

# NATIONAL HEALTH INSURANCE PROPOSALS

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**HEARINGS**  
BEFORE THE  
**COMMITTEE ON WAYS AND MEANS**  
**HOUSE OF REPRESENTATIVES**  
NINETY-SECOND CONGRESS  
FIRST SESSION  
ON THE  
SUBJECT OF NATIONAL HEALTH INSURANCE  
PROPOSALS

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OCTOBER 19, 20, 26, 27, 28, 29; NOVEMBER 1, 2, 3, 4, 5, 8, 9, 10,  
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# NATIONAL HEALTH INSURANCE PROGRAMS

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WEDNESDAY, NOVEMBER 3, 1971

U.S. HOUSE OF REPRESENTATIVES,  
COMMITTEE ON WAYS AND MEANS,  
*Washington, D.C.*

The committee met at 10 a.m., pursuant to notice, in the committee room, Longworth House Office Building, Hon. Wilbur D. Mills (chairman of the committee) presiding.

The CHAIRMAN. The committee will be in order please.

Our first witness this morning is the Honorable John C. Harrison, who is president-elect of the National Tuberculosis and Respiratory Disease Association. We are very pleased to have with us our former colleague on the Ways and Means Committee, now U.S. Senator from the great State of Montana. We are glad to have you back with us, Lee Metcalf.

Will you proceed with the introduction of Justice Harrison.

## STATEMENT OF HON. LEE METCALF, A U.S. SENATOR FROM THE STATE OF MONTANA

Senator METCALF. Mr. Chairman, it is always a pleasure to appear before this great committee. In spite of the fact that there is a considerable number of new members since I had the privilege of serving with you, it is a homecoming to be here and meet all of the members with whom I did serve.

I am especially honored in having with me one of the most distinguished citizens of the State of Montana, an old friend of mine, a man who has been head of various charitable community organizations, a justice of the Montana Supreme Court now for 12 years and the president-elect of the National Tuberculosis and Respiratory Disease Association.

Justice Harrison is accompanied by Dr. Robert Anderson, who is the managing director of that association, and they are going to testify, as you know, on the proposed national health insurance program. I hope that this appearance before the committee will not place in jeopardy the tax-exempt status of this great organization, which has done so much and contributed so much to the health of the Nation. It is now my honor to present Mr. John Harrison.

The CHAIRMAN. We will just have to protect him against that possibility, won't we, Senator?

Senator METCALF. I will join with the distinguished members of the committee in that.

The CHAIRMAN. Any time we have done something to the law that denies a person operating a charitable organization from appearing before the Congress in behalf of legislation that is for or against the betterment of that project, I think we have gone a little too far, and some people think we have.

Senator METCALF. I certainly agree.

The CHAIRMAN. We appreciate having you with us and we appreciate your coming over and presenting Mr. Harrison and we appreciate having Dr. Anderson with us also.

**STATEMENT OF HON. JOHN C. HARRISON, PRESIDENT-ELECT, NATIONAL TUBERCULOSIS AND RESPIRATORY ASSOCIATION; ACCOMPANIED BY DR. ROBERT ANDERSON, MANAGING DIRECTOR**

**SUMMARY**

1. Existing government and private health insurance programs provide inadequate coverage of services needed by patients with chronic respiratory diseases, such as tuberculosis and emphysema.

2. Outpatient care, including medical supervision, drugs and home health services is critical to the treatment of chronic respiratory illness. Coverage of outpatient services is very restricted under most programs.

3. A national health insurance program must provide for outpatient services if it is to be responsive to the needs of chronic respiratory disease patients.

4. Coverage of treatment for tuberculosis must be the same in both general and specialized hospitals; and public health surveillance of tuberculosis must continue.

Justice HARRISON. Gentlemen, the National Tuberculosis and Respiratory Disease Association appreciates the opportunity to comment on services which a national health insurance program should provide if it is to meet the needs of respiratory disease patients. I am Justice John Harrison, of the Montana Supreme Court and appear here in my capacity as president-elect of NTRDA.

The NTRDA is concerned with the control of respiratory diseases, particularly emphysema and bronchitis, as well as tuberculosis, which remains a major public health problem. Present Government-financed medical care programs and private insurance plans do not meet all the needs of patients with these long-term illnesses and few patients are able to cover the costs from their own resources. It is for these reasons that the NTRDA board of directors adopted a resolution in February 1971 which called for a national prepaid health insurance program providing universal coverage.

We believe that the success of any insurance program will be dependent on the orderly expansion of facilities and manpower and the coordination of the various components of the delivery system. Lack of services for respiratory disease patients is illustrated in a recent survey by the Regional Medical Programs Service, which showed that only 30 percent of short-term general hospitals had mechanical respirators, a basic therapeutic device used for relief of respiratory insufficiency.

This situation reflects lack of respiratory disease specialists and other skilled personnel. In June 1970, 48 out of 72 medical schools had a total of 85 unfilled funded pulmonary disease faculty positions, a fact which directly affects our ability to increase the short supply of personnel trained to take care of respiratory disease patients.

Control of tuberculosis is a public health responsibility because of the contagious nature of the disease. Thus in years past Federal, State, and local governments have generally provided for the care of many such patients in Government hospitals or health department clinics. The treatment of patients with emphysema and other non-contagious respiratory disease has taken place mainly within the private medical care system.

With the advent of medicaid and medicare, those programs assumed some of the costs of care of eligible patients in both the public and private sectors. However, State definitions of eligibility on the basis of income prevent many patients with respiratory disease from receiving care under medicaid. Limitations on scope of medicaid services have resulted in others not receiving adequate care under the program. For instance, drugs cannot be furnished under the medicaid program in certain States. Drugs are essential to the treatment of tuberculosis and other respiratory conditions.

Medicare covers only part of the cost of a chronic illness for those who are eligible. Few private medical insurance plans provide for the continuous and comprehensive services which chronic respiratory disease patients need to maintain themselves, even if they are able to afford the cost of the premiums.

The essential elements of care of chronic respiratory disease within various health care settings have been set down by expert committees of the NTRDA. They are described in "Standards for Tuberculosis Treatment in the 1970's," and "Standards for the care of Patients with Chronic Respiratory Disease," which are appended.

We respectfully request that these expert statements be used in envisioning the kinds of services that must be provided for respiratory diseases under any insurance program.

#### CRITICAL SERVICES

##### A FULL RANGE OF OUTPATIENT SERVICES INCLUDING HOME HEALTH CARE

Of course, chronic respiratory disease patients must have available to them hospital and nursing home care, especially in periods of acute respiratory distress. However, most of the care of these patients can be met in the outpatient setting, including both medical and home health services. Reimbursement for these services has been subject to considerable limitation under existing insurance programs, a situation which in turn has restricted their utilization and development. If the national health insurance program is to have meaning for persons with chronic respiratory disease, it must enable adequate outpatient medical care and services in the home.

Outpatient supervision of the tuberculosis patient must be available not only during the period of active disease, but throughout his life to prevent relapse. Outpatient examination and supervision of contacts of active cases or persons suspected of having the disease is as important as treatment of the active case. Outpatient care is not only important from the standpoint of the patient's well-being, but to the efficiency and economy of the system. The latter point is illustrated in tuberculosis where infusion of approximately \$66 million of

Federal funds in outpatient clinics during a recent 5-year period led to an estimated savings of \$430 million in hospital costs.

Although emphysema remains an irreversible condition at the present stage of our knowledge, the patient can be helped to remain ambulatory through the use of various treatment and rehabilitative processes. Patients with chronic respiratory disease usually need outpatient medical care on an intermittent but continuing basis for the rest of their lives.

As in the hospital, a full array of diagnostic procedures, including laboratory services, pulmonary testing and X-ray, must be covered by insurance benefits as well as therapeutic services, such as inhalation therapy and drugs.

Some patients will be so disabled and restricted in their activities that they will have to be taken care of in a residential institution or at home. Unfortunately, in many areas home health services are nonexistent or so limited that they cannot meet current needs. Much more attention must be given to how the needs of homebound patients can be met under a medical care program. Certainly the use of ancillary personnel specifically trained for home duty under the supervision of registered nurses must be expanded. These people should be able to provide housekeeping or maintenance services along with services of a personal health care nature.

#### DRUGS

Drug treatment, which plays such an important preventive and therapeutic role in respiratory disease, can be administered successfully on an outpatient basis. Therefore, it is essential that drugs be available both in the outpatient area and in the hospital.

Drug treatment can render the patient with active tuberculosis noncommunicable in a short period of time. In order to completely arrest the disease process, drugs must be taken daily for more than a year. Drug treatment can also prevent a tuberculous infection from progressing to an active infectious state. Thus it must be available to TB contacts and suspects as well as identified cases.

Patients with chronic respiratory diseases are both more vulnerable and more affected by acute respiratory infections so it is essential that they have access to antibiotics. Drugs for the improvement of breathing capacity and for the relief of cardiac impairment, which frequently occurs in cases of respiratory insufficiency, are equally important.

#### HOSPITAL CARE FOR TUBERCULOSIS

We bring to the committee's attention a special problem which exists in the case of specialized tuberculosis hospitals under the medicaid program in order that this practice will not be carried over to a national health insurance program. Although all care of tuberculosis will ultimately be in general hospitals, there are existing specialized TB institutions of high quality which are still needed in some States.

However, under present Federal medicaid regulations, tuberculosis hospitals cannot be reimbursed for the care of patients who are under the age of 65. General hospitals suffer no similar restriction. A national health insurance program should allow equal coverage for care in tuberculosis and in general hospitals since treatment is the same in both types of institutions.

## PUBLIC HEALTH ASPECTS OF TUBERCULOSIS

Continuity of care is important in a chronic communicable disease such as tuberculosis, not only because of the medical risk to the patient of interrupted treatment, but because of the public health risk. Important as services of a national health insurance program will be to individual tuberculosis patients, a health insurance program cannot provide public health surveillance of tuberculosis patients and contacts or an overview of the tuberculosis problem. Therefore, it is necessary that Congress continue to support the Communicable Disease Control Act, which does make this type of surveillance possible.

We thank you for your invitation to present this information and hope it will be of help to the committee.

The CHAIRMAN. We thank you, sir, for your very fine testimony. We appreciate, Dr. Anderson, your accompanying Justice Harrison and we appreciate your bringing back to the committee our longtime friend and longtime colleague on the committee, Justice Harrison.

Mr. Ullman?

Mr. ULLMAN. Thank you, Mr. Chairman.

Justice HARRISON, we appreciate your testimony on the very important problems of respiratory diseases. The committee recognizes there are some special problems here that need to be taken care of. I also want to welcome my old friend from Montana, Lee Metcalf. You come in very good company.

The CHAIRMAN. Are there any further questions or comments?

Mr. Waggonner.

Mr. WAGGONNER. Thank you, Mr. Chairman.

For the record, Justice Harrison, how many people are we talking about who are known tuberculosis cases in the United States today?

Justice HARRISON. Known—there are probably 1,250,000 known persons needing treatment.

Mr. WAGGONNER. Do you have any breakdown of that figure of the numbers who might be considered outpatients and the number who require hospitalization?

Dr. ANDERSON. There are about 20,000 beds for tuberculosis in special tuberculosis hospitals, so the bulk of the patients are being treated on an outpatient basis either because their disease is active or to make sure their disease stays inactive.

We also use a drug to prevent the development of disease, so the 1,250,000 persons the justice mentioned cover persons in all of these situations.

Mr. WAGGONNER. Are these 20,000 beds both public and private?

Dr. ANDERSON. For the most part they are public beds, sir.

Mr. WAGGONNER. Could you tell me something about what the occupancy factor is?

Dr. ANDERSON. There are about 16,000 to 18,000 of those beds occupied now.

Mr. WAGGONNER. In other words, we have some space that is not utilized?

Dr. ANDERSON. Yes, sir. Increasingly the management of tuberculosis patients has moved to the outpatient area. Prior to the days of drug therapy tuberculosis treatment required up to 2 years of sanatorium-type hospitalization. Now if the patient comes with a new case

of tuberculosis, if he needs hospitalization—he is ready to be discharged in about 3 months, on the average.

Mr. WAGGONNER. Your statement dealt in some length on what needed to be done to control the known cases. Does the association have some sort of a program which is preventive?

Dr. ANDERSON. Yes, the preventative is the use of isoniazid for persons who are infected with tuberculosis but who have not yet developed destruction of the lungs. If destruction has begun, this one drug has to be supplemented with drugs like streptomycin, para-aminosalicylic acid; and a new drug called Rifampin has come on the scene.

Mr. WAGGONNER. Have you done anything toward expanding into more of the public health areas, especially with the newer efforts to move toward preventive procedures?

Dr. ANDERSON. Yes, particularly we find the associates of cases of tuberculosis to whom the cases may have passed their infection; and for them we are using the preventive treatment approach.

Mr. WAGGONNER. What would happen if you adopted the testing programs that are used for vision and hearing, for example, for preschool or public school, especially elementary youngsters, to include testing for tuberculosis?

Dr. ANDERSON. This is a basic element of the program as it has operated in the past and up to now. Actually, with the impetus that Congress has given to the control of tuberculosis, the infection rates for children entering school now have been considerably reduced over what they were 20 years ago. So we are now emphasizing the tracing of contacts of cases of tuberculosis as the more efficient and effective way of finding people who need either preventive therapy or therapy for disease.

Mr. WAGGONNER. What has been your experience—you told me we have about 1,250,000 cases now, known cases—what has been your experience through the years with the introduction of new and more effective drugs, for example, what was that figure 10 or 20 years ago?

Dr. ANDERSON. The 1,250,000, Mr. Waggonner, is the total number of persons who are under supervision and treatment. For active disease—that number is about 45,000 to 50,000. There is an equal number who have disease that is stabilized, but they still need treatment. The bulk of the 1,250,000 are persons taking preventive therapy.

Mr. WAGGONNER. Has this overall figure been reduced with improved treatment? How many known cases were there 10 or 20 years ago?

