manpower. We recognize that we have an enormous shortage of manpower now in suburban America. We have enough doctors on Route 128 in Boston, Lexington, Weston, and Camden, but we don't have any in 130 counties in rural America and in the inner-city areas where in many respects the health problems are most severe.

I would ask you as the representatives of the medical profession, how are we going to get you and the professional doctors into those areas of greatest need? We know that you are enormously committed. Obviously, Dr. Lambright is here in the city, he is providing services, he comes here with the finest qualifications. Dr. Bilton also has obviously shown a special concern, but how are we going to get more doctors down here into the city?

Dr. LAMBRIGHT. My implication is that there are not enough doctors to go into all these areas if they were willing to do so. You couldn't find enough to solve that problem, so we have to—we used the paramedical personnel to begin to find out where the problems are. Once we solve the problems, then we take it in a step-by-step approach, and then we may bring in more and more qualified people to handle these problems.

Senator KENNEDY. I am hopeful we can get the medical society to take strong positions favoring the use of paramedical personnel. Far too often in the past they have not.

Dr. LAMBRIGHT. Well, we need your help, we need the help of all of the people in the State of Ohio to help change some of these medical practice laws in the State as well as other States.

Senator KENNEDY. We are glad we have you in the forefront as spokesmen for the medical society. I am hopeful that others have your foresightedness.

Dr. BILTON. The Academy of Medicine has already made a statement concerning this.

Senator KENNEDY. Well, statements are statements, but we need more than that.

Dr. BILTON. Sir, I say we make more than statements, we are very anxious to pursue this. However, we are hampered by the State laws at the moment, and we are working in this area so that people who are graduates of two programs in town would be qualified to do something without the risk of legal implications.

Senator KENNEDY. Full utilization of paramedical personnel, greater development of neighborhood health centers, HMO's, maybe medical foundations, these are going to take enormous efforts on all our parts, don't you agree?

Dr. BILTON. No question.

Senator KENNEDY. Thank you very much.

Our next witness is Kenneth E. DeShetler, the Insurance Commissioner of the State of Ohio. We want to welcome you, Mr. DeShetler. You come with some special credentials. Mr. DeShetler was a judge in the highest court in Toledo, Ohio, and was willing to give up that responsibility with all the security and honor that is suggested by it, in order to come into one of the most difficult and challenging jobs in public life today. He is the insurance commissioner for a great industrial State.

We are very honored that you would come here. We know that you have been greatly concerned about health.

Mr. DESHETLER. Thank you, Mr. Chairman. That is a very gracious way of explaining the fact that I have only been in office 2 or 3 months, and I appreciate it.

Senator KENNEDY. Some of us haven't been in a great deal longer.

STATEMENT OF KENNETH E. DeSHETLER, INSURANCE COMMISSIONER OF THE STATE OF OHIO

Mr. DESHETLER. Mr. Chairman, Ohio's health care system like that of almost all other States, continues to be severely strained by powerful forces. Three factors especially—shortages of physicians and other medical manpower, poorly distributed manpower and facilities, and improper utilization of health care facilities—make adequate health care inaccessible to many and expensive for all.

Many proposals have been made by legislators, medical leaders, and others which were designed to alleviate the difficult health care situation.

A broad-gaged approach, aimed at correcting problems in the organization, delivery, and financing of personal health services for the entire population is absolutely essential.

Most hospital administrators questioned in a UPI survey could see no leveling off of spiraling cost and charges for at least 5 years, if then.

The overall increase in Blue Cross rates in Cuyahoga County alone from 1953 to date was 451 percent for the single subscriber and 512 percent for family subscriber.

Many factors account for this increase but certainly one of the most important is a total change in the attitude of the public about hospitalization. Whereas hospitalization was once anXiously avoided, it is now taken for granted even in cases of minor illnesses.

Once the patient has paid his health insurance, he is frequently inclined to take advantage of that prepayment whether or not he really needs a doctor's care or hospitalization.

In addition to subscriber over utilization of his hospital insurance, the problem is further complicated by the fact that Blue Cross is unable to control costs in the health care system. Resignation to that inability to control costs is reflected in a letter from a Blue Cross officer to a subscriber in which he said, "Nothing that we do will ever reduce hospital costs."

A prevalent philosophy with Blue Cross seems to be that all hospitals must be saved from insolvency. Such a philosophy of insuring even the most inefficient operations has created a very soft cushion for the hospitals and amounts to an almost unlimited subsidy of inefficiency. The treasurer of a local contracting hospital told me that there is no drive or incentive in the hospitals to keep cost down.

The composition of the board of Blue Cross in no sense is representative of its subscribers and yet both Mr. Ells, chairman of Blue Cross and Mr. Burt, president of Blue Cross contend that their basic loyalty is to the subscriber. This creates substantial problems when you consider that the Blue Cross boards are dominated by at least a majority of hospital-oriented people who have the seemingly impossible task of serving both the hospitals with which they are affiliated and the subscribers to whom they are accordingly pledged.

Subscribers and Blue Cross, however, are not alone at fault for contemporary health care problems.

Government at every level must share in the blame for the acute problems that face us in health care delivery and cost. Government has failed to recognize the needs of its people and when vested with authority to control has failed to control.

Doctors share the blame for not sufficiently policing their ranks for the unscrupulous doctor who over utilizes hospital facilities and over treats patients and the unscrupulous surgeon who performs a greater number of operations than medically necessary.

Hospitals share the blame for failing to effect economies within the hospital in buying supplies, laundry, et cetera.

Hospitals have failed to utilize industrial engineering skills to effect efficiencies in hospital operations. Some doctors have acquiesced to the hospital's preference for full beds by admitting patients on Friday or Saturday for operations scheduled during the next week. Blue Cross has allowed its rates to be distorted by paying for indigent care as an allowable part of cost. This clearly is the responsibility of the Government and should not be assessed to individual subscribers.

We have seen an amazing proliferation of exotic medical facilities. Many cities have open-heart surgery facilities far in excess of their capacity for reasonable utilization. Many cities have Cobalt treatment facilities far in excess for those needed for the community.

This is directly traceable, I believe, to the prevalent practice of closed staffing in most hospitals. Closed staffing prevents doctors from taking their patients to any community hospital they desire. This then militates against the effective distribution and utilization of high-priced medical faciliies. I have inquired about the closed staff practice and after pressing for an answer I'm told it relates to the doctor's competence. If in fact that is the purpose of closed staffing, it really amounts to a concealment of and subsidy of medical incompetence. The effect of such practice, it would seem, only guarantees a reshuffling of incompetent doctors but does nothing to get them out of practice. The net effect, I take it, is to collect all of the incompetents in one or two hospitals.

It would seem that a doctor is either competent to practice medicine or he is not. Supporting closed staffing and its attendant problems it seems to me, is like saying that a doctor is competent to practice but not on this side of town. Doctors ought to be allowed to practice in any hospital because they are competent or barred from all hospitals because they are not.

It is unseemly for doctors to argue for closed staffing on one hand and complain about the increasing cost of malpractice insurance on the other. The problems which surround closed staffing are myriad.

In some instances private groups of doctors operate emergency rooms as a strictly individual proprietary function. It would seem that if doctors can make money from the emergency rooms the hospitals could also, and thereby reduce costs ascribable to other patients.

A spokesman for Ohio Nurses Association said in a rather frank admission, "The consumer of health care services already suffers from inflationary prices, health personnel shortages, and a dehumanized health delivery system."

At this time, Mr. Chairman, with your permission, I would like to read excepts from several letters from our files.

This is directed to Director of Insurance:

DEAR SIR: We do not wish to appear before your board relating to the March 25 hearing, but would like our complaint noted. After 25 years we must drop our Blue Cross because of the high cost. I have sent in the other portion of our bill explaining we cannot afford this price, and could barely afford the $45.40

we paid before. This price of $95.62 is fantastic. Something is drastically wrong when people have to make a choice like this.

With the prices of everything like they are today, this is the straw that broke our back with this long strike now we are even lucky my husband is working. All working people would be happy if something could be done about this situation.

Another letter from a man says, relating to he and his wife:

My social security check, husband and wife, amounts to $145.30 a month, a total of $1,800 a year. Blue Cross and Blue Shield amount to $712 a year of my income.

Nearly 40 percent went to Blue Cross and Blue Shield.

Another letter saying:

We will be unable to attend the meeting scheduled * * *.

And at the end of the letter he says, to sum it all up:

We are captive Blue Cross subscribers. The contract is very expensive, has inadequate benefits, and is unfairly subject to rate increases which discriminate people who solely depend upon themselves to finance it. Something must be done to provide everyone with a right to the advances in medicine and to maintain good health without having to completely bankrupt themselves to get it.

It should be available to all for a fairly determined and equally share cost.

And another letter:

I receive survivor's benefits from social security because I am a widow with a dependent child. I borrowed enough 2 months ago to pay the outrageous sum of $95.40 for Blue Cross, not Medical Mutual. I have now received billing for the next two months. In order to maintain some semblance of independence and not become another name on the welfare to overburden the already overtaxed citizens of the State, I will have to drop this insurance.

My husband is 51 years old, I am 46 years old. Our payments were raised to $90.00 every two months. We have been unemployed for the last two months, we have to drop our Blue Cross because we won't be able to keep up with the huge payments. I have been a subscriber since 1943, and on the family plan for 20 years.

Senator KENNEDY. What happens when they have been subscribers since 1943 and paid the benefits, and then get sick only 30 or 45 days after they lose their job?

Mr. DESHETLER. If they are out of the plan, they are out.

Senator KENNEDY. Even though they have paid in since 1943?

Mr. DESHETLER. Well, the amount that they would have paid would have been protection for the past exposure, which does not contemplate future exposure.

Another excerpt:

It was most welcome news to hear about the hearing on Blue Cross-Blue Shield rate increase. I no longer believe this organization is acting in good faith.

Another letter:

We pay $705 a year for Blue Cross coverage. This is 15 per cent of our total gross income. Where do we make cuts in our living to cover such high premiums?

The only place they can be cut is the quantity and quality of food on the table, and that certainly does not make for good health.

And I have here another letter from a doctor, just reading a portion:

You no doubt know that Blue Cross came into being solely at the instigation of the hospitals themselves, and has been handmaiden of them ever since. The hospitals have had little incentive to keep down costs. Every increase in price is immediately and without hesitation met by Blue Cross and it at once is passed on as higher rates to the membership.

The cost of getting hospitalization is so high that people can no longer afford not to belong to Blue Cross or some other organization.

In my experience, their first loyalty is the hospital. At any rate, it is noteworthy that someone in a responsible position apparently is aiming to put some restrictions upon the free-wheeling practices of the past.

We do not suggest, sir, that the people who are operating the hospitals are evil people conspiring against the common good. We are, however, suggesting that human nature is such that it reacts most efficiently to a stimulus. Like everyone else in the world, doctors and hospitals will only be as efficient as the forces that work upon them compel them to be.

Nowhere in the Blue Cross program is there an effective mechanism to restrain costs of building or operating hospitals. Many professional people in the health care system characterize the Blue Cross payment plan as a cost plus system and contend that Blue Cross pays every claim put before it.

There appear to be certain immutable laws at work in the health care system. Among these are the following:

1. That Blue Cross functions most smoothly by paying all claims put before it.
2. That a hospital to be efficient for its own purposes must maintain a high rate of bed occupancy.
3. That a hospital with a high rate of bed occupancy must acquire new beds and additional space.
4. That hospitals with new beds must fill those beds for the reason set forth in No. 2 above.