Dr. ANDERSON. About 15 years ago there were about 300,000 persons who were taking drugs because they had active or inactive disease. So we have cut the number down by more than 60 percent.

Mr. WAGGONNER. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Carey.

Mr. CAREY. Thank you, Mr. Chairman.

I would like to take this opportunity to welcome our good and highly regarded colleague from the Senate, Judge Metcalf, here with Justice Harrison. The purpose of the few brief questions I want to address at this time, Mr. Chairman, is to indicate my strong concern for the preservation of this kind of an association and similar associations as very valuable to us in the conduct of our legislative inquiry and oversight.

I am concerned because, as we heard yesterday from the National Association on Mental Health, these disease-oriented and spirited associations who gather together to represent patients and to cope with conditions in society may be seriously impaired by reason of the Internal Revenue Service's interpretation of what they are doing in terms of substantial legislative activity.

I want to ask a few questions to see if this association is undergoing the same kind of confusion, I might say, or interference in their work which has been happening among some mental health associations.

What kind of legislative activity does your association engage in? Do you appear before the Appropriations Subcommittee of this body or of State bodies?

Justice HARRISON. Congressman, this association is a national association with many, many constituents and affiliates. Our national association has appeared when invited on particular health problems. My last appearance and only other appearance before a congressional committee was to ask the Congress to move the Indian Health Service from the Department of Interior to the Department of Public Health. That was back in 1952.

Congress did. I think this one appearance representing a national health association did a great service to the Indian citizens of this country as far as their health is concerned. We struck a real blow for health. This was the result of volunteer people throughout the whole country in this tuberculosis movement getting behind our Congress and saying, "This we want done."

I am a volunteer. If I can't appear before my city commission, my county board of commissioners, my legislature to tell them what our specialty knows and what our problems are because of a tax status problem, we are in serious trouble. I think I can echo the feeling of the whole volunteer health movement, heart and all the rest, because our people have talked about this.

When you have a government agent come in to look at your books to see what is substantial in the way of your legislative activity, there is a question—and I am a judge—what is substantial? It is a serious problem before the health group in this country, and I am sure others, and I urge you to give it great consideration.

Mr. CAREY. Thank you, Judge. I apologize for taking the committee's time on this. I was delayed in getting down from New York because of the weather conditions.

I want to add a footnote that the respiratory ailments of millions of New Yorkers would be affected today, as on most days, when we have an inversion of smog. The environmental aspect of your work has been extremely helpful to us who live in such areas.

I want nothing to stand in the way of the work you are doing to keep the attention of public figures on everyone's health. I understand the chairman at the onset of the hearing today engaged in a colloquy with Judge Metcalf and I hope we can agree that this practice of the Internal Revenue Service goes far beyond the purview of the act. I hope this will be properly reformed so that disease-oriented groups who are trying to concern themselves, as you are, with the health of all of our citizens will be encouraged and that you will not be impeded in the great work you are doing.

The CHAIRMAN. We thank you for coming to the committee, Justice Harrison, and bringing with you those at the table. Thank you, Lee, for coming.

Our next witness is Dr. Bernard Shannon of the American Optometric Association.

**STATEMENT OF BERNARD J. SHANNON, O.D., TRUSTEE, AMERICAN OPTOMETRIC ASSOCIATION; ACCOMPANIED BY RICHARD W. AVERILL, DIRECTOR OF THE WASHINGTON OFFICE; AND DONALD LAVANTY, DIRECTOR, NATIONAL AFFAIRS DIVISION**

Dr. SHANNON. Mr. Chairman and members of the committee, it is gratifying to present the views of the American Optometric Association on the emerging national health insurance concept.

I am Dr. B. J. Shannon, a practicing optometrist in Mauston, Wis., and a trustee of the American Optometric Association. The American Optometric Association is a federation of 51 affiliated optometric societies chartered in the 50 States and the District of Columbia. Total membership in the organization is at an alltime high of 16,680. There are some 18,300 optometrists actively engaged in full-time practice in the Nation today.

With me today are Mr. Richard W. Averill, Washington office director of AOA, and Mr. Donald Lavanty, director, National Affairs Division.

At this point I would like to submit our full statement for the record and make a brief summary of that statement.

The CHAIRMAN. You may do so.

(The statement referred to follows:)

**STATEMENT OF BERNARD J. SHANNON, O.D., AMERICAN OPTOMETRIC ASSOCIATION**

**INTRODUCTION**

Mr. Chairman and members of the Committee, it is gratifying to have this opportunity to present the views of the American Optometric Association on the emerging National Health Insurance concept.

I am Doctor B. J. Shannon, a practicing optometrist in Mauston, Wisconsin, and a Trustee of the American Optometric Association. A biographical sketch is attached to this statement. The American Optometric Association is a federation of fifty-one affiliated optometric societies chartered in the fifty States and the District of Columbia. Total membership in the organization is at an all time high of 16,680. There are some 18,300 optometrists actively engaged in full time practice in the Nation today.

**GENERAL STATEMENT OF AOA POSITION**

The membership of the American Optometric Association believes that your Committee and the entire Congress will, in careful deliberation, determine whether or not a National Health Insurance system is the best possible method of meeting the pressing needs of America's 206-million citizens. If, in the wisdom of the Congress, such a system is to come into being, the profession of optometry wants to assume its proper share of responsibility in the planning and delivery of essential health care services—including optometric vision care—under whatever system emerges.

It is our hope to place on record today the importance of professional vision care as a primary element in legislation to establish a system of National Health Insurance.

## BASIC TENETS OF OPTOMETRY'S POSITION

The American Optometric Association could support any program of National Health Insurance, regardless of its name, embodying a number of underlying principles, including the following:

1. Comprehensive optometric vision care must be recognized as a primary health care service demanding high priority as a major element in community health. Any such plan must make provision for the availability of the full scope of optometric services for persons of all ages and socio-economic groups, consistent with the scope of optometric licensing and practice in each jurisdiction.

2. Any national health insurance plan must allow for full utilization of the optometrist in solo practice, group optometric practice, or multi-disciplinary delivery systems as a primary point of entry into the health care system.

3. The plan must be financially sound and fiscally responsible from the standpoint of fairness to the Nation, to those whose contributions support the system, to beneficiaries, and to all health care practitioners whose services are to be provided. The system must provide for adequate management controls and represent total fiscal responsibility as outlined under "Methods of Financing" and related sections on methods of payment and efficiency of delivery systems, elsewhere in this statement.

4. The highest possible standards of quality health care must be assured under any National Health Insurance system. Major among these standards (although not limited to those enumerated) are:

(a) Strong, active and adequate representation of consumers and each participating health care discipline at the planning level in formulating delivery systems;

(b) Monitoring of whatever system evolves, through the mechanism of true peer review wherein the services provided by any health care professional are reviewed for efficacy and fairness by another health care professional of the same discipline and professional standards as the practitioner whose professional standards, ethical performance and procedures are to be reviewed;

(c) Maintenance of the professional integrity of the individual practitioner while working as an independent provider of services in an interdependent health care delivery system, with proper guarantees against interference in the practitioner's chosen mode of clinical practice;

(d) Assurance that the National Health Insurance system enacted provides health care services at least equal in scope and quality to those services presently being supplied under existing Federally funded health care programs. Because the long range goal of optometry's support for a National Health Insurance program is total vision care for all segments of the population, any regression or retrenchment of current programs would represent a violation of the intent of this legislation.

5. The plan must provide assurance that every beneficiary shall be protected from abridgment of his inherent right to exercise his free choice of practitioner and, insofar as possible, his free choice of the setting in which such care is rendered.

## THE NEED FOR A COMPREHENSIVE PROGRAM

All supporters and sponsors of legislation to create a system of National Health Insurance have expressed their concern that the program should incorporate the best available features of a preventive or "health maintenance" concept as well as provision for catastrophic care and extended care for the chronically afflicted. The American Optometric Association agrees with this position. It is unlikely that any system legislatively created now may form the basis of all social/health programs for the next quarter-century, just as the Social Security program itself has been the major mechanism since the mid-1930's. This likelihood makes it imperative that every basic health service—including optometric vision care—be included now, at the outset, to assure full utilization of delivery of vital services to all Americans today and in the years ahead.

In a recent Public Health Survey study of vision defects in various age groups, it was shown that approximately 95% of all individuals over the age of 60 years require some type of visual correction for optimum visual function; 82% of those aged 50-60 experienced some type of visual deficiency; 71% of those aged 40-50 were victims of visual defects; those in the 30-40 age group were affected to the extent of 48% of all studied; 39% of all persons in the 20-30 age bracket

had some type of vision defect; and that some type of visual deficiency was present in 23% of the population under age 20.

The report concluded that about 43% of the entire population or about 50% of all non-institutionalized individuals over age 3 have corrective lenses of some type.<sup>1</sup>

The concept of functional vision encompasses the total visual system, from entrance of light through the cornea to interpretation of the image by the brain. Functional vision is a basic element in the learning process, in maintaining and expanding national productivity, and in providing satisfactory later years for our elderly. The following information attempts to delineate these relationships.

#### VISION CARE AND LEARNING

Vision screening and examination of pre-school aged children would provide detection of vision problems and allow prevention of learning disabilities before a child enters first grade. Such an approach, when followed up by periodic examinations throughout the school years, can pay tremendous dividends. Among these potential dividends are those related to the psychology of success and the bolstering of a child's self-image, to the degree that he is capable of effectively and comfortably performing tasks associated with study.

Obviously, the ability to function at a level closer to one's own mental capacity will reap satisfaction and a very real sense of achievement. Because 80 percent or more of the learning process is directly related to functional vision, it is clear that professional care of functional vision must be viewed as an essential element in any program which is designed to be comprehensive with respect to types of care provided and the age groups to be included as beneficiaries.

When he announced his "Right to Read" program, President Nixon referred to the fact that an estimated 10-million children of school age are affected by learning disabilities associated with impaired vision. This is probably a conservative figure, in that HEW 1968 statistics show that 41% of all the Nation's 81,200,000 children under age 18 can be expected to have some type of visual problem.<sup>2</sup>

Whether a child's vision problem is a simple refractive error, a developmental or functional vision problem, or some type of congenital or organic disease, his ability to learn will be impaired.

In an article, "Eye Findings in Children with Reading Difficulties," it is estimated that one child in four among the 4-million entering the first grade each year has some difficulty in learning to read. 99% of those who fail first grade and 90% of those who fail second grade do so because of reading difficulties.<sup>3</sup>

In addition to the psychological scars traceable to a child's sense of failure when he has to repeat a grade in school, there is a large and direct dollar cost to society for extra classroom space, additional faculty, and general supportive services necessary for operation of the Nation's schools. In a publication describing the new National Reading Center, issued by the office of the President in July, 1970, the annual costs incurred as a result of repeaters in grade and high schools is estimated at \$1,700,000,000.

#### SCHOOL DROPOUTS

According to the latest U.S. Office of Education analysis, 24.1% of the young people who should have been graduated from high school in the 1968-69 class had dropped out before completing the 12th grade:<sup>4</sup>

The July, 1970 publication describing the new National Reading Center, issued by the Executive Office of the President, stated that all of the 700,000 youngsters who drop out of school each year are two to three years behind their age group in reading skills.

The child who cannot see material placed on a blackboard or whose near-point visual function is impaired in such a manner that he cannot clearly and comfortably see reading material at the usual 12 to 20-inch distance at his desk, is obviously working at a great disadvantage. Too often, this inability to see well leads to failure in the classroom, dropping out of school, and subsequent anti-social behavior.

<sup>1</sup> "Vital and Health Statistics," Series 10, No. 53, USPHS, June 1969.

<sup>2</sup> "Vital and Health Statistics," Series 10, No. 46, USPHS.

<sup>3</sup> Robert V. Shearer, M.D., *Journal of Pediatric Ophthalmology*, Volume 3, No. 4.

<sup>4</sup> "Digest of Educational Statistics, 1970," Division of Statistical Information and Studies, National Center for Educational Statistics, U.S. Office of Education.

## JUVENILE DELINQUENCY AND CRIME

F. R. Hilbert, Chief Psychologist at Sing Sing Prison in New York stated: "The White House Conference on Juvenile Delinquency bears out various prison studies of my own. Up to 80% of the delinquents and semi-delinquents studied by the Conference had learning difficulties, specifically in reading—and poor vision was found to be a contributing factor in 50 percent of these cases."<sup>5</sup>

Working with a faculty member from the University of Chattanooga, Tennessee, in 1965, Dr. David Dzik, an optometrist, examined 125 children whose cases of juvenile delinquency had been processed by the Hamilton County Juvenile Court in that city. A report of the findings states that 95% of those examined failed the reading and comprehension tests. In another group of 111 delinquent children tested in 1967, over 70% of them failed one or more of the vision screening tests, and 90% of them were from one to seven grades below their actual grade placement in school insofar as reading ability was concerned. This suggests a strong correlation between impaired vision and juvenile delinquency.

The cost to society of delinquent or criminal acts by young people is high, especially in terms of direct dollar outlays for apprehension, detention, prosecution, and rehabilitation. Such behavior is also costly in terms of the disruptive effect on the lives of the families of these young people. The involvement of young people in crime is especially tragic when it is realized that many of them might have progressed in a normal manner and made a positive contribution to society if they had been provided adequate vision care.

## RELATIONSHIP OF POVERTY AND VISUAL DISORDERS

The direct dollar cost of uncorrected visual problems is almost impossible to determine because the effects of such conditions make themselves felt in so many ways at so many levels of society, and in every activity undertaken by humans.

The condition of poverty, much like the condition of uncorrected visual problems, affects practically every type of activity in the Nation.

In terms of education, children from poverty-stricken inner-city ghettos who most desperately need every kind of help available, are the most often neglected, especially in terms of health care.

The fact that children from lower income families receive less vision care is indicated in a survey conducted by the National Center for Health Statistics. It showed that of the families with less than \$4,000 annual income, between 8.7 percent and 8.8 percent visited an optometrist in the survey year. The incidence of optometric visits was 10.1 percent in the \$7,000 to \$9,999 bracket, and 12.0 percent in the \$10,000 or over income group. Furthermore, the proportion of white persons who had optometric visits (9.2%) was almost twice as great as that for non-white persons (5.3%).<sup>6</sup>

A Department of Labor Manpower Administration Urban Employment Survey, reported in a news release dated February 20, 1969, showed that workers living in slum areas have an unemployment rate two and one half times higher than the national average. The study was conducted by the Bureau of Census and directed by the Bureau of Labor Statistics.

In a 1968 report, the National Center for Health Statistics concluded: "Even though the measure of income used in the Health Interview Survey is the combined family income, it is reasonable to assume that, at least in families where the major breadwinner is visually impaired, the impairment itself is probably a factor contributing to the low income."<sup>7</sup>

Testimony presented before a special New York Department of Health hearing on vision care in Medicaid, Alden N. Haffner, O.D., Ph. D., Executive Director of the Optometric Center of New York, stated: "From the standpoint of his health—as with many other aspects of his human needs—the person from the low income family is disadvantaged. Adequate evidence exists to detail that that person and that family have higher incidence of disability and disease than exhibited by the more socially advantaged family. Visual disability is no exception. Columbia University's Professor Charlotte Muller, a highly respected health researcher, found visual disability more than 400 percent higher in the poor family than in the

<sup>5</sup> *Family Weekly*, August 30, 1964.

<sup>6</sup> See endnote No. 1.

<sup>7</sup> See endnote No. 2.

family with an income of more than \$7,000. The irony of the situation and the melancholy truth are that the poor need more and better care, of all types, and call ill afford it. . . ."

William C. Richardson, an instructor in hospital administration at the Graduate School of Business, University of Chicago, reported that activity-limiting chronic visual impairments are eight times as prevalent among individuals with annual family incomes below \$2,000 compared with those from families with annual incomes of \$7,000 or more.<sup>8</sup>

The shortages of health manpower in economically deprived urban areas is one of the many factors resulting in the unavailability of care. Practitioners of all types, upon discovering that a given geographical area cannot or will not support a practice, have a very strong economic incentive to abandon the area. The alarming increase in crime in the central cities has further contributed to the exodus of health care practitioners as well as business men of all types. In addition, extremely high insurance rates for offices and businesses located in the inner cities have provided a further impetus for health care practitioners to locate elsewhere. As more providers of health care leave the inner city, the availability and quality of care deteriorates even more, and the cycle reinforces and repeats itself.

There are hopeful signs in correction of this problem, but the process must be given greater impetus, greater emphasis, and additional assistance by the professions and by government.

Some of the encouraging aspects are: creation of neighborhood comprehensive health care centers, establishment of group practices which can operate as a "core" facility in a manner similar to a neighborhood health center and establishment of clinics or centers of given disciplines specifically designed to deliver care to the economically disadvantaged through utilization of voluntary manpower in both lay and professional positions with a minimum of paid professional personnel.

The possibility of obtaining more health manpower, particularly for non-white ghettos, is also typified by the fact that many health professions are now embarking on recruitment of non-white students for education in the various disciplines. Some schools of the health professions have combined with their minority recruitment efforts a reduction of entrance requirements with remedial programs to bring the first-year student up to the level of the more stringent entrance requirements. Hopefully, those recruited from minority groups will share the concern of the professions and establish their practices in locations where they may serve their own ethnic groups.

The profession of optometry has made a firm commitment to design and carry out an effective minority recruitment program. The American Optometric Association passed a resolution to this effect, and a fully-staffed, full-scale effort is now underway.<sup>9</sup>

Federal legislation proposed during the 92nd Congress also takes cognizance of the problem, and would provide forgiveness of direct Federal student loans or Federal repayment of outstanding student loans at graduation, for a new practitioner who agrees to engage in practice in a geographical area determined by the Surgeon General to be critically short in the particular type of services the graduate can offer.

#### VISION CARE AND NATIONAL PRODUCTIVITY

Good vision as a major health resource is of special importance to the safety and productivity of employees in industry. Studies conducted by a wide range of firms of different types over the years show that uncorrected vision problems among workers account for a large share of waste and spoilage of raw materials.

A report to the American Engineering Council revealed that 10,195 of the 16,581 workers examined in four different types of major industry had vision defects.<sup>10</sup> A similar study of 11,000 of its employees conducted by Pullman Company and reported in 1956 showed that 58% had defective vision.

That efficient vision reduces the number of accidents in industry is shown in the comparison drawn by Allis Chalmers Manufacturing Company between a

<sup>8</sup> *Hospitals, Journal of the American Hospital Association*, July 1969.

<sup>9</sup> Minutes, Interim Board Meeting, Board of Trustees, American Optometric Association, March 21-24, 1971, p. 17.

<sup>10</sup> Earle B. Fowler, Ph. D., "Waste in Industry," paper presented to the American Engineering Council, 1956.

control group of employees who were known to have vision defects and were not wearing corrective prescriptions and another group of the same size who were provided with corrective prescriptions. The 282 workers who received prescription eyeglasses recorded 22.8 fewer injuries the year following receipt of glasses than during the previous year. Selecting 77 pairs of individuals with the same age, experience, and occupation from among their employees, it was found that those in the "corrected" group had a record of 19.7% fewer accidents in a given year, compared with 19.4% more accidents during the same period among the "uncorrected" group.<sup>11</sup>

A study of waste and rejects in a tap and die company, conducted by Bausch and Lomb, Inc., showed the employees who failed to meet the basic vision screening standards averaged spoilage in the amount of \$79 each in a three-month period, while the same number of employees who met the screening standards averaged only \$6 spoilage during the same three-month period. The amount by those who met the screening standards was 92% lower than the spoilage of raw materials by those who did not meet the standards.<sup>12</sup>

The above are but a few examples of the effects of impaired vision on industrial productivity. It is clear that efficient vision on the job has a direct bearing on the efficiency of the worker. The savings of industry in preservation of raw materials, in decreased health care costs for employees, and the preservation of life and limb of workers in industry combine to make good vision one of the most desirable, if not the single most important health factor in industry today.

It has been gratifying to note the recent progress toward implementation of the Occupational Safety and Health Act of 1970, whose enactment was endorsed by the American Optometric Association. This legislation provides for a number of vision-related program areas in addition to the vital and long recognized need for protective eyewear.

#### REHABILITATION OF THE PARTIALLY SIGHTED

Enhancement of residual vision is one of the most important types of professional service a vision care practitioner can provide to the individual who is partially sighted. This is accomplished through the utilization of special devices to maximize residual vision to the highest possible level.

While many definitions of "low vision" exist among various Federal and State agencies and among different health disciplines, the most generally accepted definition would include severe visual impairments which produce some limitation of activity, through the category of "legally blind" (generally accepted to be a Snellen chart notation of 20/200 in the better eye with optimum available correction) and down to the category of "totally blind," with the latter term indicating absolutely no light perception.

The Director of Research at the American Center for Research in Blindness and Rehabilitation has concluded that the most meaningful figure indicating the prevalence of low vision is probably that of the National Center for Health Statistics, used in its National Health Survey, and which is defined as "severe visual impairments" for purposes of that study. This figure is 1,227,000 persons with severe visual impairments indicates the extent of the problem.<sup>13</sup>

The visual rehabilitation of individuals with severe visual impairments can have profoundly favorable effects on society generally. To mention but a few: the ability of school-age children to read and to learn; the restoration of a degree of functional vision sufficient to permit an individual to engage in some type of gainful employment; or the enhancement of visual function in the elderly population to the extent that such individuals may be able to care for themselves and assist others in their own age group to a better life.

Each of the examples cited has a very direct relationship to the condition of society today. Poor visual performance by children can lead to under-achievement in school, dropouts, and delinquency; reduced vision among those normally in the employable age group of 17 to 64 years of age can result in low productivity, costly on-the-job accidents, and unemployability; and severe visual impairments in the elderly population increase the possibility that our citizens

<sup>11</sup> *American Machinist*, April 12, 1953.

<sup>12</sup> Case histories and company names available on request from Bausch and Lomb, Inc., Rochester, New York.

<sup>13</sup> Leo Riley, M.D., "Low Vision Statistics," *Journal of the American Optometric Association*, May 1969.

aged 65 and over are denied much of the enjoyment of the life they worked for so many years to earn. Each such situation has a direct dollar cost to the individual, the family, or to society generally, besides having wide-ranging societal impact in terms of personal misery and dependence upon others (individuals or government) for financial and other types of assistance.

Studies at the Industrial Home for Blind in Brooklyn, New York, the Maryland Workshop for the Blind, the Chicago Lighthouse, and other low-vision centers have demonstrated that even among legally blind patients, some 70% of them can be successfully aided. Donald Korb, O.D., Chairman of the American Optometric Association Committee on Aid to the Partially Sighted, estimates that as few as 10% of all who could benefit from professionally prescribed optical low-vision aids and related procedures are actually not receiving such services from any source. Yet, various types of optical aids and procedures are readily available from professional eye care practitioners, in the form of microscopic and telescopic lenses and other highly specialized prescriptions. To identify those who are victims of severe visual impairments and to make professional services and the necessary optical aids available to them are two of the largest challenges facing the vision care field, educators, industry, welfare agencies, and State and Federal governments. Continued failure to bring all available scientific knowledge and expertise to bear on problems of the partially sighted represents a callous disregard for the loss of human potential.

#### VISION NEEDS OF THE ELDERLY

Nearly 100% of all individuals age 65 and over need professional care to alleviate visual deficiencies. The National Center for Health Statistics recently released several studies on changes in visual acuity, showing the almost universal affliction of visual problems in the population group over the age of 65 and that adequate professional care and management could result in restoration of near-normal levels of vision among an overwhelming majority of persons so afflicted.

Although optometric vision care is readily available in some 5,428 cities and towns of all sizes in the United States, only negligible financial assistance for vision care is available to the elderly through health care programs partially financed with public funds. Consequently, only 19.8% of the 65-and-over age group receive vision care of any kind in any one year. By anyone's standard, the frequency of examination indicated is far below the recommended minimum level of care, which should be no less than one complete visual examination every two years. This surely must be considered a major unmet need which any National Health Insurance program should cover.

An older individual who suffers a severe impairment or loss of vision frequently becomes a problem to himself and to others with whose lives his is intertwined. A limitation of mobility is one of the first noticeable effects when a person realizes he is unable to see well. This is almost certain to bring about an onset of another type of problem.

When mobility is restricted, an aging person soon withdraws from active participation in civic and social affairs. This has unfortunate consequences, for the knowledge and skills acquired by the aging person in a lifetime of productivity are soon lost to society.

By contrast, aging individuals who seek and obtain proper visual corrections in time to ameliorate the effects of poor vision can and do make further contributions to society. Many undertake the learning of new skills in fields which had previously been avocations or hobbies. The restoration of retention of adequate visual skills permits the aging patient to take part in such activities as watching television, engaging in absorbing hobbies or crafts, or taking part in such community-based activities as participation in "adopted grandparents" programs or others designed to utilize the inherent or learned skills and abilities possessed by our older citizens. Most such activities are precluded when an older person is unable to see well enough to take an active part.

Over 20-million individuals among the general population today are aged 65 or over. The number increases by some 820 persons everyday, as a result of better all-around health care and greater longevity. While study after study has shown that persons over age 65 consider regular visual examinations to be one of the most wanted benefits of health care programs, provision of routine vision care remains one of the most neglected areas of care for the elderly. This is readily explained by the fact that Medicare and other Federal and State programs for

the most part consider "economically catastrophic" care to be more important than the preventive care typified by regular professional visual examinations.

However, available studies indicate that the need for catastrophic care could be reduced by regular visual care. Ray Over, Ph.D., reported in the December 1966 issue of *The Gerontologist* that 85 percent of all serious injuries resulting from accidents experienced by persons aged 65 or over are caused by falls, and that fully  $\frac{1}{4}$  of such falls are considered attributable to impairments to the visual system. The reduction of the need for catastrophic care which could be achieved simply by improving the visual performance of elderly persons is obvious. It is entirely possible, in fact, that the relatively small cost of preventive visual care would be more than offset by the savings effected in avoidance of emergency care.

The reduction of accidents involving the elderly is only one aspect in the overall requirement for better vision care for the aging. Manifestations of systemic disease are readily observable by professional examination of the eye and its related structures. Among these are diabetes, brain tumor, and certain cardiovascular conditions. Glaucoma and other organic conditions in the ocular system are also detected in the course of a full professional visual examination, often providing an opportunity to arrest or correct such conditions before permanent or irreversible damage is done to the ocular system.

The consistency of optometry's record of detecting disease and referring patients to other health care practitioners for appropriate medical, surgical, or other treatment is a source of pride for all optometrists. As early as 1960, a study revealed that an estimated 818,360 patients were referred annually by optometrists to other health specialists. The major share of these (53.7%) were to ophthalmologists; 32.8 were sent to general medical practitioners, and 3.3% were referred to dentists.<sup>14</sup>

The prescription and application of contact lenses as prosthentic devices replacing the human lens of the eye which has been removed during cataract surgery is another important function today's professional eye practitioners can and do provide. The contact lens, a device which has undergone rapid changes and improvements over the past few years, is a most effective means of restoring visual function to an eye from which the natural lens has been removed.

Any condition which affects such a large segment of the population in all age groups is certain to manifest itself in a variety of ways closely related to the general health of the public and the economic well being of the Nation. Therefore, the correction of visual disorders must be viewed as a primary health care need requiring high priority in the National Health Insurance system.

In addition to the attempt to provide the Congress with this overview of vision care as it affects American life in general and why it must be a primary health need of the American people, we also alluded to some other facts at the beginning of our statement which we feel are important concerns the Congress must address itself to if it should develop a program of National Health Insurance.

Among these elements are the principles of the methods of payment to providers of health services; the use of optometry as a primary point of entry; the financial soundness and fiscal responsibility of a program; the relationship of any National Health Insurance program to the Health Manpower needs of America; and the health education of the American public.