Mr. Chairman, I am sure you have heard many of these same comments in other cities, but I would be rather surprised if Ohio's problems varied remarkably from those of other States.

During the course of our hearings March 25 and 26 held in this city, I made the following recommendations at that time:

1. Utilization studies.
2. Increased public accountability for the cost and quality of health care.
3. Institution of cost control systems.
4. Screening out of certain elements of cost, i.e., teaching cost, bad debts, depreciation methods, and so forth.
5. Consider method of recapturing intern costs.
6. Improve doctor utilization of hospital facilities.
7. Centralization of expensive medical facilities.
8. Centralization of testing and laboratory facilities.
9. Greater subscriber representation on boards of Blue Cross.

The Health Insurance Association of America suggests the following recommendations for renovation of our health care system:

1. Placing emphasis in coverage on ambulatory care, including prepaid group practice, community ambulatory care centers, organized home care services, allied health services, and care in other facilities which are less costly than are hospitals.
2. Relating coverages to preventive services.
3. Providing incentives for prompt treatment, including rehabilitation.
4. Restructuring coinsurance and deductibles.

5. Stronger suport for communitywide planning for health care facilities and services.

They also recommended increasing health manpower through a series of consolidated and expanded Federal training and scholarship programs and grants and measures to improve cost and quality controls of care provided by hospitals and doctors.

Some of the recommendations involve a substantial departure from traditional practices. In the past, the major emphasis in health insurance coverage has been primarily on care rendered in a hospital or other facility after the person became ill. The new stress is on preventive services and ambulatory care and it is designed to reduce the incidence of costly hospitalization and length of stay.

Another recommendation by the association urged insurers to help induce hospitals to adopt such cost-saving techniques as diagnostic workups performed before the patient is admitted, to save the day or two a patient must spend in a high-cost facility while waiting for the results of the laboratory tests; to use hospital facilities on a seven-day-a-week basis; to share equipment; and to adopt central mass purchasing.

As an example of the saving possible in one area of the health system, it has been estimated that some $1.7 billion could be saved each year if the average length of hospital stay could be reduced by 1 day for the Nation as a whole, as a result of out-patient diagnostic testing and other approaches.

Other recommendations of the association were that insurers assume a more active role in improving the distribution and availability of health services, particularly in inner-city and rural areas, through financial contribtutions and manpower; and that companies give increasing attention to capital funding investments in such facilities as nursing homes, ambulatory care centers and rehabilitation centers.

The recommendations were made following consultations with prominent medical economists, hospital administrators, physicians, and public health representatives.

In the recommendations of the association, it was noted that there was a consensus among the medical experts consulted that the Nation's health care systems must and will change in the 1970's. The report said:

> One reason for the pressure for change is that the present systems do not deliver to all segments of the public the highest level of care that medical science currently knows how to deliver, and the care that is delivered is not delivered as economically as present day technology would permit.
>
> Health care delivery systems should be responsive and relevant to the continuing health needs of people, rather than only to their episodic medical needs.
>
> Systems should be oriented to the whole person and his needs for disease prevention and health maintenance, rather than primarily to medical treatment and management of disabling conditions.
>
> Such systems should also integrate and interact with other social and environmental systems that serve in the public interest, and they should be structured so as to provide access to quality health care to all, regardless of location, resources, or cultural or social variables.

Senator KENNEDY. Let me just ask you one question. Based upon your experience and study, do you think the insurance companies are ready to assume major new responsibility and resources to meet the health crises?

Mr. DeSHETLER. I don't know that the insurance companies are ready. I would say in my frank opinion, they may be as well prepared as anyone else at this point to handle that matter. I see the problem largely lies beyond the people but with the hospital and Blue Cross, in the hospitals and the practices there for the rather high cost of medical care. Blue Cross, for instance, runs on a rather nominal percentage of total intake for administration, something like 4 percent for administrative costs. But they are totally, in my judgment, unable to control the costs in the hospitals, and that single element of high medical costs, which is the hospitalization.

Senator PACKWOOD. This morning we had a group discussion among proponents of the Kaiser and Blue Cross programs, debating comprehensive prepaid coverage as compared with fee for service.

Interestingly, Kaiser indicated that even in their hospitals costs are only 5 to 10 percent less than normal hospital costs. In lieu of this fact, where Kaiser has a direct interest in keeping costs down, what would you suggest that Blue Cross could do to dramatically bring hospital costs down?

Mr. DeSHETLER. First of all, you might take it in two points. He said his costs were 5 to 10 percent lower for their hospitalization.

Senator PACKWOOD. One reason why their overall hospitalization costs are less is the emphasis on preventive medicine. But when hospitalization does occur, costs of running the hospital are at best only 10 percent lower.

Mr. DeSHETLER. That would be a substantial savings, and you combine it with the fact that many of the prepaid group practices hospitalize only half as many people, you can see why they come up with the essentially lower rates.

Senator PACKWOOD. I am referring to the cost of running Kaiser hospitals. They are run as efficiently as possible, and yet their costs are only 10 percent lower than other hospitals.

Mr. DeSHETLER. Even 10 percent, any reduction in hospital costs would certainly be welcome to the public.

Senator PACKWOOD. Certainly if we could reduce costs 10 percent through increased effiffciency, that is good. Then we have 10 or 20 percent cost increases which do not reflect inefficiency, but reflect spiraling operational expenses.

Mr. DeSHETLER. I am not ready to concede we have to have spiraling hospital costs, and apparently everyone else is.

Senator PACKWOOD. As Insurance Commissioner, do you have the power to approve or disapprove insurance rates?

Mr. DeSHETLER. Blue Cross rates, yes, sir.

Senator PACKWOOD. Why don't you disapprove them until reforms are effected?

Mr. DeSHETLER. I havn't approved any.

Senator PACKWOOD. And under that system is Blue Cross going to stop writing insurance?

Mr. DeSHETLER. No, sir; but what I am going to ask of Blue Cross the next time they ask for a rate increase, I am going to ask that they demonstrate precisely what they have done in conjunction with the hospitals to lower the cost.

Senator PACKWOOD. Until that is done, you are not going to approve any of their rate increases?

Mr. DESHETLER. I may well not.

Senator KENNEDY. Thank you very much. That is a splendid statement. You have outlined some very significant areas into which we ought to be looking in terms of cost control. I want to thank you very much, sir.

I hope you will let us know informally what is happening out here in Ohio, what kind of steps are being taken.

Now, we will open the hearing to anyone who wishes to speak. We are going to ask each person to come up in the order that they signed up. We are going to limit it to one person per minute. For those who don't get a chance to speak, we will offer you an opportunity to file with the subcommittee whatever comments you would like to make, and we will make it a part of the record.

Mrs. Arthur Woods.

Mrs. WOODS. I am sorry, Senator, I can't follow your 1 minute rule, I am going to have to take three or four because I came here prepared to talk, and I want to talk. I would also like to recognize my Congressman, the Honorable Louis Stokes, Administrative Assistant, Mr. Clarence Finch. Honorable Congressman of the 21st District has recognized the needs, the health needs particularly in our inner-city and I wanted to recognize Mr. Finch.

You tell Mr. Stokes I did this because he is my favorite Congressman.

My concern for public health service is extended in appearance as vice chairman of the Metropolitan Health Planning Corp. Unfortunately, three things seemingly matter in a presentation, gentlemen: who said this, how it is said, and what is said. And of the three, the latter usually matters least.

I sincerely hope such will not be the case in this instance, as I speak with great sincerity of purpose, positive conviction and a hope for meaningful change in a different area of health service. I feel through painful experience and harrowing experiences that all emergency health services should be completely removed from the jurisdiction of the Cleveland Police Department. Emergency service, such as calls to the scenes of heart attacks, drownings, automobile accidents, shootings, sudden severe illnesses or any other traumatic experience. Because of current sociological changes in our urban structure, particularly in the central city, the police department cannot be depended upon to respond immediately, to present a proper attitude toward the patient's family, circumstances, and because of evident lack of proper training, the police cannot be further depended upon to administer needed first aid, or respond efficiently to any specific area of concern.

I would like to cite one case out of four that I was definitely involved in, one case is July 20, 1969, when my husband died. The police were called at 10 minutes to 12 and after three calls, repeated calls, the police finally arrived at 12:15. At the time I thought my husband had suffered a heart attack.

An autopsy, though, revealed that he had died from a massive cerebral hemorrhage, but neither I nor the police knew that at the time. I live at 1937 E. 89th Street, which is only a few blocks away from the Fifth District Police Department. The police, in not arriving until 12:15, did not come directly to the house. They parked across the street from the house, evidently afraid of the area and what might happen,

since we had had a Glenville incident, and they were very particular about any calls of this sort in the inner city.

When they did finally come into the home, the police had been told, mind you, that my husband had suffered a heart attack because the telephone operator did call the police department. They did not come up with a cot to take him out, they did not come up with blankets, they came in the house, stepped over my husband and asked me was I married to this man.

And they didn't have a resuscitator either. Well, I was, at the time, giving him artificial respiration and he was still breathing. The police, I said, "Please go down and get the resuscitator, he is still living." And the police said, "Well, I think it's too late now."

I said, "You are not a doctor." And they became very hostile toward me. One finally went down for the resuscitator and came back and told the other one, asked the other one did he know how to use it, because he didn't. So he didn't get the resuscitator.

And I still have, for the information of the fifth district, I still have their blanket at my home where they did not cover him up to take him out to the hospital.

They complained about my steps, how narrow they were, and how heavy my husband was. But I, together with my sister, had lifted him up and put him on the floor. He did weigh 185 pounds, but when you are confronted with an emergency, you have additional strength.

I also will not cite the instance of the death of my son who was shot, and it took them 25 minutes to get there. He died July 4, 1966.

My mother on May 3, 1965, suffered a heart attack. The police were called and did not come for approximately 35 minutes. She is dead.

And a young man was shot in front of our house. My husband and I let him in the house, and this was in 1963. He collapsed on the floor and the police came 45 minutes later. He was finally taken to University Hospital, after the police had manifested their adverse attitudes.

My suggestions are these: I am hopeful that the government would train some paraprofessionals that could travel from the hospitals. Now I know in New York City, they have ambulances coming out from the hospitals, but we do not have that here in Cleveland. And interns travel with the ambulances so that you have professional people administering health services.

Also, we do have in Cleveland, I must pay a special tribute to our magnificent fire department. And they do respond in instances where there are traumatic things happening.

And the fire department, of course, cannot bear the brunt of all the things that happen in the city of Cleveland. But I still feel as though that when a police department has proven itself so inefficient and having no empathy at all to the needs of the people in the central city, particularly in the areas where black people live, and I feel as though these services should be removed from the police department and the government should do something in the area of traumatic illnesses.

Thank you.

Senator KENNEDY. Thank you very much. That is a very good comment. One of the real problems in the whole delivery system is transportation. It varies dramatically in the major cities. In rural areas,

it's virtually nonexistent. We were in Nashville a week ago where ambulances are run by the funeral homes on a special contract.

The first contact that a sick person has in emergency care ought to be with individuals who are trained and equipped to provide very critical help and assistance.

This is essential, and any health system should provide it. You shouldn't have delays in getting help to come. And when the ambulance comes, it should provide topflight professional help on the way to the hospital. This point hasn't been made before this afternoon, and I think it's entirely appropriate she took the additional time to make it.

Maryanne Ganofsky.

STATEMENT OF MISS MARYANNE GANOFSKY, SOCIAL WORKER IN THE DIVISION OF CHILD PSYCHIATRY AND DIVISION OF PEDIATRICS AT UNIVERSITY HOSPITALS IN CLEVELAND, OHIO

Miss GANOFSKY. I would like to address myself to something that hasn't been talked about this afternoon at all, and that is another side of medical care, primarily psychiatric care.

My particular interest is children, as I am a social worker in the Division of Child Psychiatry and also in the Division of Pediatrics at University Hospitals here in Cleveland. I am not speaking for the hospital in any way, I am speaking primarily as a concerned professional who has come in contact with some very serious problems about psychiatric care.

I think of prime concern is what happens to families who do not have insurance when a psychiatric illness befalls them. This is not unusual, because psychiatric care is extremely expensive. It's much more long term than medical illnesses, so that insurance companies are not as eager to write them into their policies. It's not unlikely that a family has, on full medical coverage, only 50 to 80 percent psychiatric coverage, which is less than useless in some place like Cleveland where medical costs are so high.

It's also very prevalent with families who have no insurance at all, such as those on welfare. They can receive medical care for their children because the county will pay for it when the child has a problem. They cannot receive private care, the only thing available to them are the very few State hospitals in Ohio. There are three State children's hospitals for psychiatric care in Ohio.

One is in Cleveland, halfway between Cleveland and Akron that has 90 beds; there is one in Columbus that has 30 beds, and that is a daycare center because the building is so dilapidated that they can't stay there at night. Then there is one in Dayton that has 90 beds, so that is the total of 210 beds for the State of Ohio for psychiatric patients.

What happens very frequently with these families is they come to us as a private hospital seeking psychiatric care; they don't have insurance, the State of Ohio has decreed to the county welfare department that they are not allowed to buy private psychiatric care for patients, because the reason is again that there are State facilities.

And of course, 210 beds in the whole State for how many children there are, just isn't, you know, reasonable.

Very often, the families then go to the State facilities and find that they can't get their child in becauuse they are overcrowded. Then a child who has some serious behavioral problem that needs the type of control that a psychiatric hospital offers, cannot receive it. They are left on the streets in a very untenable situation where they are not able to get outpatient care because that is not sufficient, and there is no bed available for them.

This is not so unusual in the State of Ohio, that children are not provided for. I think one thing we haven't talked about today is children. Not only are there no facilities for children who have psychiatric problems, there are no facilities for children with a whole string of medical problems.

If a youngster has a degenerative illness that is progressively getting worse and requiring custodial care, there is no facility for them. The child is either left at home or in some hospital. I am sure part of the reason for the high cost of care comes from a child who is stuck in our hospital at $145 a day, receiving nursing care because they cannot go on to a nursing facility, because the State either doesn't provide the money, or the facility isn't there, or the agency for the family isn't able to mobilize itself.

I think it's just unbelievable the way we take care of children in the State, and it seems any youngster who is stuck with a progressive illness where there is very little hope of rehabilitation, and I think sometimes psychiatric problems fall into this category, there is nothing available for them.

One of the things I would like to suggest, Senator Packwood asked earlier about suggestions. I dont know quite how it would be done, but I think it should be considered and if there is some way if the Federal Government begins to move into the whole area of health, that they can provide some incentives to the States, and I suppose ours is not the only one who cares so little about children, that they can provide some incentive to the States to begin to build the necessary facilities, not only for psychiatric care, but for long-term medical kind of problems. I suppose there has to be, financially, some way to help pay the cost of the child care in the hospital, because these are certainly going to be long-term problems to finding some way to help our State legislature see that this is necessary, and to begin to provide the facilities which currently just don't exist.

I don't—I think that if I had the time, I could cite you loads of cases where families have been left out in the cold simply because things they need simply aren't available. And my task has been one of trying to find the facilities for them, making telephone calls all over the State and I get the answer, "No, I am sorry. He is too old for our program; he is too young for our program; he is too sick for our program, too well for our prgram," then having to go back to the families and explain what happened.

And I think our children deserve better than what we are giving them.

Senator PACKWOOD. Again, I want to hearken back to this morning's testimony from Kaiser. Kaiser has a resident psychiatrist. What is your experience with the quality of the psychiatric care for children under the Kaiser plan?

Miss GANOFSKY. I may be slightly prejudiced in this, working in a psychiatric facility, but I think the care is good if the family has the financial wherewithal to pay for it.

If they don't have the financial wherewithal, then it isn't even a matter of poor care.

Senator PACKWOOD. I am referring here not to families with the wherewithal, but to the families who belong to the Kaiser Foundation, in this case members of the Meatcutters Union.

Miss GANOFSKY. I happen to know one or two of the people who are the psychiatric consultants to Kaiser, and I happen to think they are excellent people. So I would assure the care they are receiving is very good.

Senator PACKWOOD. At some point we will have to make some decisions on financial health insurance. In this case we see private industry paying for the insurance and providing the care and there seems to be a good response from the people covered by Kaiser.

Miss GANOFSKY. It certainly has been my experience from talking to people who are covered by it, they are pleased with their coverage. We have not had a child referred from the Kaiser Hospital to our hospital, but knowing the people who are on their staff and talking to a few people informally, it's been my impression that it's certainly good care.

Senator PACKWOOD. Thank you.

Senator KENNEDY. Very good comment.

I hope you will make some suggestions to us on what do you think we might be able to do to improve child care. Perhaps you could visit with some of your friends and send your suggestions to us.

Next, we have Rev. Floyd Perry.

Reverend PERRY. My name is Rev. Floyd Perry, my address is 12905 Signet Avenue, Cleveland, Ohio. This is a personal experience that I would like for you to hear and bring out my personal experience.

I would like to suggest, concerning the persons that spoke concerning going to emergency rooms at the hospital and failed to get the proper kind of help, someone asked what would they suggest should be done along that line. I would suggest that when things happen on that sort, that there should be an action taken in regards to penalties or reprimanding or dismissal of the person that would neglect someone actually that is seeking the help.

On the 7th of December 1969, I was admitted to the hospital. First may I say that I am a senior citizen on social security. I was admitted on the 7th of December and stayed there until the 26th of December 1969. I was dismissed on the 26th and went home, stayed there until the 8th of January. I was admitted back to the hospital for 3 days, they thought that a blood clot had formed and I stayed there 3 days. I was released, cameback home and on the 18th day of January, I had an illness and my doctor had to get me in the hospital right away.

From the 18th of January to the 7th of February, I was in the hospital, and this cost me $6,550.

Medicare paid all except $1,200. After getting out, my wife had to go to the hospital, she stayed in the hospital for 5 weeks and it cost her $6,000 and some. And the insurance paid $995 out of the $6,000. That left the wife's bill $5,100 and some, and so my bill was $800 and some paid.

Well, I wasn't able to pay the amount left, so what I did, I went to the manager of the cashier's department and related to him my condition. And after hearing what I said to him, he said to me, he said, "Reverend, I will see what I can do, I will talk to the board and see just what can be done."

And he did talk to the board, and one Sunday I went to church, came back home, and there was a letter in my mailbox. I don't generally go to the mailbox on Sunday, but that day I was impressed to go there and there was the letter from the hospital stating that that $5,000 was paid by the foundation.

And I realized that it was just a warmth that touched the heart to do that, because I wasn't able to pay.

Now in regards to a bill that I read that Senator Kennedy and others have written up, I really think it's a fine bill and anything that I can do to help foster that bill or get it passed, I will be very glad to do that.

I realize with the hand of the Lord, that He would touch the hearts, and I give God the credit for even touching their hearts that the bill be paid. Everybody is not that fortunate.

I really will do all in my power to help push the bill that you have. There are so many senior citizens, that the amount of money we get is so small and until we can actually hardly exist. And I was disabled for quite a while, so when I became 65 I got a letter from the Government stating that this would be cut. So I wrote my Senators and also Congressmen, and explained that the small amount that I was getting and knowing that they had had an increase, they had just gotten from $30,000 to $42,000 and can hardly make it, I expect for a man making $1,995 a year, how are you expecting us to make it?

So, therefore, I said, "Damn the evil war." That many of us wasn't able to go to war to help win the war, now we get old and can't work, and the Government only gives this small amount to us to exist. And I think it's really unfair, and I am advocating that if there is any way that the Government can add on to social security of the senior citizens, it will be a blessing.

Senator KENNEDY. Thank you very much, Rev. Perry. This is a very interesting and heart warming conclusion to your story, getting relief from these hospital bills. As you point out, you are very unique, very fortunate to have gotten this relief. You reminded us also of inadequacy of social security.

I don't think there is any group in our society that is hurt as much by the devaluation of the purchasing power of the dollar as are those living under social security. The Congress has failed to face up to the extraordinary inflation and yet we put a ceiling on what retired people on social security can earn.

This is a tragic situation.

Ladies and gentlemen due to a prior commitment, Senator Packwood and I have to leave. We have a transcriber here who is going to continue. I have asked my assistant, Miss Souliotis, to stay for another 40 minutes.

For those who want to tell their stories, she will take the testimony, and it will be in the transcript. Senator Packwood and I will get a chance to review it later.

For those that by 4:15 are unable to tell their story, Dr. Max Davis will be good enough to help you transcribe your comments.

I want to express my very sincere appreciation to you. We have been here for some 2 hours and 40 minutes, you have been very attentive, and have reflected the deep concern that all of us as Americans ought to have with these problems. This isn't just a problem for those of us in the Congress or for the doctors or even for the consumers, it's an American problem.

We have to come up with some solution to this, and we will make every effort.

I want to express my very sincere appreciation for the comments that have been made here. I think they have helped us understand the problems. I want to thank all of you for your courtesy, kindness, and attendance at this hearing this afternoon.

(Senator Kennedy left the hearing room.)

STATEMENT OF DR. DAVID L. KELLER, CLEVELAND, OHIO

Dr. KELLER. This is in connection with section 65. We are talking about the best health care for the community, and it has been shown in articles cited in the March edition of the New England Journal of Medicine and by the Joint Commission of Hospital Accreditation that podiatrists are now to be considered physicians and surgeons of the feet. Therefore, under your section 65, we seem to be listed under subfunds.

If we are such an integral part, as has been proven over the years, of the medical community, why are you trying to eliminate us as an organization, as a profession?

I, myself, am in the 10th year of my medical training and I feel after 10 years of medical training to be an integral part of the health team.

STATEMENT OF LILLIAN CRAIG, CLEVELAND, OHIO

Miss CRAIG. My name is Lillian Craig, I live at 3111 Church, near west side.

I work for the West Side Opportunity Center, and I am also on ADC. And I am one of the more fortunate people, because I am covered by medicaid. We are concerned about the marginal income families who aren't covered by anything in my neighborhood.

Women are waiting until they are 8 months pregnant to go see a doctor because they can't afford to pay a doctor.

The hospital, the Lutheran Hospital, is in our neighborhood. You have to sign a blank note, blank. They are turning people away from this hospital.

The medicines that people have to take are so fantastically high priced that if I was not covered by welfare, I couldn't work, I would be dead. Because I pay close to $60 a month for my medicine, or welfare pays it.

The city doctors are run by the health department here, they are worse than veterinarians. They do not treat people for the illness, they treat people in general terms. They carry no antibiotics, and that is it.

The teeth and eyes of these little kids, they are growing up, there is no chance for them to have any good medical care.

STATEMENT OF MARY DANIELS, CLEVELAND, OHIO

Mrs. DANIELS. My name is Mary Daniels, I live at 1020 East 86th Street. Nothing was mentioned about people on disability. I go to the doctor two, three times a month, that is $10 each time.