At this point in our statement, we would like to enumerate these principles as we view them.

#### METHODS OF PAYMENT TO PROVIDERS OF HEALTH SERVICES

Renumeration of health care practitioners providing services under any system of National Health Insurance which may be adopted should be adequate, equitable, and sufficiently flexible to be made consistent with the various modes of delivery which might be utilized in the program.

Payment for services might be based on negotiated fees consistent with the usual and customary fees for the services of each discipline. One alternative is a fixed-fee schedule or relative value scale agreed to upon consultation between

<sup>14</sup> Galen F. Kintner, O.D., "Optometry's Role in Health Maintenance—A Study of Referrals," presented to the Medical Care Section, American Public Health Association, November 2, 1969.

representatives of the respective professions and appropriate negotiating bodies of the Federal Government, either on a Nationwide scale or regionally. Another alternative is the capitation system proposed in the Senate and House bills supported by the Committee of 100.

An outstanding prepaid vision care mechanism, Vision Institute of America (VIA) is available as a fiscal intermediary or as a contractual supplier to a fiscal intermediary in the event a National Health Insurance plan is adopted and requires the use of a third party payment system. VIA has six years of actuarial and administrative experience in prepaid vision plans, and would be readily adaptable to requirements of a National Health Insurance program. The VIA plan would also provide a ready-made peer review mechanism for the services of optometrists.

The American Optometric Association pledges its cooperation in helping to develop suitable systems of payment which would be fair to all parties and within the previously stated parameters of financial soundness and fiscal responsibility.

#### OPTOMETRY AS A PRIMARY POINT OF ENTRY

The American Optometric Association believes that by virtue of educational background and qualifications, optometrists must be utilized as primary points of entry into any system of National Health Insurance for the patient.

The optometrists' professional education and the Code of Ethics to which he subscribes impose a requirement that he refer to other appropriate health care practitioners any patient whose eyes, upon examination, exhibit signs of ocular pathology or systemic disease.

This capability to detect disease is well recognized by the Federal government. In fact, Secretary Elliot Richardson, in his September 11, 1970 report to the Congress on the Health Professions Educational Assistance Act stated:

"Although the primary service performed by most practicing optometrists is the provision of eye examinations and visual analyses, optometrists are trained to detect any departure from the optimally healthy eye. The scope of optometric services has expanded beyond basic clinical refractions, fabricating and dispensing eye wear; now included are visual screening examinations, clinical instrumentation, contact-lens fitting, visual training, orthoptics, low-vision aids for the partially sighted, artificial eyes, industrial vision-consultation, and public and community health. The most rapidly expanding area of service is in school consultation and remedial services for low achievers. The optometrist is trained and bound by professional ethics to refer patients in whom indications of disease have been found to a physician or other health practitioner for definitive diagnosis and appropriate medical, surgical, or other treatment."

#### FINANCIAL SOUNDNESS AND FISCAL RESPONSIBILITY

Earlier in this statement, reference was made to the need for a program which is both financially sound and fiscally responsible. The American Optometric Association believes that to be financially sound, any National Health Insurance system must be built upon a foundation of good principles whereby financing comes from all segments of society, for the ultimate good of the entire socio-economic system and all the individuals who benefit from a National Health Insurance plan.

Regardless of the eventual determination made by the Congress as to what portion of the program costs will be paid by individuals, what portion by employers, and what portion of the total should come from general funds of the Federal government, the American Optometric Association believes that the system should be actuarially sound to the extent that we, as a Nation, do not mortgage the financial resources of future generations for the sole purpose of solving today's health care problems. With respect to the term "fiscally responsible," we believe a National Health Insurance system can be so characterized only if responsible fiscal management is applied at every level and that maximum health services will be delivered at the lowest cost consistent with high quality care.

Several suggestions have been advanced by legislators, by various health leaders, and by labor organizations, which lead us to believe that a very close look must be taken as to the most practical approach to implementing a National Health Insurance system. Recommendations from both public and private sectors

must be taken into account in determining whether and how the system should begin and develop. In any case, no individual or group of individuals should be subjected to a reduction in either the level of services nor the quality of services delivered under Federally funded or Federally assisted programs currently in operation. The principles inherent in the term "fiscal responsibility" also require the institution of fair and accurate methods of reviewing utilization and providing sufficient administrative authority to allow shifts in emphasis which such utilization and review show to be necessary.

#### MANPOWER NEEDS AND THE NATIONAL HEALTH INSURANCE PROGRAM

Implementation of a National Health Insurance program will, without question, generate a further crisis in the available supply of health manpower. Any plan undertaken must take into account—both from the standpoint of funding and operation—the need for continuing or increased support of educational institutions which produce primary health care professionals and ancillary personnel.

It has been projected in recently concluded health manpower hearings before the House and Senate Health Subcommittees during extension of the Health Professions Educational Assistance Act that an 11,000-man shortage of optometrists exists in the Nation today and that with projected population increases, the shortage will be 23,000 by 1980.

With an increased program of health care as envisioned by the type of legislation you are considering, the Congress must be cognizant of the shortages which now exist and which would be further aggravated upon activation of the new system. We recommend that provisions be made for increasing the numbers of health care practitioners, and that regardless of the system adopted, every health care professional should be utilized at his highest level of skills.

Under the Health Professions Educational Assistance Act, Federal grants are available to schools of medicine, dentistry, osteopathy, podiatry, pharmacy, veterinary medicine and optometry to aid them in the education of more health professionals to meet the manpower requirements for the Nation. Grants are in the form of construction monies, institutional support, student loans and scholarships.

Commensurate with the awarding of these grants to assist the schools there has been a requirement that student enrollment be increased. That is, in order to qualify for the various grants, the schools and colleges must increase enrollment each year by either 5% or five students, whichever represents the greater number.

Schools and colleges of optometry have increased their total enrollment from 1,754 attending 10 institutions in the academic year 1965-66 (the first year optometry was eligible for the grants) to 2,821 in eleven institutions during the 1970-71 academic year. Schools and colleges of optometry have faithfully lived up to the enrollment increase requirement in order to make more optometric manpower available. (See Attachment "A" for enrollment figures 1964-65 through [projected] 1974-75)

1971 amendments to the Health Professions Educational Assistance Act will require even greater enrollment increases for the grant monies, in a further attempt to alleviate the shortages.

If a comprehensive health care system is adopted, we respectfully bring to the Committee's attention that such a program will require even more health manpower and that certain additional support for schools and colleges must be considered when these institutions attempt to meet the increased demand for graduates.

In the case of optometric schools and colleges, the task will be formidable, indeed, just from the standpoint of projected enrollment increases required to qualify for grant monies. The addition of a comprehensive system which will raise an even more serious manpower problem is a factor which must be given careful attention by the Congress in its consideration of legislation of this type.

#### HEALTH EDUCATION OF THE PUBLIC

To make any program of National Health Insurance achieve its full potential, beneficiaries must be made aware of the services available. More importantly, they must be educated to the concept of using preventive health care services as a means of avoiding costly, painful or debilitating catastrophic care at a later date.

Programs of public health education are encouraged by the American Optometric Association, which in 1959 adopted as one of its eight major organizational objectives the following:

"Increase the public awareness of the needs for, the benefit from, and the full scope of optometric care."

We urge that provision be made in any National Health Insurance legislation to support continuing, broad-based health education programs designed to reach every American who may now or later require services authorized under the program.

#### CONCLUSIONS

The current series of hearings represents an attempt to obtain a body of salient facts which will assist you in determining the best possible system of providing and delivering high quality health services to all Americans regardless of age, race, sex or socioeconomic standing.

In virtually the same manner, the American Optometric Association has devoted a great deal of time and energy to consideration of these basic principles and has recommended to you those elements the association feels must be a part of any system established for delivery of comprehensive health services. We hope that our comments here today shall have been of value to you in making sound judgments regarding the desirability of creating a National Health Insurance system and the need for inclusion of optometric vision care as a primary element in any system adopted.

As indicated, based upon educational experience, optometrists are qualified practitioners of eye care and should represent a primary point of entry into any system of National Health Insurance for the benefit of the beneficiary. Also, due to the favorable distribution of optometric manpower which shows that optometrists practice in 5,428 cities and towns in the United States, it certainly is incumbent upon all to realize the availability of this existing manpower resource to be utilized in National Health Insurance.

The American Optometric Association will welcome the opportunity to assist the Congress in any appropriate manner regarding National Health Insurance legislation.

I would like to thank you for providing me the opportunity to bring the Committee our thinking on this important subject at this time. I will be pleased to answer any questions you, the Committee, may have.

ATTACHMENT "A".—STUDENT ENROLLMENT AND GRADUATES IN COLLEGES OF OPTOMETRY: ACADEMIC YEAR 1964-65 THROUGH 1969-70, WITH PROJECTIONS TO 1974-75

Academic year	Students					
	Total	1st year	2d year	3d year	4th year	Graduates
All colleges:						
1964-65	1,547	593	503	381	70	377
1965-66	1,745	643	574	460	68	413
1966-67	1,882	669	577	533	103	481
1967-68	1,962	646	617	558	141	477
1968-69	2,203	771	590	591	251	441
1969-70	2,488	786	728	578	396	445
1970-71	2,821	879	718	694	530	530
1971-72	3,093	886	797	723	687	687
1972-73	3,209	900	801	792	716	715
1973-74	3,366	964	839	796	767	765
1974-75	3,542	1,044	897	910	791	790

Dr. SHANNON. The membership of the American Optometric Association believes that your committee and the entire Congress will, in careful deliberation, determine whether or not a national health insurance system is the best possible method of meeting the pressing needs of America's 206 million citizens. If such a system is to come into being, the profession of optometry wants to assume its proper share of responsibility in the planning and delivery of essential health care services, including optometric vision care.

It is our hope to place on the record today the importance of professional vision care as a primary element in legislation to establish a system of national health insurance.

#### BASIC TENETS OF OPTOMETRY'S POSITION

The American Optometric Association could support any program of national health insurance, regardless of its name, embodying a number of underlying principles, including the following:

1. Comprehensive optometric vision care must be recognized as a primary health care service demanding high priority as a major element in community health. Any such plan must make provision for the availability of the full scope of optometric services for persons of all ages and socioeconomic groups.

2. Any national health insurance plan must allow for full utilization of the optometrist in solo practice, group optometric practice, or multidisciplinary delivery systems as a primary point of entry into the health care system.

3. The plan must be financially sound and fiscally responsible from the standpoint of fairness to the Nation, to those whose contributions support the system, to beneficiaries and to all health care practitioners whose services are to be provided.

4. The highest possible standards of quality health care must be assured under any national health insurance system. Major among these standards are:

(a) Strong, active, and adequate representation of consumers and each participating health care discipline at the planning level in formulating delivery systems;

(b) Monitoring of whatever system evolves, through the mechanism of true peer review wherein the services provided by any health care professional are reviewed for efficacy and fairness by another health care professional of the same discipline and professional standards as the practitioner whose professional standards, ethical performance and procedures are to be reviewed;

(c) Maintenance of the professional integrity of the individual practitioner while working as an independent provider of services in an interdependent health care delivery system, with proper guarantees against interference in the practitioner's chosen mode of clinical practice;

(d) Assurance that the national health insurance system enacted provides health care services at least equal in scope and quality to those services presently being supplied under existing federally funded health care programs. Because the long-range goal of optometry's support for a national health insurance program is total vision care for all segments of the population, any regression or retrenchment of current programs would represent a violation of the intent of this legislation.

5. The plan must provide assurance that every beneficiary shall be protested from abridgement of his inherent right to exercise his free choice of practitioner and the setting in which care is rendered.

## THE NEED FOR A COMPREHENSIVE PROGRAM

Most supporters and sponsors of legislation to create a system of national health insurance have expressed their concern that the program be comprehensive and should incorporate the best available features of a preventive or "health maintenance" concept as well as provision for catastrophic care and extended care for the chronically afflicted. The American Optometric Association agrees with this position.

In a recent Public Health Service survey study of vision defects in various age groups, it was shown that approximately 95 percent of all individuals over the age of 60 years require some type of visual correction for optimum visual function. At the other end of the age spectrum, some type of visual deficiency was present in 23 percent of the population under age 20. A significant part of these problems relate to the visually functional inability of the patient to perform in his environment. The social implications of these problems for all age levels is most important.

The concept of functional vision encompasses the total system, from entrance of light through the cornea to interpretation of the image by the brain. Functional vision is a basic element in the learning process, in maintaining and expanding national productivity, and in providing satisfactory later years for our elderly.

## VISION CARE AND LEARNING

Vision screening and examination of preschool-aged children would provide detection of vision problems and allow prevention of learning disabilities before a child enters first grade. Such an approach, when followed up by periodic examinations throughout the school years, can pay tremendous dividends.

Because 80 percent or more of the learning process is directly related to functional vision, it is clear that professional care of functional vision must be viewed as an essential element in any program which is designed to be comprehensive with respect to types of care provided and the age groups to be included as beneficiaries.

Whether a child's vision problem is a simple refractive error, a developmental or functional vision problem, or some type of congenital or organic disease, his ability to learn will be impaired.

## SCHOOL DROPOUTS

The July 1970 publication describing the new National Reading Center, issued by the Executive Office of the President, stated that all of the 700,000 youngsters who drop out of school each year are 2 to 3 years behind their age group in reading skills.

The child who cannot see material placed on a blackboard, or whose near-point visual function is impaired in such a manner that he cannot clearly and comfortably see reading material at the usual 12- to 20-inch distance at his desk, is obviously working at a great disadvantage. Too often this inability to see well leads to failure in the classroom, dropping out of school, and subsequent antisocial behavior.

## JUVENILE DELINQUENCY AND CRIME

F. R. Hilbert, chief psychologist at Sing Sing Prison in New York, stated:

The White House Conference on Juvenile Delinquency bears out various prison studies of my own. Up to 80 percent of the delinquents and semidelinquents studied by the Conference had learning difficulties, specifically in reading, and poor vision was found to be a contributing factor in 50 percent of these cases.