I have to have medication. And I am supposed to go to a specialist, a kidney specialist, and I need glasses, I need teeth. What is a person going to do in a case like that, ask God to take you?

That's all.

STATEMENT OF WALTER RATCLIFFE, CLEVELAND, OHIO

Mr. RATCLIFFE. Senator Kennedy, my name is Walter Ratcliffe with the Office of Economic Opportunity, supervisor of the Outreach Department, Economic Department, Kinsman Opportunity Center.

I am a kidney patient. I lost both my kidneys, September 1970.

As we have had one speaker for the kidney foundation—I mean for the kidney patient, I do feel that he adequately covered it. Our prices vary somewhat, the fact I find that my machine is more expensive than his, the machine I have at home cost $10,000 a year. My medical expense last year came to $12,000 a year not including the cost of the machine. I am now on home dialysis, which makes it possible for me to be able to work, because 2 days a week prior to that, I had to go to the hospital to be dialyzed, until I was able to get the machine at home.

At the present time, I am involved in trying to help the people throughout the community be cognizant of the tremendous cost that is involved with kidney illness, and hoping that other kidney patients who have met this plight.

Three weeks ago I flew to Indianapolis, Ind., to help a lady there that had just lost both of her kidneys and had 10 children. And the black paper there, the Indianapolis Recorder was starting a fund to try to raise money for her machine at the cost of $10,000.

I spoke at several churches and worked with the paper and we found on the last report they have raised $9,000 on the lady's machine, which is really merely the initial cost, because the upkeep of the machine runs you another $10,000 a year.

I do feel indeed fortunate that since I was inflicted with this horrible kidney disease which is so extensive, that I was in Cleveland, Ohio where they have the finest medical center facilities in the world to combat it. Mount Sinai Hospital, where I was a patient and Cleveland Clinic are probably two of the finest kidney units in the whole world because many places, they don't have even these facilities.

My grievance is that now that medical science has made this tremendous innovation of finding how to keep you alive once your kidneys are gone, that the costs are so tremendous that it's beyond the reach of the average poor working man.

I would like to see the Government in some manner be able to supplement this cost, even though I was assured by Kaiser Foundation and they have been very wonderful to me and helped me like I said, my

bill was better than $12,000 last year, which leaves me a balance of better than $2,000 that I will have to try to pay. The hospital and foundation have been very considerate, and again I say I have been blessed by living in Cleveland, Ohio.

So that is about it.

STATEMENT OF DR. TILMAN BAUKNIGHT, CLEVELAND, OHIO; ACCOMPANIED BY VALLRIE BRADLEY

Dr. BAUKNIGHT. My name is Dr. Tilman Bauknight and I represent the Forest City Dental Inc., which is a group of 15 black dentists here in Cleveland. And our purpose is to bring to the attention some of the things that we feel that are being neglected in the formation of the National Health Insurance bill.

The first issue that I would like to bring up is the fact that the Job Corps Center for Women recently ran out of medical funds, and one of the first programs that had to be cut out was the medical and dental program. And I submit to the Senator and to the committee members that this program, the Job Corps program for women should be supported in terms of refunding and increasing the funds for the tremendous job that they are doing.

Their supportive services would be to provide the dental care and treatment of their students. Their students come from all over this country and from the poor and deprived areas, many of which have never received dental services before in their life.

And we have with us today a girl who is from Detroit, Mich. Her name is Vallrie Bradley, and she happened to be one of my patients there at the Job Corps. And she can tell you her story, and what dentistry did for her there.

And then I can go into the dentistry on the national scene later.

Miss BRADLEY. My name is Vallrie Bradley, I am a student at the Cleveland Job Corps Center for Women, I come from Detroit, Mich.

I am the first of 11 children, and my mother has been on ADC or welfare since. I had never seen a dentist until I arrived at the Cleveland Job Corps Center where I was given oral surgery twice and had a partial plate put in, and a whole top plate, which my mother could not afford under ADC or welfare.

And if there is any possible way for Senator Kennedy to put dentistry in the bill, it would be a great help and a great appreciation to the Cleveland Job Corps for Women.

Dr. BAUKNIGHT. Now, we just asked Dr. Davis here who is a dentist, a very prominent dentist and he is representing the official dentistry capacity, and I just asked him a question did he know whether or not fluoride treatment was paid for under the Ohio fee scale for welfare patients.

In other words, could a welfare patient receive treatment, fluoride treatment, and the dentist be paid.

He said he did not know, and the fact of the matter is that the welfare fee schedule does not make any allowances for fluoride treatment. Yet we know that topical application of fluoride is the single most effective agent in reducing the incidence of decay.

So I am saying that I do feel that the people who are connected with the formation of these policies are not addressing themselves to the

needs of the masses of poor people, and especially black people, because they can't relate to them.

You see, I picked this up and I am only a dentist for 5 years, but when you look through the fee schedule, I can't do a topical fluoride treatment on a poor kid.

I also notice that for one to clean teeth, according to the welfare fee schedule, they will pay the dentist $4, which is a ridiculous fee. There is no provisions for orthodontic treatment, there are no provisions for crown and bridge treatment, and I want to make that clear, because here according to the ADA official bulletin, when you read this, you would pat yourself on the back, because you are proud to be a dentist, because it says, "More preventive care, less tooth repair."

But when you really get down and read through here, you find the types of services that they are proud to claim credit for.

For instance, fixing bridge, a single crown plate, these are the services completed, first you have services completed in 1950, then I will read the same services completed in 1969.

For a single crown placed in 1950, there were 2,600,000; in 1969, there were 11,400,000. For orthodontic treatment in 1950, there were 7,800,000 orthodontic treatments; in 1969 there were 20 million orthodontic treatments.

In 1950 there were 2,600,000 fluoride treatments; again in 1969, there were 12,200,000 fluoride treatments given.

So here I am saying that what the ADA is proud of is that preventive dentistry is paying off for those patients who can really afford it. It's a luxury item for those patients who can't afford it, as indicated by the high fees charged with crown and bridge treatment or orthodontic treatment, indeed, they are retaining and saving their teeth.

We are also aware of the fact that the age groups showing the greatest number of office visits would be from the ages of 5 to 15. This would include all the preschool dental examinations and all the examinations given by visiting health nurses, and this type of thing. But the gae brackets outside of the age of 15, it goes steadily down.

So my recommendation is that we would include in a national health system, age groups, especially from 30 to 50, so that we can take steps to preserve the natural beneficiary rather than see the facts borne out that by the age of 50 years, one of every two Americans have full dentures, or one out of three patients at the age of 35 require full dentures.

Finally, I would like to add to the record a note that I wrote to the Director of Welfare Services here in relationship to a dental case of Mr. Robert Carter. Robert Carter comes from a family of six children. His mother is an ADC patient, but Bob won a scholarship to Dartmouth and he had several teeth missing, and I wanted to get authorization to construct a prosthesis for him.

The letter I wrote went as follows:

I would like to have special permission to construct a partial for this patient due to what I believe is a most unusual situation. That his mother has six children, including an older brother who is in college. Robert is attending Dartmouth and is on the Dean's List, he is a B plus student. His mother is working at present, and thus off the ADC rolls. But in my opinion, the Welfare Department would be in fact be aiding the entire society by helping a person better themselves in breaking the chain of welfare dependency.

I began dental treatment on this student 3 years ago, and I think he should be allowed to obtain a partial.

The letter I got back in response went as follows:

DEAR DR. BAUKNIGHT: I have read with very careful interest your letter of September 29, 1969, regarding authorization to construct a partial for Robert Carter. Your letter was reviewed with the Chief of the Bureau of Medical Assistance. While we share with you your concern for Robert, your opinion in breaking the chain of welfare dependence, and your altruistic attitude, the current policies and regulations of the Cuyahoga County Welfare Department will not permit us to authorize this.

I certainly hope that you will not consider Mr. Barbin's nor my attitude callous in this matter. However, we must abide by the policies and regulations of the agency. Please note that we are totally sympathetic with this very increasing problem.

All of these things are really brought out in the fact that the ADA according to the ADA News of March 29, 1971, on a feature page says, "Board Favors Nixon Health Plans if Dental Care Will be Included." So I am saying that the ADA has made a statement, or has come out in favor of the Nixon health plan although it does not include any form of dentistry.

So if the ADA cannot see the need—well, I think it's pretty obvious that the ADA is not concerned about poor people or black people and their needs for dental care. And again, my recommendation would be that in consideration, or in the formation of these health insurance policies, that black representation, both lay and professional be included.

Thank you.

STATEMENT OF DR. N. M. CAMARDESE, NORWALK, OHIO

Dr. CAMARDESE. My name is Dr. N. M. Camardese, 48 Linwood Avenue, Norwalk, Ohio.

Senator Kennedy, first of all I want to congratulate you and offer your high commendation for the immense efforts that you are putting forth to take the story to the local community and attempt at getting their answers.

Secondly, I wish to express my gratitude for being given the opportunity and privilege to enter a few remarks. Your Honor, I happen to be a naturalized American citizen. I was born in Italy, I think America is the greatest country God gave the world ever, and it seems at times such as our modern, somewhat confusing state, that we seem to forget that indeed America is the best country in the world and that it is only America that has approximately 110 plus countries on its relief rolls, quote unquote, that it is helping.

I would think that first and foremost, the most important value things that we must keep uppermost, is to preserve freedoms and a free America. Health care, medical care, personal problems, communist problems, all of these must be looked at in a vein of preservation of freedoms.

I firmly believe and have the strongest faith in the American individual, and it is only as individuals, who had faith in God and themselves and a very strong faith as this, that this country was built. This we must maintain at all costs.

I also should like to express that the larger an organization, a community, a country, the larger a problem gets, the more necessities that the answers come from local communities. The resources of the American citizen are tremendous if he is permitted to involve himself and

given the motivation. I should like to give you the benefit of a survey that I conducted in my own private practice. It is extremely interesting, because whereas we are continually hearing of doctors' fees spiraling upward, upward, upward, when I questioned my patients in a written survey, which took approximately 1½ to 2 hours of the patient's time to reply, it is interesting to note that when it came to doctors' fees, it ranked No. 10 of 13 items which my patients were given to list in priority of their needs from their private physicians.

Item No. 1, incidentally, was medical knowledge. Furthermore, when the question to the patient would favor total medicare from infancy to old age, there was 95.42 percent against this type of medical health services. When my patients were questioned on favoring American medicine and how it stood in the world, 72.22 percent thought it was the best in the world. Zero percent thought it was poor, zero percent thought it was the poorest or the worst in the world; 83.33 percent of those replying stated it was as good as anywhere in the world.

When questioned on the present medicare law, 71.7 percent of those that answered were against the present medicare law as it is; only 28.3 percent were for it.

With reference to the type of family doctor and/or practitioner most desirable, the answers were as follows:

Solo practitioner was wanted by 73.6 percent; joint practice with a partner was desired by 25.5 percent. And when polled on combining practices, several doctors in a group, only 1.7 percent were in favor of this.

When given the opportunity to express their comments as they wished, and make suggestions with reference to how I might better serve my patients, the overwhelming majority were comments of gratitude, and there were several worthwhile suggestions as to how I might improve my care for them.

Both of these were highly appreciated, and in those instances where it was beneficial to the patient, these submitted suggestions were implied.

Again, thank you very kindly, and I respectfully submit this.

STATEMENT OF MRS. MILDRED BARRY, REPRESENTING THE HEALTH PLANNING DEVELOPMENT COMMISSION OF THE WELFARE FEDERATION

Mrs. BARRY. I am Mrs. Mildred Barry, representing the Health Planning and Development Commission of the Welfare Federation, which is the voluntary health and welfare planning council in this area. I have two persons with me who are prepared to testify, whom I will introduce in a moment.

First, let me say that our health commission is a citizen's group of over 80 persons, lay and professional from a wide variety of backgrounds and experiences who are interested in promoting improved health programs. Several years ago we conducted a health goals study, partially supported by the U.S. Public Health Service. We have compiled a reference book on "Health and the Poor" drawing on testimony and surveys of local consumers as well as Federal, State, and local data. We have worked with neighborhood groups as well as health agencies. We have recently completed a dental study under contract

with the areawide comprehensive health planning agency. From these and other experiences we believe that we are qualified to speak out on health problems. Currently we have a task force studying the several national health plans but we are not yet ready to testify about specific legislation.

Health problems of the poor are recognized by us all, but the problem is not limited to the poor. In many respects the most neglected group is that above the poverty level who have little if any recourse when medical crises occur. Mrs. Caroline Hatten will describe one such situation, and has been authorized and requested by the family to do so.

STATEMENT OF MRS. CAROLYN HATTEN, HSC, CLEVELAND, OHIO

Mrs. HATTEN. This is a summary of how a hard-working, childless couple's dream of self-sufficiency—earning their own way, owning their home, paying their bills—was destroyed by excessive medical costs. The plight of this middle-aged couple came to our attention on August 5, 1970, at the Vocational Guidance and Rehabilitation Services (VGRS) outreach health care station then located in the VGRS' building. I was the neighborhood health worker to whom this desperate couple was referred at the stage when the rising costs of lifesaving medical treatment had finally exceeded their efforts to pay for these services. By this time, having exhausted both savings and medical insurance policies, this hapless couple had already suffered over 4 months without any kind of medical care from either private physicians or hospital outpatient services. Fortunately, physicians from Case Western Reserve University Medical School, serving as volunteer project staff, were able to help them reenter the health care delivery system. However, we were not able to prevent the death of the cancer stricken wife 5 months later nor to forestall the financial bankruptcy of the husband. I now wish to place in the record my knowledge of this case as an illustration of the hardship of financing medical care in the United States.

First of all, this industrious, frugal black couple took the normal measures to insure themselves against the possible financial setbacks of illnesses. Mr. and Mrs. Shed Johnson were both employed and had hospitalization policies through their places of employment.

In February 1969, Mrs. Johnson began to experience pain in her left hip; she also felt a "lump" in the same area. Faulty self-diagnosis delayed her seeking medical care for 6 months. On August 13, 1969 she saw a private physician who hospitalized her immediately. She was discharged 1 month later with the diagnosis of Riticulune Cell Carcinoma of the hip bone (cancer). The recommendation from this hospital at the time of discharge was that she be treated at a private hospital on an outpatient basis with X-ray therapy. However, additional examinations at this second hospital revealed that she had a pathological fracture of the left thigh bone with many cancerous growths of the soft tissue. She was then transferred to a third hospital for 6 months for long term rehabilitative care. She was discharged for followup care through her private physician and at this point, was confined to a wheelchair and homebound.

Now, her problem of financing medical care became acute. She had exhausted her hospital insurance and no longer could pay her private physician for home care. Without a private physician's certification, the Visiting Nurse Association could not continue to provide home nursing service. Knowing no other avenue of obtaining needed medical treatment, she suffered at home untreated for over 4 months. By chance, she was referred to the VGRS health care project by a concerned community worker.

Upon visiting the home, our medical team found Mrs. Johnson without hope of medical care and Mr. Johnson overwhelmed with mounting medical bills. Upon recommendation of VGRS' physician, we began the tedious process of helping Mrs. Johnson back into the health care delivery system. We provided 32 trips with escort and orderly service to outpatient clinics and for periods of hospitalization. Professional staff served as Mrs. Johnson's advocate in getting her the needed services.

Mrs. Johnson was admitted to a general hospital on September 25, 1970, discharged October 5, 1970; readmitted November 1, 1970, and discharged November 16, 1970. During the interim she was seen in the outpatient clinics. The costs continued to be added to their medical bills. On December 11, 1970, she was admitted to a chronic disease hospital as a medical indigent and died there January 23, 1971.

Mrs. Johnson was not able to work from the onset of her illness in August 1969, which meant that Mr. Johnson's weekly income of $165 prior to deductions did not enable him to keep up with the medical bills. When he was under great pressure to pay them, he would borrow from a loan company and compounded his financial situation by having to make not only the payments but also to pay high interest rates.

The insurance policies paid about one-third of the costs and Mr. Johnson was responsible for the balance. He presently owes $19,796.76 for hospital and medical expenses. At one hospital alone his bill is $13,732.03. This does not include expensive medications and supplies which he was able to pay for out of his limited earnings. A lien has been placed on his home by one of the hospitals and foreclosure is imminent.

With the help of VGRS' lawyer, Mr. Johnson is filing bankruptcy as there is no other feasible way for him to solve his financial situation. This means he will lose his house which is mortgaged, his car, any saleable household effects and, at the age of 56, he will have to start from scratch.

Mrs. BARRY. Our next witness is Mrs. William Brooks, a resident of a public housing project and president of Seniors of Ohio. Many assume that health care of the elderly is taken care of by Social Security, medicare and medicaid but such is often not the case as Mrs. Brooks will point out.

STATEMENT OF MRS. WILLIAM BROOKS, RESIDENT OF A PUBLIC HOUSING PROJECT AND PRESIDENT OF THE SENIORS OF OHIO

Mrs. BROOKS. Mr. Chairman, I learned of an older woman who has a medical bill of $50 per month. She has a savings of $1,000 which she is saving for her funeral and burial and will not go into it. For this

reason she is ineligible for A.F.A. However, how long would this last at $50 per month?

Husband needs dental care. He cannot get out of the house and no doctor will call. He could get this badly needed dental care through the Home Service of Highland View Hospital that brings the unit into the home. This requires a doctor's clearance, but no doctor to recommend it, hence no dental work.

Patient needed a brace, but brace shop would not take the medical assignment on medicare. Wanted patient to pay $75 to the brace shop if some one would loan same and repay with refund from medicare. Thus no braces.

Many patients have been sent home from the hospital unable to care for themselves as medicare would not pay the extended care facility.

There is a need for someone to interpret the news in the vicinity of the home dental unit, visiting nurse, and why no doctor is available to make a home visit when the need is present.

Q. This patient had been robbed by a confidence man, who was very much in need of glasses. Were obtained through a local agency and paid by the welfare fed.

Mental patient operated on for colostomy. Needs homemaker, no results.

Blind man wishes full time housekeeper, no results.

Blind man found suffering. Automobile had fallen on him badly injuring his leg. With hospital care he is improving. The hope is he will be well enough to move in metropolitan housing.

These are a very small number of senior citizens because they are poor and uninformed as to their rights and services avavilable to them, not the least of which is relief from the rat infested dwellings they are forced to live in causing poor health conditions to occur. Gentlemen these statements are all authentic.

This information was obtained through a built-in clinic in M.P.H. and from senior workers in Seniors of Ohio Inc.

Mrs. Barry. Now I should like to take a couple of minutes to identify several other problems.

1. Prostheses and appliances. Our community information service gets many calls from people who cannot afford to purchase or rent prostheses and appliances, from dentures to wheel chairs, or cannot afford to keep them in repair. This is a neglected subject in plans to finance health services.

2. Dental care is minimumly covered by the Blues, private insurance and Government support programs. I believe the Kennedy bill is the only national proposal that makes any attempt to include dental care. Yet a dental maintenance program started at an early age could significantly reduce the widespread incidence of dental disease, the financial burden of costly dental procedures, and the attendant effects of dental disease and loss of teeth on a person's general health and nutrition. According to estimates made in our dental study, 80 percent of the population in this county do not have the financial resources to purchase extensive or complete dental care.

3. Barriers to the receipt of health care, repeatedly expressed to us by consumers are: high costs, transportation and other arrangement

difficulties of getting to health facilities, long waits, communication difficulties, and derogatory attitudes shown by some health personnel.

4. Financing mechanisms have focused on high cost services, particularly inhospital care. Too little financial support has been provided for prevention, ambulatory care, home health services, nursing home care, psychiatric care, and certain types of rehabilitative and aftercare services.

Our health commission is deeply concerned about problems such as these and believes that we must look to government for the financial undergirding necessary for a balanced and inclusive range of health services if we believe—as we do—that health is a right.

STATEMENT OF KARL C. JOHNSON, VICE PRESIDENT, GARDEN VALLEY NEIGHBORHOOD HOUSE BOARD OF TRUSTEES, CLEVELAND, OHIO

Mr. JOHNSON. Thank you for the opportunity to be heard.

The health professional and the eleemosynary institution have failed to remedy the structural weaknesses in our health care delivery system. It is now time for the Government to step in.

President Nixon's national health strategy does not cover domestic workers. At this time they are supposed to be covered by social security, but the average suburban housewife does not make the appropriate deductions or contribute her share as employer. This means that thousands of domestic workers in the Greater Cleveland area are not accumulating the required numbers of quarters of experience to qualify for social security benefits. Now we are told that they mustn't get sick either.

Your plan, Senator, calls for regional and local boards to determine local priorities. I am afraid that in Cleveland, that would be a little bit like leaving local voting in the south up to southerners, rather than insisting upon adherence to the law.

In spite of an HUD requirement that tenants and community people be involved, our local metropolitan housing authority has consistently ignored the problems of residents of public housing. Improper maintenance, vermin, and assorted indignities have become a way of life. An advisory committee exists, but is rarely convened.

One family received an eviction notice. When the father inquired as to the reasoning, the answer, "immoral behavior" was given, for a woman was seen entering and leaving the premises during the day. In truth, the lady was a homemaker, trained at our community college, and paid by the county to assist this family that had lost its mother. But typical of the indignities visited upon the poor, no one checked.

Senator, unless you include a specific requirement that minority and community people be included on any local or regional policymaking body, the leaders of Cleveland who normally sit on such bodies will be insensitive to the true needs of those who would be served by the Kennedy Health Security Act.

Cleveland has compiled additional evidence of its lack of caring. There are between 50,000 and 60,000 substandard housing units in this area. This means that more than 200,000 people are currently housed inadequately.

In Cleveland, the United Appeal is responsible for raising volunteer donations which are then budgeted, planned, and dispersed by the Welfare Federation. In recent years, in the light of increasing individual contributions, but declining corporate ones, it has become customary to set a goal that they think can be achieved, instead of setting one based upon the need of the agencies served.

When the private sector fails, government, theoretically, steps in. When government fails, voluntary agencies are formed to fill the breach. What are the poor to do when everything fails?

Minority groups statistically carry more than their share of poor health. It is an advantage to be white, not black, or Indian, or Puerto Rican. Health impairment and income are directly related in disorder after disorder. Even life expectancy depends upon skin color.

In the schools, we have discovered that there is a direct correlation between the level of poverty, the mobilty of a child, and his reading score. The poorer he is, the more he is forced to move from school to school, the lower his reading ability tends to be. If Johnny can't read, how can he get a job? If he has no regular source of income, where can he go for adequate health care where he will be treated with dignity and respect? Where can he go that he will be treated?