The cost to society of delinquent or criminal acts by young people is high, especially in terms of direct dollar outlays for apprehension, detention, prosecution, and rehabilitation.

## RELATIONSHIP OF POVERTY AND VISUAL DISORDERS

The condition of poverty, much like the condition of uncorrected visual problems, affects practically every type of activity in the Nation. In terms of education, children from poverty-stricken inner-city ghettos who most desperately need every kind of help available, are the most often neglected, especially in terms of health care.

That children from lower income families receive less vision care is indicated in a survey conducted by the National Center for Health Statistics. It showed that of the families with less than \$4,000 annual income, between 8.7 and 9 percent visited an optometrist in the survey year. The incidence of optometric visits was 12 percent in the \$10,000-or-over income group.

## VISION CARE AND NATIONAL PRODUCTIVITY

Good vision as a major health resource is of special importance to the safety and productivity of employees in industry. Studies conducted by a wide range of firms of different types over the years show that uncorrected vision problems among workers account for a large share of waste and spoilage of raw materials.

It has been gratifying to note the recent progress toward implementation of the Occupational Safety and Health Act of 1970, whose enactment was endorsed by the American Optometric Association. This legislation provides for a number of vision-related program areas, in addition to the vital and long-recognized need for protective eyewear.

## REHABILITATION OF THE PARTIALLY SIGHTED

Enhancement of residual vision is one of the most important types of professional service a vision-care practitioner can provide to the individual who is partially sighted. This is accomplished through the utilization of special devices to maximize residual vision to the highest possible level.

## VISION NEEDS OF THE ELDERLY

Nearly 100 percent of all individuals age 65 and over need professional care to alleviate visual deficiencies.

Although optometric vision care is readily available in some 5,428 cities and towns of all sizes in the United States, only negligible

financial assistance for vision care is available to the elderly through health care programs partially financed with public funds. Consequently, only 19.8 percent of the 65-and-over group receive vision care of any kind in any one year. By anyone's standard, the frequency of examination indicated is far below the recommended minimum level of care, which should be no less than one complete visual examination every 2 years. This surely must be considered a major unmet need which any national health insurance program should cover.

#### METHODS OF PAYMENT TO PROVIDERS OF HEALTH SERVICES

Remuneration of health care practitioners providing services under any system of national health insurance which may be adopted should be adequate, equitable, and sufficiently flexible to be made consistent with the various modes of delivery which might be utilized in the program.

Payment for services might be based on negotiated fees consistent with the usual and customary fees for the services of each discipline. One alternative is a fixed-fee schedule or relative value scale agreed to upon consultation between representatives of the respective professions and appropriate negotiating bodies of the Federal Government, either on a nationwide scale or regionally. Another alternative is the capitation system proposed in the Senate and House bills supported by the committee of 100.

#### OPTOMETRY AS A PRIMARY POINT OF ENTRY

The American Optometric Association believes that by virtue of educational background and qualifications, optometrists must be utilized as primary points of entry into any system of national health insurance for the patient.

The optometrist's professional education and the code of ethics to which he subscribes, impose a requirement that he refer to other appropriate health care practitioners any patient whose eyes, upon examination, exhibit signs of ocular pathology or systemic disease.

This capability to detect disease is well recognized by the Federal Government. In fact, Secretary Elliot Richardson, in his September 11, 1970, report to the Congress on the Health Professions Educational Assistance Act, stated:

Although the primary service performed by most practicing optometrists is the provision of eye examination and visual analyses, optometrists are trained to detect any departure from the optimally health eye. The optometrist is trained and bound by professional ethics to refer patients in whom indications of disease have been found to a physician or other health practitioner for definitive diagnosis and appropriate medical, surgical, or other treatment.

#### FINANCIAL SOUNDNESS AND FISCAL RESPONSIBILITY

Earlier in this statement, reference was made to the need for a program which is both financially sound and fiscally responsible.

Regardless of the eventual determination made by the Congress as to what portion of the program costs will be paid by individuals, what portion by employers, and what portion of the total should come from

general funds of the Federal Government, the American Optometric Association believes that the system should be actuarially sound to the extent that we as a Nation do not mortgage the financial resources of future generations for the sole purpose of solving today's health care problems.

With respect to the term "fiscally responsible," we believe a national health insurance system can be so characterized only if responsible fiscal management is applied at every level, and that maximum health services will be delivered at the lowest cost consistent with high quality care.

#### MANPOWER NEEDS AND THE NATIONAL INSURANCE PROGRAM

Implementation of a national health insurance program will, without question, generate a further crisis in the available supply of health manpower. Any plan must take into account both from the standpoint of operations and funding the need for continuing or increased support of educational institutions which produce primary health care professionals and ancillary personnel. An 11,000-man shortage of optometrists exists in the Nation today, and that with projected population increases, the shortage will be 23,000 by 1980.

With an increased program of health care as envisioned by the type of legislation you are considering, the Congress must be cognizant of the shortages which now exist and which would be further aggravated upon activation of the proposed system. We recommend that provisions be made for increasing the numbers of health care practitioners, and that every health care professional should be utilized at his highest level of skills.

Under the Health Professions Educational Assistance Act, Federal grants are available to schools of medicine, dentistry, osteopathy, podiatry, pharmacy, veterinary medicine, and optometry to aid them in the education of more health professionals to meet the manpower requirements for the Nation. Grants are in the form of construction moneys, institutional support, student loans, and scholarships.

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#### HEALTH EDUCATION OF THE PUBLIC

To make any program of national health insurance achieve its full potential, beneficiaries must be educated to the concept of using preventive health care services as a means of avoiding costly, painful, or debilitating catastrophic care at a later date.

#### CONCLUSIONS

The American Optometric Association has devoted a great deal of time and energy to consideration to these basic principles and has recommended to you those elements the association feels must be a part

of any system established for delivery of comprehensive health services. We hope that our comments here today shall have been of value to you in making sound judgments regarding the desirability of creating a national health insurance system and the need for inclusion of optometric vision care as a primary element in any system adopted.

As indicated, based upon educational experience, optometrists are qualified practitioners of eye care and should represent a primary point of entry into any system of national health insurance for the benefit of the beneficiary. Also, due to the favorable distribution of optometric manpower which shows that optometrists practice in 5,428 cities and towns in the United States, it certainly is incumbent upon all to realize the availability of this existing manpower resource to be utilized in national health insurance.

The American Optometric Association will welcome the opportunity to assist the Congress in any appropriate manner regarding national health insurance legislation.

I would like to thank you for providing me the opportunity to bring this committee our thinking on this important subject at this time. I will be pleased to answer any questions you, the committee, may have.

Mr. ULLMAN (presiding). Thank you, Dr. Shannon. I want to thank you for doing a very excellent job in summarizing your paper.

Are there questions?

Mr. Waggonner?

Mr. WAGGONNER. This is not intended in any way to be an unfriendly question, Dr. Shannon, but at the outset you referred to several instances to essential health care services with relation to optometrists. For the record, this poses some sort of question in the minds of some. Can you tell me exactly how you would define the health care services that your profession could supply or does supply?

I am differentiating, let me say, between vision care and health care.

Dr. SHANNON. We feel that vision care is an essential part of health care as we hope we related in our statement. Maybe I can just try to summarize briefly an answer to your question.

The broad responsibility of the optometrist upon seeing his patient is to determine any related visual health problems. Very often we see in my practice people coming into the office who are basically healthy people. During the case history or parts of the examination we determine that the patient is not healthy.

There are many kinds of physical problems, general systemic problems which result. At that point the patient is referred either for care or if it is a visual type of problem the optometrist handles, he goes on. The type of service the optometrist renders is very broad, all the way from consulting with industry, working with nursing homes, doing visual rehabilitation in various kinds of cases, contact lens work, children's work, reestablishing proper visual functions for children and sometimes adults who never really learn to see because vision is really a learned process and sometimes it is not learned and many optometrists' time is involved in that activity, so the activity of the optometrist with his patients is very, very broad, much beyond the reputation we have perhaps of being frames and lenses type of people.

That is really a very small part of the total profession of optometry.

Mr. WAGGONNER. There was a television show on WTOP last night

which you may or may not have seen. This program went into some detail concerning a situation which they describe as existing within the District of Columbia with respect to eye examinations by optometrists and ophthalmologists.

One of the features of the program was an experiment conducted by a WTOP newsman in which he went to a dozen or so optometrists and described in some detail the classic symptoms of a disease of the eye.

In view of what you have just said and in view of what optometrists have said through the years, as I recall, not a one of those consulted—of the optometrists consulted—referred the newsman to an ophthalmologist. That might be expected. In fact, the truth of the matter is some of the optometrists consulted failed to make an inquiry into the complaints after the disease was described.

Could you comment on that?

Dr. SHANNON. I am not from the District. I did hear a brief comment there was such a program. I have not seen it.

Mr. LAVANTY. This involves a tremendous amount of exposure to another piece of legislation that we have been working on for years in the District of Columbia Committee of this House to upgrade the District of Columbia licensing law which has been in existence since 1924 and has not been amended since that date.

Problems of continuing education as related to the District of Columbia practitioners in a corporate setting, which involves another area of concern, have been aired before the District of Columbia Committee and again we have a bill introduced in this Congress to try to update the practice of optometry.

I do not think you will find this situation existing in other areas of the country.

Mr. WAGGONER. Are you saying the standards are higher over the country?

Mr. LAVANTY. I don't think there is any comparison with the District of Columbia.

Mr. WAGGONER. You don't believe this is happening over the rest of the country?

Mr. LAVANTY. We have statistics on record showing the amount of referrals optometrists make to ophthalmologists or to other practitioners if there is a brain tumor, diabetes, or anything else, and we would be happy to supply those statistics for the record.

Mr. WAGGONER. Would you do that please.

(The statistics referred to follow:)

The following figures represent a survey done for the American Public Health Association on the amount of referrals optometrists have made to physicians and other health practitioners. This study was done for the APHA for presentation to the medical section on November 2, 1960. The results are as follows:

There were 18,500 optometrists in active practice at the time and they saw some 37,368,000 patients;

Of these, 818,360 patients were formally referred to other types of health services;

Of all formal referrals, 86.55% were made to some branch of medicine;

53.7% made to ophthalmologists and 32.8% to general practitioners.

Thus, in the year: 439,460 patients were referred to ophthalmologists; 271,622 patients were referred to general practitioners; 26,990 patients were referred to dental surgeons.

Mr. ULLMAN. We appreciate your bringing to the attention of the committee, Dr. Shannon, a matter to which I feel we must give

very serious consideration in putting together a national health insurance program.

Thank you again.

Dr. SHANNON. Thank you.

Mr. ULLMAN. Our next witness is Dr. Stuart Bondurant, vice president, American Heart Association.

Doctor, if you will further identify yourself and your colleague, we would be very happy to recognize you.

**STATEMENT OF DR. STUART BONDURANT, VICE PRESIDENT, AMERICAN HEART ASSOCIATION; ACCOMPANIED BY DR. EZRA LANDIN, ASSISTANT MEDICAL DIRECTOR**

Dr. BONDURANT. Thank you, Mr. Chairman and members of the committee.

I am vice president of the American Heart Association. Accompanying me is Dr. Ezra Landin, assistant medical director of the American Heart Association.

Mr. ULLMAN. We are happy to have you, too, sir. You are recognized.

Dr. BONDURANT. I am appearing today in behalf of the American Heart Association, a national voluntary health organization with 55 affiliates and some 89,000 professional and laymen members throughout the United States.

At this point, Mr. Chairman, I wonder if I might ask that the record show the testimony as actually given. We have made some minor changes in the sequence and some of the phraseology and if that would be possible, it would be very helpful to us.

Mr. ULLMAN. You would like to have the whole testimony appear as if read?

Dr. BONDURANT. That is right.

Mr. ULLMAN. Without objection, that procedure will be followed and you may proceed as you see fit.

Dr. BONDURANT. The American Heart Association deeply appreciates the opportunity the committee has extended to it to relate the proposed national health insurance program to our activities.

The sole purpose of the American Heart Association is to improve the health care of our Nation with respect to the diseases of the heart and blood vessels. Our programs are often closely coordinated with those of the National Heart and Lung Institute and other Federal and State agencies. We are proud of our 25 years of accomplishments in research, education, and community aid.

Nonetheless, diseases of the heart and blood vessels remain the largest national killer and we are convinced that a national health insurance program must provide special resources dedicated to prevention and treatment of these diseases if it is to be effective in reducing the awesome mortality.

Let me briefly describe the scope of the cardiovascular disease problem. The cardiovascular diseases are the Nation's biggest health menace. They account for more than a million deaths in the United States each year. Thus they are responsible for about 54 percent of our total annual death toll.

The heart and blood vessel diseases take the lives of more Americans each year than cancer, pneumonia, accidents, and all other causes of death combined.

Heart attack is the biggest single U.S. killer, taking more than 670,000 lives in the latest annual count. Stroke is third, after cancer, accounting for more than 211,000 in the latest year.

Moreover, it is believed that 13 percent of our population, or approximately 27 million Americans, are afflicted with one or more of the cardiovascular diseases.

Included are at least 21 million Americans with high blood pressure, one of the diseases that sets the stage for both heart attack and stroke and one disease whose treatment is now known to be effective in many population groups.

There are about  $3\frac{3}{4}$  million Americans who have coronary heart disease.

There are more than  $1\frac{1}{2}$  million who have rheumatic heart disease.

There are  $1\frac{1}{2}$  million other Americans who have survived strokes or who are stroke-prone.

To cite the number of victims is to state only a part—although a formidable part—of the heart-and-blood-vessel disease problem.

Another part of the problem is the cost of these diseases.

The heart-and-blood-vessel diseases cost the Nation \$17.3 billion annually, including lost income and payment for medical care. In addition, they cost the Nation's businesses about 52 million man-days of production each year, a drain on the gross national product that can only be a speculation.

And there are dozens of hidden costs such as losses in management skills, losses in production know-how; losses in training and development, and losses in labor replacement and transferral.

We in the American Heart Association do not believe that our Nation can afford such costs or should sustain them. Moreover, we believe that these costs can be cut sharply by gaining better control over the diseases causing this devastation. This is our major objective. Despite our progress of the past two decades, we are still confronted with a terrible disease problem—and more than a million deaths a year.

One of the major reasons why this is so is that too many Americans are not being exposed to the benefits that medical science has developed for them.

Let me explain that with a few more figures:

Of the 21 million victims of high blood pressure in the United States—already mentioned—one-half do not even suspect they have this often "silent" and often dangerous disease, forerunner of heart attack and stroke.

Of the 670,000 Americans who die of heart attack each year—also mentioned previously—and this included recently professional football players and football coaches—almost half never even get to a hospital for help.

If they did—and if all of our key hospitals had as much coronary care equipment and as many trained operating teams as they need—we estimate that about 50,000 lives could be saved each year.

A broad research program coordinated with the Heart and Lung Institute has produced important advances in the detection, diagnosis and treatment of the diseases of the heart and blood vessels.

For the cardiovascular patient, especially the 13 million with hypertension who are unaware of their condition, earliest diagnosis is often essential.

We already have multiphasic screening centers that can perform tests to determine high blood pressure and high blood cholesterol and other simple tests quickly, cheaply and with a minimum of manpower.

We have more sophisticated equipment to perform more complicated diagnostic tests, such as high-speed X-rays of the blood vessels of the heart and of techniques for measuring the flow of blood to the brain in patients with strokes, to name just two.

For treatment of the cardiovascular patient, we have many well-equipped coronary care and intensive care units designed to recognize sudden, unexpected changes in a patient's heart function and to bring a specially-trained medical team to his bedside in seconds with emergency resuscitation equipment.

We have developed drugs to help high blood pressure patients, anti-clotting drugs to help prevent life-threatening venous blockage, and surgical procedures to correct inborn and acute structural defects, procedures that were the vaguest dreams only 20 years ago.

In some sections of the country, we have rehabilitation clinics to aid stroke victims, and heart-load capacity-testing centers for the benefit of post-heart attack victims.

In the area of the prevention of the heart-and-blood-vessel diseases, we have been able to describe some of the factors that appear to contribute to heart attack, and to suggest programs designed to reduce the risk of suffering an attack.

And, at the same time, we have developed screening programs to help detect the cardiac-prone.

We have been able to describe the usual or most frequent symptoms of heart attack so that the average person—even if he isn't aware that he is at risk—can recognize them and attempt to avert severe organic damage by getting medical help at once.

And we have also been able to describe a set of symptoms that indicates the possibility of stroke and singles out persons who should have immediate medical examinations so that they can be benefited—perhaps even saved from a serious cerebral incident—by early therapy or surgery.

These and many other facilities, procedures and therapeutic aids—including even clinics to help the cigarette-addicted to break their habit—are available to help reduce the mortality and morbidity toll among heart-and-blood-vessel disease victims.

There is need for more such help, to be sure. But of prime importance here and now is this:

There are too many Americans who, for many reasons, don't have access even to the facilities we already have or which could be constructed.

There are too many who, in the face of rising costs, just can't afford to have periodic heart examinations or to take tests, valuable though they may be to a healthier life.

There are those who live in areas that actually are without testing facilities—and some even without doctors for routine examinations.

There are others who, quite simply, are victims of an expensive fallacious philosophy of treating disease instead of preventing disease—who reluctantly, and sometimes only as a last resort, seek out a physician to combat a stubborn ailment, but who are actually not aware that the physician often can help to prevent the disease as well as to cure it.

I feel sure you will agree that there is much that we are now able to do to gain more control over the heart and blood vessel diseases.

We have much of the ability, the “know-how,” the techniques. One of our problems is to get them to the patients—or more accurately, to make it possible for the patients to have access to our growing expertise.

We are not yet delivering to our potential heart disease victims—and to those who already have significant early symptoms that have not been recognized—the full measure of health care of which we are capable.

The American Heart Association, therefore, feels strongly that it must present its case in behalf of the cardiac patient—both for today and for tomorrow.

Since diseases of the heart and blood vessels are the leading cause of death in the United States, and since the American Heart Association is dedicated to improved prevention and treatment of these diseases, it follows that Heart Association programs will necessarily interact with the health-care delivery system of the United States.

To that end, we feel that health legislation, including health insurance, must respond to the needs of the 27 million Americans who are afflicted with cardiovascular disease, and must attempt to extend prevention of needless and untimely deaths.

Before attempting to draft legislation to correct the conditions I have been describing, it seems to us that the basic problems, the major deficiencies in health care, must be singled out and identified first.

I might mention here that a special committee has been appointed by the American Heart Association to review the shortcomings considered particularly relevant to patents with cardiovascular disease.

This committee identified a number of such shortcomings and we have chosen to express them in general terms although the intent is to indicate that each of these shortcomings applies specifically to the cardiovascular patient as well as to the broad field of health care delivery.

The first point is that medical care, and particularly cardiovascular care, is insufficient for large numbers of people in the United States, particularly for the poor and near poor, in urban areas and for many rural sectors.

This assertion is substantiated particularly in the field of cardiovascular disease.

This is due in part to a lack of medical manpower and, as well, to a poor distribution of medical personnel and to lack of adequate facilities.

Only a beginning has been made to train and use ancillary professionals to multiply the effectiveness of physicians.

The health care system is traditionally geared to curing the ill and not sufficiently equipped to protecting the healthy through the application of preventive medicine.

Health-care costs have increased much faster than the rate of inflation, due—at least in part—to inappropriate use of resources such as the practice of encouraging hospital admission for cases that could be handled less expensively on an out-patient basis.

Because there have been few innovative programs instituted for delivering comprehensive health care, for too many in the Nation, even the barest of medical services are often inaccessible.

The American Heart Association believes that a national health insurance program can and should help to correct some of these deficiencies, and we approve of such an approach.

We shall not attempt to comment on the individual bills which have been introduced thus far.

But we can say that any national health insurance program that will rectify at least some of the shortcomings I have singled out must satisfy the following general principles, which are stated in general terms although each one applies specifically to that large group of patients who have cardiovascular disease:

Adequate health care should be available readily to all Americans at all economic levels and in all geographic areas;

High priority must be given to providing care for the poor, the near-poor and the aged;

Parallel provisions must be made to assure an expanded and more evenly distributed system of health care, including broader use of preventive medicine.

Because of the need to insure a coherent system for health care delivery, impediments to coherence such as laws restricting group practice, should be removed.

Facilities must be adequate so that every American is enabled to exercise his personal initiative and responsibility for guarding and improving his own health.

The plan must provide personnel, resources, and organization designed to cope with the Nation's great killer diseases: heart disease, cancer, and stroke.

Any health insurance system should provide a voice for both, the consumer and the provider in establishing priorities.

Means for restricting further cost increases should be built into the system through rigid cost accounting and coupled with objective analysis of the benefits derived from each element of the system in order that continuing modifications of the system can be based on a cost effective consideration at least in part.

Finally, the health insurance should include provision for continued funding to assure a sufficient core of clinical faculty at teaching hospitals and physicians in advanced stages of training to cope with the complicated and serious diseases that are our Nation's great killers.

In this connection I would comment, consistent with the thinking of the American Heart Association, that even if every bit of available knowledge that we have today concerning cardiovascular disease were fully and effectively applied to every single person with heart disease in the Nation, we would be left with a residual mortality that would be so great that it would be unacceptable.

The only way this situation can be improved is by the generation of additional information or understanding concerning heart disease and this is another way of saying we need more information and therefore we need more research.

It would be a mistake to assert that improvements in the health care delivery system will solve the problem of mortality due to cardiovascular disease unless based on further extension of our information derived from continuing and expanded research programs.

We must continue to provide funding for the training of ancillary health personnel and for improved administration of elements of the health care delivery system.

Also for continuing evaluation of the full effectiveness of health insurance program particularly as it moves in the direction of developing preventive techniques.

We hope that the data and views we are providing today will be useful to you and will be considered in preparation with new legislation.

I would be happy to try to answer any questions related to this presentation.

We thank you for your attention and your interest.

(Dr. Bondurant's prepared statement follows:)

#### STATEMENT OF DR. STUART BONDURANT, AMERICAN HEART ASSOCIATION

I am Dr. Stuart Bondurant, Professor and Chairman of Medicine at Albany (N.Y.) Medical College. I am appearing in behalf of the American Heart Association, a national voluntary health organization with 55 affiliates and some 80,000 professional and laymen members throughout the United States.

The American Heart Association deeply appreciates the opportunity the Committee has extended to it to relate the proposed National Health Insurance program to our activities. We are attempting, through research, education and community aids, to help control heart and blood vessel diseases and to prevent untimely deaths from the two leading cardiovascular killers, heart attack and stroke.

Let me briefly describe the scope of the cardiovascular diseases problem. These diseases are the nation's biggest health menace. They account for more than a million deaths in the United States each year. Thus, they are responsible for about 54 percent of our total annual death toll.

Stated another way, the heart and blood vessel diseases take the lives of more Americans each year than cancer, pneumonia, accidents and all other causes of death combined.

Heart attack is the biggest single U.S. killer, taking more than 670,000 lives in the latest annual count. Stroke is third, after cancer, accounting for more than 211,000 in the latest year.

Moreover, it is believed that no fewer than 27 million Americans are afflicted with one or more of the cardiovascular diseases. That is more than 13% of our population.

Included are at least 21 million Americans with high blood pressure, one of the diseases that sets the stage for both heart attack and stroke.

There are about 3¼ million Americans who have coronary heart disease.

There are more than 1½ million who have rheumatic heart disease.

There are 1½ million other Americans who have survived strokes or who are stroke-prone.

To cite the number of victims is to state only a part—although a formidable part—of the heart-and-blood vessel disease problem.

Another part of the problem is the cost of these diseases.

The heart and blood vessel diseases cost the nation \$17.3 billion annually, including lost income and payment for medical care. In addition, they cost the nation's businesses about 52 million man-days of production each year, a drain on the Gross National Product that can only be a speculation. And there are dozens of hidden costs such as losses in management skills, losses in production

"know-how"; losses in training and development, and losses in labor replacement and transferral.

We in the American Heart Association do not believe that our nation, despite its ranking in the world, can afford such costs or should sustain them. Moreover, we believe that these costs can be cut sharply by gaining better control over the diseases causing this devastation. This is our major objective. In the past two decades we have made enormous progress toward our goals.

But despite great, life-saving gains which I shall detail later, we are still confronted with a horrifying disease problem—and more than a million deaths a year.

If you were to ask me to single out the one major reason, among many contributory reasons, why this is so, I would have to say that too many Americans are not being exposed to the benefits that medical science has developed for them. Let me explain that with a few more figures:

Of the 21 million victims of high blood pressure in the U.S.—already mentioned—one-half do not even suspect they have this often "silent" and often dangerous disease, forerunner of heart attack and stroke.

Of the 670 thousand Americans who die of heart attack each year—also mentioned above—almost half never even get to a hospital for help.

If they did—and if all of our key hospitals had as much coronary care equipment and as many trained operating teams as they need—we estimate that about 50 thousand lives could be saved each year.

For, as I have already suggested, we have made enormous progress. We have coped, with gratifying success, with the heart and blood vessel disease problem on the three classical levels—first diagnosis, second treatment, third prevention.

For the cardiovascular patient, especially the 13 million with hypertension who are unaware of their condition, earliest diagnosis is essential. We already have multiphasic screening centers that can perform tests to determine high blood pressure and high blood cholesterol quickly, cheaply and with a minimum of manpower. These are fairly simple tests. We have more sophisticated equipment to perform more complicated diagnostic tests, such as high-speed X-rays of the chambers of the heart and the mechanisms of the circulatory system, to name just a few.

For *treatment* of the cardiovascular patient, we have many well-equipped coronary care and intensive care units designed to recognize sudden, unexpected changes in a patient's heart function and to bring a specially-trained medical team to his bedside in mere seconds with emergency resuscitation equipment.

We have developed drugs to help high blood pressure patients, anti-clotting drugs to help prevent life-threatening venous blockage, and surgical procedures to correct inborn and acute structural defects. In some sections of the country, we have rehabilitation clinics to aid stroke victims, and heart-load capacity-testing centers for the benefit of post-heart attack victims.

In research, particularly, progress has been dramatic. Radioisotopes, ultrasound and other new techniques have opened new approaches to diagnosis. New drugs have begun to solve critical high blood pressure and blood-clot problems. Electronics have helped prevent or control often-fatal sudden irregularities in heart rhythms. And amazing developments in surgery have made it possible to achieve results that were the vaguest of dreams only 20 years ago.

In the area of the *prevention* of the heart and blood vessel diseases, we have been able to describe the factors that appears to contribute to heart attack, and to suggest programs to reduce the risk of suffering an attack. And, at the same time, we have developed screening programs to help detect the cardiac-prone.

We have been able to describe the usual or most frequent symptoms of heart attack so that the average person—even if he isn't aware that he is at risk—can recognize them and attempt to avert severe organic damage by getting medical help at once.

And we have also been able to describe a set of symptoms that indicates the possibility of stroke and singles out persons who should have immediate medical examinations so that they can be benefited—perhaps even saved from a serious cerebral incident—by early therapy or surgery.

These and many other facilities, procedures and therapeutic aids—including even clinics to help the cigarette-addicted to break their habit—are available to help reduce the mortality and morbidity toll among heart and blood vessel

disease victims. There is need for more such help, to be sure. But of prime importance here and now is this:

There are too many Americans who, for many reasons, don't have access even to the facilities we already have on hand.

There are too many who, in the face of rising costs—an increase of 170 percent in the health field in the past ten years—just can't afford to have periodic heart examinations or to take tests, valuable though they may be to a healthier life.