It is a well-known fact in the inner city that it takes the overworked police ambulances more than an hour to respond to an emergency call. It is also known that those police ambulances will pass by hospitals on their way to those emergency wards that accept indigent patients. When the ambulance arrives, there is another wait, because there are others to be cared for.

The out-patient clinic is widely heralded by most hospitals as their contribution to the community. What it is, in fact, is a quick method of training medical personnel. The institutionalized health care available through the average clinic destroys the dignity and self-esteem of the poverty patients who must resort to it. When the police ambulance arrives, more often than not the patent must deliver detailed information concerning the status of his poverty before he receives treatment.

One clinic patient had seen so many different doctors on her trips to the hospital that she thought the name of her physician was Dr. Staff. No, she didn't know what he looked like.

Have health care institutions been created to treat illness, or to provide jobs and job training. If your health security act seeks to make the total population eligible for health care, that will not be possible using existing institutions administered in traditional fashion.

There is a saying in the black community that drug addition did not become a major issue until suburban white youngsters began popping pills and mainlining. If you check the chronology of both events, you will find the statement difficult to disprove.

All across the Nation there is a 20 percent increase in welfare families ever year. In Cleveland, the rate is 33 percent per year. That adds up to an increase of 100 percent since 1968.

But every museum in town has successfully mounted a sizeable building program. The Cleveland Museum of Art is one of the wealthiest in the Nation. Not only could it submit a bid of over $1 million for

a Rembrandt, it has added a multi-million-dollar addition. Less than a mile away, there is grinding poverty.

The Health Museum is the first of its kind in the United States. It is located in the midst of the inner city, but all of the bricklayers who were working on its new wing were white, until a call from a concerned neighbor asked why. Two bricklayers, readily identifiable as black, were on the job the following day.

The Natural History Museum has added many cubic feet to its display capabilities. If we can buy paintings, build museums, talk about health, and stuff animals, why can't we build houses, heal the sick, and generally improve the lot of the poor? It would appear that the people with the ability to help are preoccupied with other concerns. That is regrettable.

Tuberculosis is on the run. We now have the knowledge, experience, equipment, and medicines to eradicate it. But doctors who specialize in diseases of the chest can tell you that many indigent patients must be hospitalized, not because of the seriousness of their condition, but to guarantee that they get the necessary medication. How can they be concerned about some little white pills, when nearly every waking moment is a battle against starvation, vermin, brutality, and violence?

In England, an indigent family that is being treated, may find that their doctor has prescribed nourishing food as a part of the treatment. I hope, Senator, that your Health Security Act will contain provisions that will permit doctors to prescribe an adequate diet, and then make the food available to those for whom it will be a matter of life and death, and not just good taste.

Agian, in tuberculosis control, it has been discovered that some patients do not have the carfare to make periodic trips for medication. The local (Cleveland) branch of the Tuberculosis and Respiratory Disease Association has included this need in its budget for the coming year.

Residents of the Garden Valley area must take two buses, transferring in the heart of town, to get health care at unusual hours. In the middle of a winter night, how likely is a poverty parent to risk taking a sick child out to ride the bus? What if that child's care depended upon promptness for a cure? And if the parent did choose to take the child on the bus, what would happen to the other children? Who would care for them?

Finally, if 50 percent of the 525,000 hospital bed patients in the United States are confined for psychogenic disorders, what, Senator Kennedy, does your Health Security Act do for them? My wealthy friends are eccentric and visit their private analysts periodically. My poorer friends are crazy, and are confined.

You have made yourself vulnerable to this tirade, sir, by being interested enough to come to Cleveland and listen. I have subjected you to it because I want your efforts to do more than solve the financial plight of Cleveland's hospitals, or cause large numbers of people to feel better about all of the good things we are doing for the poor. We must admit that they have been the victims of malignant neglect, and resolve to remedy that.

Thank you for listening.

(The following was subsequently supplied for the record:)

April 16, 1971

Senator Allen Ellender
Old Senate Office Building
Washington, D. C., 20510

The strict confidentiality of patient's charts has always been a foundation of American medicine, recognized as necessary and the patient's entitled right. The steering committee of the Mid-Ohio Council of Medical Staffs which represents over 400 private physicians joins with the Council of Medical Staffs of New Orleans in rejecting the compliance with third party carrier requests for copies of such charts.

Blue Cross requested of the Harding Hospital in Columbus a copy of a psychiatric patient's complete chart. We urge you to stop this invasion of privacy.

James S. McCaughan, Jr., M.D.

cc: Dr. Jose L. Garcia Oller
Congressman Chalmers P. Wylie
Senator Wm. B. Saxbe
Senator Robert A. Taft
Congressman Samuel L. Devine
Dr. Donald H. Burk

United States Senate
COMMITTEE ON ARMED SERVICES
WASHINGTON, D.C. 20510

April 23, 1971

James S. McCaughan, Jr., M.D.
497 East Town Street
Columbus, Ohio

Dear Dr. McCaughan:

This will acknowledge and thank you for your recent telegram relative to your opposition to the Social Security Law for Medicare that a copy of a patient's chart must be furnished to the insurance carrier before reimbursement can be effected.

In an effort to be of all possible assistance, I have brought your views to the attention of the Commissioner of the Social Security Administration for his consideration.

Please be assured that as soon as I receive a reply to my inquiry, I will be in touch with you again.

With best wishes,

Very truly yours,

Wm B Saxbe

William B. Saxbe
United States Senator

WBS:bh

SAMUEL L. DEVINE
12TH DISTRICT, OHIO

DISTRICT OFFICE:
408 FEDERAL BUILDING
COLUMBUS, OHIO 43215
221-3533

Congress of the United States
House of Representatives
Washington, D.C. 20515

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE
SUBCOMMITTEE:
TRANSPORTATION AND AERONAUTICS

COMMITTEE ON HOUSE ADMINISTRATION

JOINT COMMITTEE ON PRINTING

April 19, 1971

James S. McCaughan, Jr., M.D.
497 East Town Street
Columbus, Ohio 43215

Dear Doctor McCaughan:

Thank you for the telegram to Senator Allen Ellenders concerning the confidentiality of patient's medical files.

I share your views and have brought this matter to the attention of the House Ways and Means Committee, which is presently considering amendments to the Medicare program.

Sincerely,

Samuel L. Devine, M. C.

SLD:jl

cc: Wilbur D. Mills

ROBERT TAFT, JR.
OHIO

United States Senate

WASHINGTON, D.C. 20510

April 21, 1971

Mr. James McCaughan, Jr.
497 East Town Street
Columbus, Ohio

Dear Mr. McCaughan:

This will acknowledge your wire of the sixteenth. I believe you meant to send your message to Senator Russell Long as he is Chairman of the Senate Finance Committee and the matter to which you refer would come before that Committee. I will endeavor to discuss this with Senator Long at an early date.

Sincerely,

Robert Taft, Jr.

CHALMERS P. WYLIE
15TH DISTRICT, OHIO

1331 LONGWORTH HOUSE
OFFICE BUILDING
TELEPHONE: 225-2015

DISTRICT OFFICE:
FEDERAL BUILDING
85 MARCONI BLVD.
COLUMBUS, OHIO 43215
TELEPHONE: 469-5614

JACK M. FOULK
ADMINISTRATIVE ASSISTANT

Congress of the United States
House of Representatives
Washington, D.C. 20515

COMMITTEES:
BANKING AND CURRENCY
SUBCOMMITTEES:
SMALL BUSINESS
BANK SUPERVISION AND INSURANCE
CONSUMER AFFAIRS

VETERANS' AFFAIRS
SUBCOMMITTEES:
EDUCATION
HOSPITALS
INSURANCE

April 19, 1971

Dr. James S. McCaughan, Jr.
497 East Town Street
Columbus, Ohio

Dear Dr. McCaughan:

This is to acknowledge and thank you for a copy of your telegram to Senator Allen Ellender. I am sure you will hear from him in the near future.

I agree with you that patient's charts should remain confidential.

If I may be of any further service, please write again.

Very truly yours,

Chalmers P. Wylie, M. C.

CPW:cwf

C O P Y

Department of Justice, State of Louisiana
Office of Jack Gremillion
Attorney General

February 25, 1971

Mr. Haller Alexius, Administrator
St. Tammany Parish Hospital
Covington, Louisiana

Dear Mr. Alexius:

Your letter of February 5, 1971, addressed to Attorney General Jack Gremillion, has been assigned to this writer for attention and reply. Your letter inquires as to the extent your hospital must release patient medical information to health insurance companies when furnished with a proper authorization by the patient. There appears to be no statute which deals with the release of hospital records in response to written authorization by the patient. However, R.S. 44-7 which deals with the release of records under certain circumstances empowers the governing authority of the hospital to make rules and regulations regarding the inspection and copying of these. As you know, the governing authority of the St. Tammany Parish Hospital Service District is the Board of Commissioners, and such commissions are empowered to make and promulgate rules and regulations by virtue of R.S. 46-1055.

I trust that the above is responsive to your inquiry. Should you require further clarification, please feel free to re-communicate with this office.

Very truly yours,

(signed) Louis A. Gerdes
Special Counsel

LOUISIANA STATE MEDICAL SOCIETY RESOLUTION

MAY, 1971

Concerning Release of Medical Information to Insurance Companies, Service Contract Corporations, Government "Carriers," and Government Agencies, from Medical Records Departments of Hospitals. Introduced by: Jose L. Garcia Oller, M.D., Charles W. Miller, M.D., Christopher Bellone, M.D., Michael Smith, M.D., Kenneth Ritter, M.D., Robert Meade, M.D., Wesley Segre, M.D., and Edward Hyman, M.D.

1. All inquiries for medical information will be accompanied by a properly executed and current authorization for release of information signed by the patient or his proper representative. Upon receipt of an inquiry, the Medical Record Department will submit information in the face sheet of the chart, which includes identification data, the admitting and final diagnosis, and the name of the operations performed, including the verified pathological diagnosis, if any. If an insurance company requires additional information, the insurance representative will be referred to the attending physician. Requests for the "entire medical record" or "photostatic copies of the history, physical, and progress notes" are considered unethical and unacceptable.

2. It is recognized that an insuror may request under the "contestability clause" specified by the law in most states, specific antecedent information during the period of contestability. This request to the physician shall identify the specific information requested from the history of the present illness. On requests for past history, a list of such antecedent information as may be related and pertinent to the insurance policy in question will be provided by the insuror. The physician may then review the medical record(s) and provide the pertinent information. Operative report and pathology tissue report copies should not be necessary since the surgery is clearly listed in the front sheet and is self-explanatory as to the procedure involved and the verified pathological diagnosis, if any. Reports of x-rays, EKG or other laboratory aids used by the physician in establishing the clinical diagnosis should not be necessary.

3. For the purposes of financial audits and government provider audit programs,"the provider need only show the auditor that part of the records relating to the physician's authorization for services and not the notes made by nurses and physicians or diagnostic data which are confidential information."

4. The physician may honor requests for unusual information of a technical nature which the patient himself may not be able to provide and not covered in 2 above.

5. Certifications and recertifications are to be filed separately from the body of the medical record and shall be made available to the carrier or state agency. These should not be entered on the progress notes.