There are those who live in areas that actually are without testing facilities—and some even without doctors for routine examinations.

There are others who, quite simply, are victims of a fallacious philosophy of "disease care" instead of "health care"—who reluctantly, and sometimes only as a last resort, seek out a physician to combat a stubborn ailment, but who are actually not aware that the physician can help to prevent the disease as well as to cure it.

I feel sure you will agree that there is much that we are now able to do to gain more control over the heart and blood vessel diseases. We have the ability, the "know-how", the techniques. Our problem is to get them to the patients—or, more accurately, to make it possible for the patients to have access to our growing expertise.

Stated most bluntly, gentlemen, we are not yet delivering to our potential heart disease victims—and to those who already have significant early symptoms that have not been recognized—the full measure of health care of which we are capable.

The American Heart Association, therefore, feels strongly that it must present its case in behalf of the cardiac patient—both for today and for tomorrow. Since diseases of the heart and blood vessels are the leading cause of death in the United States, and since the American Heart Association is dedicated to improved prevention and treatment of these diseases, it follows that Heart Association programs will necessarily interact with the health-care delivery system of the United States.

To that end we feel that health legislation, including health insurance, must respond to the needs of the 27 million Americans who are afflicted by cardiovascular diseases, and must attempt to extend prevention of needless and untimely deaths.

Before attempting to draft legislation to correct the conditions I have been describing, it seems to us that the basic problems, the major deficiencies in health care, must be singled out and identified first. Here is a suggested list of deficiencies as many of us in the Heart Association have seen them during our recent years of experience in cardiovascular medicine:

1. Medical care is patently insufficient for large numbers of people in the United States, particularly for the poor and near-poor in urban areas, and for many rural sectors.

2. This is due to lack of medical manpower but, as well, to a poor distribution of medical and ancillary professional people and to lack of adequate facilities.

3. Only a beginning has been made to train and use ancillary professionals to relieve overburdened physicians of tasks that do not necessarily require their specialized skills.

4. The health care system is traditionally rigidly geared to curing the ill and not sufficiently equipped to protecting the healthy through the application of preventive medicine.

5. Health-care costs have increased much faster than the rate of inflation, due—at least in part—to the practice of encouraging hospital admission for cases that could be handled less expensively on an out-patient basis.

6. Both the government and private sectors have been too slow to recommend and institute innovative programs for delivering necessary health care with the result that, for too many in the nation, even the barest of medical services are inaccessible.

The American Heart Association believes that a national health insurance program can and should help to correct some of these deficiencies, and we approve of such an approach.

We shall not attempt to say which of the several bills introduced thus far are meritorious bills. To do so would be to exceed the authority that has been vested in the Association's study group whose views we are reflecting.

But I can say that any national health insurance program that will rectify at least some of the shortcomings I have singled out must be written with the following principles in mind:

1. Adequate health care should be available readily to all Americans at all economic levels and in all geographic areas. High priority must be given to providing care for the poor, the near-poor and the aged.

2. Parallel provisions must be made to assure an expanded and more evenly distributed system of health care, including broader use of preventive medicine.

3. Because it seems likely that broader recourse to group practice—either pre-paid or fee-for-service—will play a role in improved health care delivery, state laws banning or restricting such systems must be changed.

4. Facilities must be adequate so that every American is enabled to exercise his personal initiative and responsibility for guarding and improving his own health.

We do not feel qualified, either, to comment on the methods of financing a health insurance plan. We recognize that there are many causes competing for the taxpayer's dollar. At the same time, we believe that the cause of public health is crucial. We hope that the Congress will be generous initially, and that, as time changes its priorities, it will be able to place even greater emphasis on the concern for public health.

Further, we hope that:

1. Any health insurance system would provide a voice for both the consumer and the provider in establishing priorities, and

2. That means for restraining further cost increases would be built into the system through rigid cost accounting and through limiting patient admissions by increasing use of out-patient or ambulatory facilities.

Finally, it is essential that the cost of health insurance and of an improved delivery system not interfere with continued funding to assured a sufficient core of clinical faculty at teaching hospitals, continued growth of research in medicine—a vital source of teaching faculty. And we must continue to provide for increased funding for the training of ancillary health professionals, for the improvement of administration, and for continuing examination of the actual effectiveness of any health insurance program that is eventually devised.

We hope that the data and views we are providing today will be useful to you and will be considered in the preparation of new legislation.

I would be happy to try to answer any questions related to this presentation. Thank you for your attention and interest.

Mr. COLLIER. Just one question, Dr. Bondurant.

You cite inadequate delivery of medical care for persons afflicted with cardiovascular diseases even when there are early symptoms of disease which I presume would be readily detectable.

You cited a figure of 670,000 deaths due to heart attacks each year; is that correct?

Dr. BONDURANT. That is correct.

Mr. COLLIER. In light of the previous statement which I made and which you made, do you have any figures to indicate or to provide a breakdown of the number of victims of heart attacks in the age bracket under 35 years of age?

I ask that obviously because it is far more common later in life and even natural causes. I am just trying to find out how this figure would break down as related to the earlier symptoms which are neglected.

Dr. BONDURANT. The numbers are interesting, Congressman Collier.

Fourteen percent of all of the deaths are in the age group of 25 to 34. As I quickly add up the figures here, if my addition is correct, in the under-35 age group, to answer your question directly, there are 38 percent of the total deaths.

Mr. PETTIS. Would the gentleman yield?

Mr. COLLIER. Certainly.

Mr. PETTIS. How many of the 27 million Americans who have heart disease are in this category?

These have been diagnosed and you know about these.

Dr. BONDURANT. In the under-35 age group?

Mr. PETTIS. Yes.

Dr. BONDURANT. May I reinterpret the last part of your question?

Twenty-seven million Americans have not been diagnosed as having heart disease because the total population has not been surveyed, but from surveys of representative groups of the population and extrapolation of the incidence rates to the population at large, the number of 27 million is obtained.

The fact that we don't know exactly how many Americans have heart disease I think is an indication of the indictment of the system. We have to extrapolate because our people have not been examined for this purpose.

I do not have before me at the moment an age breakdown on the incidence figures, but we can certainly provide that for the record.

Mr. PETTIS. Thank you, and I thank the gentleman for yielding.

Mr. COLLIER. Finally, it would be safe to conclude, then, that if this care were available and early symptoms could be properly treated in this age bracket under 35, therein would lie the greatest area of extending life. I don't know how many of this figure would be in the category of victims beyond 65 where there would be less response to medical care in cardiovascular cases. While we certainly don't want to neglect those past that age, the emphasis would necessarily be in the younger age bracket where there could be a great deal more done in terms of the longevity of the victim?

Dr. BONDURANT. That is entirely correct. The usual breakdown on this is before age 65 and after age 65. I suppose the No. 1 mix depends on his age. There is no doubt that the answer to your question is an affirmative one—that is that the number of people in our working population and the number of people below age 35 who stand in need of added care and who would be substantially benefited by it, is a very substantial number.

Mr. COLLIER. Thank you very much.

Mr. BYRNES. Mr. Chairman?

Mr. ULLMAN. Mr. Byrnes.

Mr. BYRNES. You outlined some of the basic problems we have in the health-care area, and one of the things you have impressed on us the most is that the question of availability is part of the real crisis that we have.

I assume that it is probably more pronounced in the cardiovascular area than in others because of the need for specialists and special equipment and facilities.

The two points you make on page 10 emphasize this question of availability.

But how do you cope with that? In other words, you have, in geographic terms, disparities that are very big and heavy.

They exist between locations within a metropolitan area.

You have outlined what is a most serious problem and I think everybody has recognized it. I don't think I have seen a paper which does not call attention to that fact, but how do you correct it?

That is really what the committee is searching for in many of these areas. The problems in many cases are real and apparent, but the question remains: How do we handle them?

How do you get doctors to settle in Appalachia in greater numbers, for example?

Dr. BONDURANT. You have asked a very challenging question certainly and I would respond with respect to the cardiovascular considerations but I think these applied more broadly to the tremendous considerations that are confronting the committee.

Mr. BYRNES. If we could solve it for the cardiovascular area, the others would be easy, isn't that right?

Dr. BONDURANT. The Heart Association has spent a good deal of money and has marshaled a considerable amount of the Nation's cardiovascular brains to help determine what could be done about this and it has been involved in a variety of ways.

I would advance for the record now several of the concepts which have been developed as a result of these considerations within the American Heart Association. One fundamental one, I think, is recognizing the disparity in this Nation geographically and in a variety of other ways. The judgment of most people is that there is not a single solution to the problem of availability. We will have to design a system that is not replicated across the Nation in identical units—that, because of differences in population density, transportation systems and a variety of other things, there will need to be a variety of responses to this problem.

Among the elements that have been considered and many of which have been tested are, I am sure, entirely familiar to the committee. Included are such things as the use of allied health personnel in lieu of physicians in remote areas, improved two-way communications such as television systems to link the allied health personnel to centers.

Traveling physicians have not been entirely explored or exploited. Physicians may have their offices in remote places for several days a week.

Mr. BYRNES. The big point is, there are a lot of things you can do. I can show you some communities in northeastern Wisconsin where they will offer all kinds of incentives to get doctors to come and practice there. They will build the buildings for you, supply a good share of the equipment and everything else.

How do you get doctors for these areas? You talk about the traveling doctor. But can you really get doctors to live or travel in a rural area?

I am not complaining about the doctors. They want to live near the hospitals and other facilities in which they are performing their services. They and their wives want to have the various things that city life offers. It is easy to say we could meet rural medical needs with the traveling doctor, but how do you get doctors to do this work?

Dr. BONDURANT. Here I can reflect only a personal opinion. I doubt that we will ever be able to persuade a substantial number of the current medical students and young physicians in training to do this as solo individual positions or more pertinently perhaps, to take their wives into this kind of a life.

My own personal judgment is that a possible answer to this exists in having the physician a member of a group or a team in which he is not the only man who travels around, but he periodically serves this function. In other words, I despair of being able to recruit for the places in upstate New York, for example, where I have a personal responsibility for helping to fill exactly these needs.

I have failed in spite of very substantial efforts to induce the young physicians for whom I am responsible for training.

Mr. BYRNES. As part of developing an insurance program, one of the high responsibilities which we have is facing up to this matter of distribution. You tell the Ways and Means Committee, "You find the bill." Here is the challenge. I recognize that challenge. All I am trying to determine is how, within a Government program or within a program relating to health insurance, one can best cope with this distribution of medical services.

Mr. COLLIER. Would the gentleman yield for one comment?

Mr. BYRNES. I yield.

Mr. COLLIER. Have you had an opportunity to explore the program which now for nearly 2 decades has been in effect in the State of Illinois conducted by the Illinois Agricultural Association, which provides each year 10 medical full scholarships with the stipulation that the medical student upon completion of his medical training will practice in a rural area and "the rural area" is defined so there is no question that it is rural, for 5 years. In the event he does not, of course, he is required to pay the full amount of the stipends he received.

Perhaps this and the exploration in how this program has worked would be the best approach to providing the incentive to go into these areas with perhaps 7 years instead of the present 5 and because the cost of medical education is reaching a point of being virtually prohibitive, if this could be made a large program rather than when you take a vast institution like the University of Illinois and there are only 10 such scholarships, if this were done on a national basis and if it were one of the requirements of a full medical scholarship. This, it seems to me, demands some exploration and it would seem to me the medical profession has a responsibility to explore this and to give this some attention as a possible vehicle to solve this problem.

Dr. BONDURANT. To my knowledge there have been eight States in which such programs have been operational for at least 15 years. To my knowledge there is no evidence that these States, including Illinois, are any better off with respect to physicians in the isolated communities than are the States that have not had such programs.

A similar kind of program that has been tried in Kansas, Oklahoma, and several other States is a preceptor program of encouraging or requiring the student to go out and actually work in the community in the hopes this would attract him and make him more comfortable. The best analysis I know of shows it has had a negative effect on where the student chooses to practice.

There is a body of data available concerning the various efforts that people have made in various States. I think the answer is the one I am afraid I gave you in the first place, and that is no one has yet found a program of which I am aware that has satisfied the question that was put to me concerning the availability.

Mr. BYRNES. It is not just a question I am putting to you. You put it to the committee. You are experts, and this is one of the areas, I assume, you must be concerned about and your statement evidences it. For example, how do we make available to these people diagnostic services so they can tell they have heart problems? We have to get at that if we are going to save these lives.

I am really throwing the ball back to you and saying I am not an expert, have no expertise at all. The only study I have had is what I have had to face up to in the past year or so as this question has become more prominent.

What ideas do you have? That would be more helpful to us than telling us we have a problem. I know that and everybody on this committee knows it.

Dr. BONDURANT. We do have some ideas and the Heart Association has been doing some things about availability specifically. Part of the problem of availability, for example, concerns the level of insight of the potential patient, our citizens.

They need to know they need to seek medical care in order for them to appear and take advantage of availability. This is one of the most important ones particularly with respect to sudden death due to heart attacks. The major cause of people not getting to the hospital—the people who die suddenly before they get to the hospital with heart attack—is not that it takes too long to go in a car, but they decide too late to go.

Part of the availability is an educational program. We think that should be an important part of a national program.

A second part of availability has to do with the education of the professional or allied health or nonprofessional people who participate in the system. You can build a coronary care unit in a hospital by training the nurses and doctors in that community how to work the equipment.

One can thereby make available in a community using existing personnel, existing bricks and mortar and a few pieces of electronic equipment and elements of the system that was not there before. So, professional education is a part of the availability question.

The harder question is really the distribution of manpower. How do you move people around? As I say, I have no pat answers to this. I agree with the implication of an earlier question that the possibility of incentives has not been entirely exploited. I believe there are possible incentives that could be used to improve the distribution of manpower.

A second suggestion that I find attractive is that of a National Health Service Corps in which physicians might serve for a period of time after graduation from medical school. This is a concept that has been advanced and championed by a number of people and one which I think merits very serious consideration. It would be a global application of the suggestion that certain students might elect such service in response to such benefits.