6. Implementation of this Resolution shall be the responsibility of the Medical Records Committee of the medical staff.

RELEASE OF
INFORMATION FROM
HOSPITAL RECORDS
(continued)

Mr. Maher stated he has been instructed by Mr. Vallon to make the following statements: (1) that Mr. Vallon has had several meetings with the Legal, Executive and Medical Committees of the Board of Managers of our Blue Cross Plan; (2) that he has discussed this subject at the last meeting of the Board. (3) Blue Cross will write to each hospital administrator in our area a policy type letter whereby we shall endeavor to explain the guidlines of our Association with regard to asking for necessary information in terms of patient and subscriber identity, which means subscriber's name, patient's name, his group and contract numbers, and his age. We don't think the Council of Medical Staffs would object to this. (4) We would also ask, where necessary, and it is done in some cases, for a brief case history. You may abstract, if you will, a very brief statement as to the reason why the patient is admitted. (5) We would not ask for progress notes or any additional information from the hospital. (6) If this information is necessary to process the case, we will write the physician.

Mr. Maher stated he has been instructed by Mr. Vallon to make the following statements: (1) that Mr. Vallon has had several meetings with the Legal, Executive and Medical Committees of the Board of Managers of our Blue Cross Plan; (2) that he has discussed this subject at the last meeting of the Board. (3) Blue Cross will write to each hospital administrator in our area a policy type letter whereby we shall endeavor to explain the guidelines of our Association with regard to asking for necessary information in terms of patient and subscriber identity, which means subscriber's name, patient's name, his group and contract numbers, and his age. We don't think the Council of Medical Staffs would object to this. (4) We would also ask, where necessary, and it is done in some cases, for a brief case history. You may abstract, if you will, a very brief statement as to the reason why the patient is admitted. (5) We would not ask for progress notes or any additional information from the hospital. (6) If this information is necessary to process the case, we will write the physician.

THE HOSPITAL MEDICAL RECORD

A Guideline for the Release of Medical Record Information

Published by the Health Insurance Council in cooperation with the American Association of Medical Record Librarians

THE SECURITY AND RELEASE OF MEDICAL INFORMATION

As a general rule, certain information is not available from the hospital medical record for release to third parties. This includes such data as detailed psychiatric examination information, personal history of patient or family, information controlled by State law, etc. Where pertinent, a brief statement may be issued regarding this type of information. Any information that would be considered an "act of defaming" the patient cannot be released. Likewise, information received from other hospitals and physicians regarding past history or treatment is for informational purposes and is not considered the property of the hospital receiving it. Correspondence or social service information which may be filed with the medical record is not considered a part of the medical record.

In preparing the following information, excerpts were taken from Guide to the Organization of a Hospital Medical Record Department, a publication of the American Hospital Association.

The information acquired in a doctor-patient relationship is generally considered to be confidential or privileged communication. The code of ethics adopted by the American Hospital Association and the American College of Hospital Administrators in 1957 recognizes the principle of the confidential nature of medical information: "The hospital organization and its individual employees jointly share the responsibility for the best possible care of the patient. To fulfill this obligation, the hospital and employees are both charged with certain reciprocal ethical obligations . . . Employees are obligated . . . to safeguard confidential information regarding patients and the hospital; to avoid gossip and public criticism of the hospital; to develop a spirit of mutual friendliness with fellow workers, and to be courteous to the public." The hospital, therefore, is responsible for providing adequate safeguards to prevent access to a patient's medical record by unauthorized persons from the time the record is initiated throughout the patient's hospitalization, and after his discharge.

There can be only one person responsible in the hospital for the medical record—the attending physician. He alone knows all the facts and is consequently the only one competent to arrive at conclusions. Intern and junior resident notes may reflect unimportant as well as important information, or important data written in considerable detail. It is the attending physician who must judge the accuracy of their notes as they pertain to the individual patient. When there is a question regarding the content of the medical information to be released, the attending physician is consulted for its accuracy or interpretation.

Confidential Information: Data in the medical records is of two types:

1. Informational data relating to the identification of the patient and the facts of hospitalization, usually found in the identification section. This data is considered non-confidential and may be released without the consent of the patient. However, even this information should be released with care and only in response to proper inquiries. Certain data that would be non-confidential in a general hospital might be considered confidential in a specialty hospital or in a special service of a general hospital, such as a Psychiatric Unit.
2. Clinical data obtained professionally and usually found in the medical section of the record, is considered confidential.

STANDARDS

FOR

ACCREDITATION OF HOSPITALS

OCTOBER 1969 JOINT COMMISSION ON ACCREDITATION OF HOSPITALS
645 NORTH MICHIGAN AVE., CHICAGO, ILLINOIS 60611

Principles and Standards Approved; interpretations only accepted for field testing

Standard III

Medical records shall be confidential, current and accurate.

Interpretation

The medical record is the property of the hospital and is maintained for the benefit of the patient, the medical staff and the hospital. It is the responsibility of the hospital to safeguard the information in the record against loss, defacement, tampering, or use by unauthorized persons. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information. Records may be removed from the hospital's jurisdiction only in response to a court order. It is recognized that in some instances, such as in the treatment of mental disorders, certain portions of the medical record are so confidential that extraordinary means may be taken to preserve their privacy. In such cases, these portions may be stored separately and data concerning identification, medications, treatments and so forth, including a resume, may be maintained in the general medical record files. For review purposes, however, the complete record must be available.

Disclosure of Contents of Audit Program

For a general discussion of the prohibition against disclosure of information, see ¶ 13,850.

Disclosure of Contents of Audit Program and Results of Audit

The three full-scale audit programs adopted to date—i.e., those for hospitals (HIM-16), home health agencies (HIM-17), and extended care facilities (HIM-18)—provide that the auditor is not to discuss or disclose the contents of the audit program, or otherwise provide information with respect to specific audit approaches, to anyone except authorized representatives of the intermediary and the Social Security Administration. The scope of the audit and *overall* audit objectives and approaches should be discussed, however, with appropriate officials of the provider during the initial conference at the start of the audit, and the results of the audit are to be discussed with officials of the provider and the intermediary during the audit and at the exit conference, as appropriate under the circumstances. (Note that the guidelines to be followed by the intermediary in determining the frequency, necessity, and scope of audit may not be disclosed; see ¶ 7627.)

.01 Sources.—Soc. Sec. Act § 1106, ¶ 16,375. Reg. § 401.1, ¶ 18,051. *Audit Program for Extended Care Facilities . . .* (HIM-18); *Audit Program for Home Health Agencies . . .* (HIM-17); *Audit Program for Hospitals . . .* (HIM-16); *Part A Intermediary Manual*, HIM-13, § 3765.

.13 Accessibility of non-Medicare patients' medical records.—Provider Relations Bulletin No. 74 [see .87, below], issued February 26, 1968, was a joint product of the staffs of the American Hospital Association and Blue Cross Association and stated our position that a Medicare audit must encompass review of both Medicare

.87 Review by auditor of provider medical records and board minutes.—The following statement is a joint product of the staffs of the American Hospital Association and the Blue Cross Association. We believe that this statement should foster a better understanding between the provider and auditor in meeting their mutual responsibilities:

Statement on Auditors' Review of Medical Records and Provider's Board Minutes Under the Medicare Program

An auditor representing an intermediary under the Medicare Program frequently has a need to review certain aspects of the medical records and board minutes of a provider. The following has been developed as a guideline for providers and auditors with respect to the extent that these hospital documents should be made accessible.

Auditors' Review of Medical Records

The following is a listing of reasons why an auditor should have access to certain portions of the medical records for all patients in the hospital.

1. The audit is designed to review the system of internal control over the processing of transactions within a hospital. The financial transaction starts with a physician's order in the medical record. It is the only source of authorization for services ordered by the physician and therefore it is necessary for the auditor to review the orders of the physician to ascertain that the charge for services rendered corresponds with the physician's orders. The auditor must trace the order for services to the department rendering the service in order to verify that the service was actually rendered, and then, he must trace the charge to the patient's ledger.

2. The use of RCCAC makes it essential that the auditor verify that all services rendered are recorded to avoid a distortion in the application of RCCAC method of reimbursement.

3. The patient signs a statement on the Inpatient Hospital Admission and Billing Form (SSA-1453) which authorizes the provider to release information necessary to support payment of the claim.

4. The provider contract provides for access to information pertinent to reimbursement.

The auditor is interested in seeing the data for only a small sample of patients. The provider need only show the auditor that part of the records relating to the physician's authorization for services and not the notes made by nurses and physicians or diagnostic data which are confidential information.

CONDITIONS OF PARTICIPATION
REGULATIONS HIR-10 (6/67) HOSPITALS

SUBPART F—Agreements with and Functions of Providers, Intermediaries, Carriers, and State Agencies.

§ 405.612 Compliance with procedural and other requirements; individual's refusal to execute request for payment.

(a) For purposes of § 405.607(a)(2), compliance with procedural and other requirements means that the provider of services:

(1) Has secured, from the individual or a proper person acting on his behalf, a written request for payment to be made to the provider, and the provider has properly filed such request; and

(2) Has in its files the required certification and recertification by a physician relating to the services furnished to the individual (see §§ 405.1625–405.1634); and

(3) Has furnished to the Secretary such information as the Secretary has found necessary in order to determine the amount due the provider on behalf of the individual for the period with respect to which payment is to be made or any prior period; and

(4) Has complied with the provisions requiring timely utilization review of long stay cases so that a limitation on days of service has not been imposed under section 1866(d) of the Act (see § 405.617).

SUBPART J

Conditions of Participation; Hospitals

405.1026(a)

405.1026 Condition of Participation—Medical Record Department.—The hospital has a medical record department with administrative responsibility for medical records. A medical record is maintained, in accordance with accepted professional principles, for every patient admitted for care in the hospital.

(a) *Standard; Records Maintained.* — A medical record is maintained for every patient admitted for care in the hospital. Such records are kept confidential. The factors explaining the standard are as follows:

(1) Only authorized personnel have access to the record.

(2) Written consent of the patient is presented as authority for release of medical information.

(3) Medical records generally are not removed from the hospital environment except upon subpoena.

SUBPART J

Conditions of Participation; Hospitals
405.1023

(n) *Standard; Medical Records Committee.* — The medical records committee (or its equivalent) supervises the maintenance of medical records at the required standard of completeness. On the basis of documented evidence, the committee also reviews and evaluates the quality of medical care given the patient. The factors explaining the standard are as follows:

(1) The committee meets at least once a month exclusive of the summer months, and submits a written report to the executive committee.

(2) The committee's members represent a cross section of the clinical services. In large hospitals, each major clinical department may have its own committee.

(3) Membership is staggered so that experienced committee physicians are always included. Senior residents may serve on this committee.

(4) Review of the record for completeness can be performed for the most part by the medical record librarian. In addition, on-the-spot scanning of current inpatient records for completeness is done on the floors.

(5) The quality of patient care is evaluated from the documentation on the chart. In some hospitals, this function may be given to an "audit" or "evaluation" committee.

(6) The committee:

(i) Makes recommendations to the medical staff for the approval of, use of, and any changes in form or format of the medical record;

(ii) Advises and recommends policies for medical record maintenance and supervises the medical records to insure that details are recorded in the proper manner and that sufficient data are present to evaluate the care of the patient;

(iii) Insures that there is proper filing, indexing, storage, and availability of all patient records; and

(iv) With the aid of legal counsel, advises and develops policies to guide the medical record librarian, medical staff, and administration so far as matters of privileged communication and legal release of information are concerned.

UNIFORM POLICY FOR RELEASE OF MEDICAL INFORMATION

All inquiries for medical and other information shall be accompanied by a properly executed and current authorization pertinent to the period of hospitalization for which the request is being made and signed by the patient or his proper representative during or after this hospitalization. Upon receipt of an inquiry, the hospital may submit only the following information: identification data, date of admission and discharge, diagnosis or diagnoses and the date at which the diagnosis of the current illness was made; statement as to the reason for the present hospitalization and the name of the operations performed upon the patient. If additional information is required, the hospital shall refer the inquirer to the attending physician for further information who shall respond without delay.

Under the provisions of Title XVIII and XIX of the Social Security Act, the medical records of such hospitals as choose to utilize the Utilization Review Committee of the official fiscal intermediary shall become available for the purpose of such utilization review to the intermediary.

For the purposes of financial audits, the confidential aspects of the record shall be removed from the sampling of records requested, prior to such audits, specifically the history and physical examination record and progress notes; except the progress notes shall not be removed when used to certify the need for hospitalization under Title XVIII of the Social Security Act.

Requests for release of medical information from attorneys claiming to represent the patient will be handled on an individual basis by the administrator.

Note: The above is recommended for adoption by the hospitals comprising District VI of the LHA by the ad hoc committee appointed for that purpose by the President, Sister Mary James.

Phyllis D. Eagan, Chairman
Sr. Mary James
David Smith
Paul Bjork

September 11, 1970

[From The Citizen Journal, Columbus, Ohio—April 9, 1971]

DOCTOR REBUTS NEW HEALTH PLAN

To The Editor:

As a private physician as well as the Chief of Surgery at the State School for the Mentally Retarded, I want to commend Governor Gilligan for distributing and showing the motion pictures taken of conditions prevalent at the State Hospital. Conditions at the State School exist which would not be tolerated for one day in private medicine, and the State School of Columbus is held as the model school for the rest of the state.

This is a vivid, close to home example of government intervention in medicine. Presently the public is being told by opportunistic politicians that there is a medical crisis, and they are going to cure it by a socialized medical program. The public is being told that they will receive the same or better medical care they now receive from private physicians and they won't have to pay for it.

THIS IS A ridiculous assumption. In the first place they will have to pay for it every year through taxes whether ill or not. Robert Myers, who was the chief actuary for the Social Security Administration for 23 years, estimates the cost will be between $660 to $1000 per worker if the Kennedy-Saxbe Health Security bill is passed. The Social Security Administration itself estimates the cost for fiscal 1974 will be $77 billion. Don't forget that the SSA has consistently underestimated the cost of Medicare and Medicaid. Politicians credibly state that the public will only have to pay a small percentage of this and the rest will be made up from general taxes. Those general taxes come from the public.

Most important, the private physician/patient relationship will be destroyed and the quality of medical care will certainly deteriorate. One need only examine presently existing government facilities such as the State Hospital to predict the future.

Public Health Service hospitals have been permitted to become so outmoded that the government decided in December, 1970, to discontinue them.

In 1969 the average stay in short-term government general hospitals was 19.9 days while 8.3 days in similar non-government hospitals.

IN THE READER's Digest of March, 1971, was a report of an intensified investigation of the VA system which showed that it was beset with critical malfunctions, problems of management, financial support and utilization of resources that mean misspent funds and mis-directed treatment. It was recommended that new managerial blood is urgently needed and they must be given authority to make decisions free of needlessly stringent bureaucratic regulations. Reports of the VA's own chiefs of services were: "tight budget policies have imposed serious fiscal constraints on our abilities to employ adequate personnel and provide necessary facilities"; ". . . insufficient equipment, insufficient personnel and grossly inadequate support in the crucial areas of pathology, radiology and clinical laboratory and physical medicine"; ". . . radiology equipment is obsolete in the worst sense of the word, broken down in the very true sense of the word." The V.A. Hospital system is a $1.9 billion a year operation with 166 hospitals. The funding for the following year is based substantially on the utilization of the hospital from the previous year, therefore there is a great tendency to keep patients in the hospital longer than in private hospitals, as is shown statistically.

Military hospitals use "walk-in clinics" for the ambulatory ill. This usually subjects the patient to a different doctor at each visit and not infrequently the clinic will be manned by a physician trained in a specialty other than what the patient's illness requires.

A SPECIAL committee on Municipal Hospital Services appointed by Mayor James Tate to study the future of Philadelphia General Hospital (a city-owned service which received $30,961,946 for fiscal 1970) reported on April 20, 1970: "The present PGH is obsolete and beyond economic renovation. This manner of allocating money deals with health problems too late, costs the most, and does little to prevent illness. Administrative and management inefficiencies were found in present operations of city personnel health programs."

It should be noted that changes in the Philadelphia General Hospital on June 17, 1970, were: per diem for inpatients $68, clinic visit $25, receiving ward visit $20. The average private physician office charge is less than $10.

Similar reports can be made for Massachusettes General, Cook County General and other city and county-owned hospitals.

Not many private patients are beating down the doors of government hospitals to obtain care.

Government is not infallible as we can see daily in the newspapers.

In RESOLUTION-62 at the annual convention in 1969, The American Medical Association reaffirmed its belief that, "It is the basic right of every citizen to have available to him adequate health care." However, it also states, "It is the basic right of every citizen to have a free choice of physician and institution in the obtaining of medical care."

If the Kennedy-Saxbe comprehensive health insurance or the American Hospital Association's Ameriplan is put into effect, the practice of medicine will be completely altered in that the private practitioner will disappear from the scene. The patient will no longer have a choice in who treats or operates on him or his loved ones.

Thus while imperfect, the greatest medical system ever devised is going to be destroyed, unless the private patients let their congressmen and their newspapers know that they still want to have some say in who treats them. Write a note to Congressmen Chalmers Wylie or Samuel Devine, or Senators Robert Taft or William Saxbe in Washington, D.C. and let them know your feelings—JAMES S. McCAUGHAN, JR., M.D., Central Ohio Medical Clinic, 497 E. Town-st.

MARVIN I. KOHN, M. D.
TIBOR V. KOVACS, M. D.
OBSTETRICS AND GYNECOLOGY
7915 MUNSON ROAD
MENTOR, OHIO 44060
TELEPHONE 257-7227

May 4, 1971

Senators Kennedy, Packwood and Taft:

I am a private practitioner of obstetrics and gynecology in Mentor, Ohio, near Cleveland. I represent no organization and hold no office in my county medical society. I took a few hours out of my practice to attend the hearings and see for myself what the Senate is trying to do. I wish to present some of my personal thoughts on these hearings and on health care.

1. The parade of witnesses before the subcommittee's hearing in Cleveland clearly showed that the problem in medical care is neither service nor availability, but money. And money was clearly a problem because of catastrophic illness. An insurance program including catastrophic coverage that would include all citizens, possibly appended to F.I.C.A., and with guarantees of insurance for the indigent and/or unemployed would certainly seem to be a rational approach to the problem of health care expense. It is also an uncomplicated approach.

The witnesses who complained about inadequate treatment in emergency rooms, or about police rescue squad ineptness, or about misdiagnosis, or about "racism" in medical care obviously had an axe to grind. If these witnesses feel their civil rights were violated a Senate subcommittee hearing on health care is a poor place to register their complaints and only serves to introduce emotionalism to the question under consideration.

2. The problem of the "doctor shortage" is more shadow than substance. A maldistribution of physicians exists, not a numerical shortage. I would suggest that the committee consider a plan, analagous to the Berry Plan, to wholly or partly finance medical eduacation and training wherein the student so financed would have a contractual obligation to practice in a doctor short area for an agreed time. There are plenty of doctors in Cleveland, but Vinton County in Ohio's Appalachia, has not a single physician for its 10,000 people. This pattern is repeated all across the country. I recall an incident 18 years ago, when I checked into a motel in Lordsburg, N.M., the innkeeper tried to get me to stay in their town because they needed a doctor!

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3. If medical care in America truly needs reorganization and restructuring as Senator Kennedy states in his speech of Jan. 25, 1971, I submit that the place to start is with government itself. Let government at all levels recognize its total responsibility in health care in the areas it already denotes as community health problems but fails to fund solutions for those problems.

An example of government failure in community health is family planning. The United States is the only major nation in the world with no government directed family planning program. True, Federal funds are available to supplement monies provided privately or by other levels of government. But a comprehensive program itself is nonexistent. As long as private agencies continue to tilt at the family planning windmill, government seems determined to ignore its total responsibility in this recognized community health problem.

Drug abuse is another community health problem neglected by government. In my county, Lake, there is a Free Clinic for Drug Abuse; it is privately organized and funded, with government making some fiscal contribution. But a health problem is either a community concern or it's not. If it is then public resources ought logically to be used to meet the problem. It is hardly equitable for private monies to be applied to public problems. Tax dollars have already been contributed for such purposes and it is certainly the government's duty to allocate those tax dollars wisely to meet problems that government itself recognizes as public.

Private funds are donated for all manner of health problems that in other nations are met by government alone. We Americans seem to be unique in our generosity to support every medical problem from M.S. to V.D. Perhaps it's time to stop private support of public health problems; maybe it's time for government to "reorganize and restructure" its delivery of public health care.

Marvin I. Kohn, M.D.

COPY—POOR

MAKE HEALTH CARE A RIGHT, NOT A PRIVILEGE

Most people needing health care in America, and most people working in health-related jobs are in trouble: Millions have no family doctor to rely on; many urban neighborhoods and rural homes have no health care at all; working people pay more and more for their health care in doctor bills, drugs, insurance payments, and taxes; if you don't like a doctor, a hospital, a nursing home you have no way to change it; and if you work in a hospital, you have no way to get training for a better job!

We believe Senator Kennedy's Health proposal has some merit, and feel that it is the best plan currently before congress.
Its GOOD points:

It greatly reduces out-of-pocket expenses for health care

It tries to eliminate insurance companies

It wants to control wasteful costs

But Kennedy's Plan is NOT the ahswer! His plan:

Fails to place family oriented doctors in every neighborhood and town.

Pays for health care by extracting billions in taxes and social security payments from working Americans, not the rich.

Allows drug companies and other health industries to make HUGE PROFITS from people's sickness.

Like Nixon's plan, creates Health Maintenance Organizations (HMO's) designed to increase their profits by keeping the patient out of the doctor's office and out of the hospital (even though the patient may need or want the care).

Also encourages a two-class system of care: Understaffed HMO's for poor and working people; private practice for the rich.

Leaves the health care system in the hands of those already proven incapable of running it—doctors, administrators and corporations; refuses to allow consumers and health workers a meaningful voice.

We feel that a National Community Health Service should guarantee health care as follows:

FREE health care of equal quality for EVERYBODY! This includes physical, dental, mental, environmental and social health care.

EQUAL DISTRIBUTION throughout the country of a massively increased number of doctors and other health workers.

TRAINING for all health workers so that orderlies, technicians and nurses can, if they so desire, receive advancement through on-the-job training, and even become doctors in this way.

END OF RACE, SEX AND SOCIO-ECONOMIC DISCRIMINATION by training tens of thousands of minority group health professionals and workers.

FINANCED PUBLICALLY AND NATIONALLY by a tax which makes the rich pay their share. Working Americans should not pay more taxes.

PROFITS ELIMINATED FROM the health care system. No individual or organization should profit from people's sickness. This means abolishment of fee-for-servicepayments to doctors, eliminates insurance companies, and places drug companies under public ownership.

NEIGHBORHOOD BASED, COMMUNITY-WORKER CONTROLLED health centers in every area of the country.

HEALTH AND SAFETY OF WORKERS GUARANTEED Employment should be made healthy for all workers in all jobs.

Power and Health to the people!

Medical Committee for Human Rights
National Health Insurance Committee

(Whereupon, at 4:10 p.m., the Senate Subcommittee on Health of the Committee on Labor and Public Welfare was adjourned.)

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