Mr. BYRNES. Thank you.

The CHAIRMAN (presiding). Mr. Collier.

Mr. COLLIER. May I pursue that very briefly?

Recognizing that about 75 percent of all of our socioeconomic problems are caused by the inability of our society to disperse popula-

tion, we have to recognize until something can be done about that if it can be done, and I think there are areas where it cannot, that we still are faced with the problem. You said, if I understood you correctly, that in those areas where the type of incentive that I alluded to earlier were in effect, that it had a negative effect.

I don't think that we can come to that conclusion without recognizing, first of all, in a large school like the University of Illinois only such 10 scholarships were set up. You could not get very much impact from the 10 students a year in light of the number of its ratio to its total enrollment.

That, I think, is No. 1.

No. 2, I think in order to make a proper evaluation of the effectiveness or ineffectiveness of this approach, it would seem what could be done is to get from the Illinois Agricultural Association, since there are only 10 a year, the names of those who entered into this so-called rural incentive program and find out whether, in fact, they did remain in a rural area for 5 years or whether they became part of that community, as so often happens, and they remain there for a more permanent period, because in looking down the road, if we are to take the hopeless view that there is no way of providing incentives and you can't even do it by this type of program, then we are just spinning our wheels.

I don't think this type of program has been thoroughly worked. When we went into the 1958 National Defense Education Act when we had a shortage of teachers and we provided an incentive in the form of a forgiveness clause for loan programs, we wound up to what extent it had this effect, but we wound up with the situation where we now have a surplus of teachers.

I can't believe particularly as I said before because of the cost of medical education becoming more and more prohibitive that a broad program of this type would not be successful and, secondly, I think we can make this determination only by taking this very scant pilot program, and I guess that is what you would have to call, in Illinois and actually make an evaluation of actually what happened to these doctors who participated in this program.

Are they still in the rural area? How many went to the rural area? How many completed this 5-year rural practice requirement?

Then I think we can get an idea as to whether or not this program could be vastly expanded and maybe this would provide some answers since apparently there isn't any other program that has worked, as you point out.

Dr. BONDURANT. I think I may have misstated, or I would certainly like the record to show that I did not mean to say, that these programs had had a negative correlation. What I meant to say, and what I hope the record shows, is that the preceptorships which had been developed in Kansas, Oklahoma, and other places had had a negative effect. I am not aware of evidence that the programs of fiscal incentive have had a positive effect, but I agree with you entirely, and I did not mean to imply to the contrary, that I know of no evidence that they had a negative effect. If I left the other impression, it was quite incorrect.

I would think there would be need to have a further analysis done than looking at what happened to the students who took advantage of

this incentive in Illinois because you never know what those individuals would have done if they had not taken this incentive. In other words, they well could have been people who were going to go into this practice, whether there was an incentive or not.

There are certainly some such people. In order to be sure that the incentive is working, it would seem to me one would have to have some kind of a comparison group of more or less similar people in whom there was not the same incentive. Perhaps in Indiana or some other State one could see if a larger proportion was going into the direction that the incentive is leading than in a State where there was the incentive.

Mr. COLLIER. The fact that there was and is a void of professional medical personnel in these areas would, I think, to some degree refute any assumption that these particular students for whom these scholarships and stipends were earmarked with this stipulation would have gone into these areas. This could be determined easily enough by the place of origin of the student and, as I understand the program, these 10 were specifically reserved and four students, upon becoming doctors, would go into these areas.

I would not want to discount in this any manner by saying that they had intended to go there anyway. I think this would probably fly in the face of the particular situations because I have had over the years inquiries from young men who were not economically in a position to go to medical school but had to look for a means by which to do this, and this is one way that they were able to attend medical school.

I presume they subsequently fulfilled the obligation that went along with it. I think an evaluation at this point, as I said, of just how this program worked could at least provide some basis as to whether or not this might be one of perhaps several approaches that would be necessary to fulfill the voids in these areas where there isn't any doctor for miles around because it just stands to reason a young man finishing medical school wants to be close to the large clinic and he wants to be in an area where there is some guarantee of patients in the conduct of his practice.

He does not have this guarantee, as you know, when he goes into a rural community.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Brotzman.

Mr. BROTZMAN. Thank you, Mr. Chairman.

I have just a couple of short questions, Doctor. First of all, it is just coincidental, but last night I happened to read the brochure in the form of the little red pamphlet that the American Heart Association puts out, which I think is very good. I read it very carefully.

How widespread is the dissemination of this brochure? I don't think I have ever seen one before.

Dr. BONDURANT. One of the major efforts of the Heart Association is in designing and circulating these brochures. We use the 55 affiliates of the association scattered all over the United States, and major organizations in the major cities and States in the country to distribute them. They are distributed in doctors' offices, in schools, in public meetings and in every way that the imagination of the people and these affiliates can conceive of distributing them and which the

national office can conceive of suggesting to the affiliates that they distribute them.

The specific pamphlet that you refer to was printed in 19 million copies and has been distributed through all 55 affiliates of the Heart Association as well as it has been possible for us to do it.

Mr. BROZMAN. I just wanted to comment, I think if you could get this into the hands of everybody in this country and if they read that and followed it, I think it would have a marked effect upon the cardiovascular statistic.

My second question: Something that has always disturbed me and, of course, events of the last few days, I think, emphasize it, what causes a situation where an individual has just had a cardiovascular examination and then topples over with some kind of heart attack. We are talking about improving the delivery system, and I don't know how rare it is or what the incidence is, but I can remember several examples of this.

Of course, we just had the situation of the football player. Can you talk about that for a moment?

Dr. BONDURANT. I can give you some numbers that put this in broader perspective. During a 1-year period in the city of Baltimore, the cases of all of the people who toppled over dead or died suddenly were reviewed. It turned out that about 25 percent of them had been to their doctor within a week of when they dropped. This is not an isolated observation you have made of the person who drops dead, but of all of the people who dropped suddenly it appears about 25 percent of them had some clue that something was wrong that led them to seek attention.

The message here, it seems to me, is very clear. We are not smart enough to interpret their symptoms nor are our tests sufficiently precise to identify the ones who are going to drop dead within a period of a week as distinguished from the much larger number of people who come to physicians with very similar complaints and who don't drop dead within that period of time.

So this is one of the things I meant when I said in the formal testimony that if we exploited to the very limit our present knowledge and abilities, we would be left with an unacceptable mortality. We just are not smart enough to identify these people. There are no tests presently available that have been shown to be sufficiently sensitive or precise enough to measure the right thing to identify these people. So we have this problem.

Mr. BROZMAN. May I ask at that point, do you have any kind of a technique, a machine, a measurement device, via X-ray or something else that can test the consistency of the heart muscles?

Dr. BONDURANT. I am not sure what you mean.

Mr. BROZMAN. I am talking about its components. You hear about a person having a heart older than his years. Is there any way of measuring what kind of shape that muscle is in?

Dr. BONDURANT. The research of the last 20 years supported by both the American Heart Association and by what is now the National Heart and Lung Institute has developed what we have to characterize as elegant techniques even by the standards of the physical standards of physical scientists, who are used to it, to characterize the heart

muscles and the arteries that serve the heart. There are still answers these techniques don't give us, but they allow us to characterize the flow of the blood to the heart with very considerable precision, to document blockages in the blood to the muscles of the heart and to document failures of contraction of the heart, changes in the elasticity of the heart muscles in reference to your question concerning the consistency of the muscles and very specific kinds of changes in the performance of the muscles.

One of the problems with these studies is, first of all, they carry a small risk, half of a percent or some such figure as that, maybe even less. But they cost about \$500 apiece in terms of total cost, so this is not the kind of thing that one could consider doing to everybody.

Mr. PERRIS. If the gentleman would yield, considering all of this sophisticated equipment and the diagnostic ability of the profession, not just laymen violate basic rules of good health, but doctors of medicine are probably as guilty as the rest of the population in doing these things. They don't sleep enough or they don't get enough exercise or they eat the wrong things just about in the same way as the general population.

Isn't this true? If this is true, one of our big problems is not in better diagnosis, but in getting people to do what is best for themselves.

Dr. BONDURANT. The American Heart Association agrees deeply and on the basis of long experience with the point you have made. There are some examples in which the record of physicians is not so bad. I think physicians are entirely aware of tobacco consumption and cardiovascular disease and the number of physicians who smoke has fallen off substantially as a result of this.

If you look at the number of eggs eaten by doctors, it is not much different than the number of eggs eaten at a meeting of lawyers.

The CHAIRMAN. Are there any further questions? Mr. Karth.

Mr. KARTH. Doctor, when you talked during your presentation about educating the public—and educating the public ought to be one of the things that we deal with here when we deal with the national health insurance bill, and I guess we touched on it just briefly now by these last two questions—certainly you are not talking about making doctors out of the general public, so you must be talking about physical examinations. Are you suggesting the national health insurance bill involve a physical examination every year?

Dr. BONDURANT. No; what I had in mind were two kinds of education. One is education concerning the value and the availability of health care and a second kind of education is education concerning specific kinds of symptoms. This is an area of particular importance to the Heart Association.

As I mentioned, most of the people who die suddenly fail to get health care because they misinterpret their symptoms. They have something wrong, they know something is wrong, but they delay seeking medical care. Education involves when should you seek medical care, which is important.

Mr. KARTH. That is a pretty sophisticated education program; isn't it? He might also want to learn the symptoms of diabetes or any number of the other dreaded diseases, not only the cardiovascular diseases. If you are talking about that and if we write that kind of health care into this bill, it would mean we are trying to make quasi-doctors out of the general public. It is a big order.

DR. BONDURANT. It is a big order. The Heart Association debated long and hard before it got into this, and many of the knowledgeable physicians felt as your question suggests, that it was not possible to do this without either making doctors or without a little bit of knowledge being a dangerous thing and leading to more harm and consequence than good. Particularly in circulating another brochure which lists the warning symptoms of heart attacks and another which lists the warning symptoms of stroke, our experience has been it is possible to do this at least for some of the major situations of concern, and in particular the ones in which time is an important element.

There is a little more time, but not always to take care of the diabetic than there may be to take care of the patient with an acute heart attack. For that reason we think there could be elements of education at this level which could be given to many people and which could be useful.

I can say personally, from experience with the patients I take care of, I make very certain that my own patients who are at risk with heart disease know what the symptoms are and have made plans for what they are going to do if this happens, and that if a man falls over in a faint and does not have a pulse, the wife should bang him hard on the chest.

MR. KARTH. I don't know how we would write something like that into the bill.

I listened to the testimony you gave and I compliment you on it. It was obviously highly skilled, professional testimony. A question comes to my mind with respect to those things you suggest we put into a national health insurance bill. Certainly you must feel that one of the bills now before the committee comes closer to meeting that criteria you have elicited than any other.

Would you care to give us the benefit of your judgment as to which one of the bills it is?

DR. BONDURANT. The association specifically considered that it would be inappropriate for it to comment on this; that it would prefer not to comment on any one of the specific pieces of legislation.

MR. KARTH. Would you like to do it as an individual, sir?

DR. BONDURANT. I think I am not prepared to do that. I appreciate the opportunity, but I am not prepared to do it.

MR. KARTH. Thank you, Mr. Chairman.

THE CHAIRMAN. Are there any further questions? If not, again we thank you for bringing your testimony to the committee.

Is Dr. Harvey Webb, Jr., present? Dr. Webb, we are pleased to have you with us this morning and if you will identify yourself for the record, we will be glad to recognize you.

#### **STATEMENT OF DR. HARVEY WEBB, JR., CHAIRMAN, LEGISLATION COMMITTEE, NATIONAL DENTAL ASSOCIATION**

DR. WEBB. Thank you, Mr. Chairman, ladies and gentlemen of the committee:

I am Dr. Harvey Webb, Jr., chairman of the Legislation Committee of the National Dental Association.

The CHAIRMAN. I enjoyed meeting here with your group in the District and I will be interested in your testimony and you are recognized.

Dr. WEBB. Thank you, Mr. Chairman.

We are very encouraged by your remarks and we hope our testimony will indicate to you our concern for a national health insurance program.

The National Dental Association represents the more than 2,000 black dentists in the United States and its territories and possessions. This meager force is the primary dental care provider for the nearly 24 million black residents of this Nation.

Since its inception in 1918 the NDA has recognized and served the dental needs of black Americans and has struggled relentlessly to maintain high-quality service, integrity of character, and self-determination. Its members are represented in most of the 52 States and hold positions of leadership and respect in numerous aspects of community, State, and national endeavor.

We have as our goal the reduction of human suffering from dental disease, the education of the population regarding prevention of the ravages of dental disease, and the constant improvement and upgrading of our professional competence in cooperation with other health programs and agencies. As a national organization we are deeply concerned for the dental welfare of all Americans, especially the poor, the minorities, and those who fall between the designations of poverty and affluence, but have limited resources to purchase needed dental services.

Therefore, we are especially pleased and enthusiastically support the proposal and enactment of a national health program that will insure equal dental care for all Americans.

The NDA has long since recognized that while a ratio of one dentist to 2,000 people may be attainable in the white community, nothing short of a miracle can transform the current one black dentists to 10,000-12,000 black citizens into a realistic and workable ratio.

In a national health program we have hope that some positive change can occur to vastly increase black dental manpower to minister to the health needs of all Americans. This will possibly mean special planning to bring the number of professionals and paraprofessionals to a more equitable level. The black dentists have served on the rural frontier as well as in the ghettos and barrios of our Nation. They have served with little input as to how the Nation, States, and localities can better address themselves to solving the problems that overwhelm him and the communities where his services are rendered.

We view the requisites of an adequate national dental health program as making special dispensation and funding for a better dental manpower ratio and a more holistic approach to the delivery of dental service to minority populations and disadvantaged populations who have been cut off from the mainstream of adequate health care.

We feel these requisites fall into two major categories:

- I. Minimum elements of any national dental program;
- II. Area of special stress for minority communities:
  - (a) Manpower development of existing human resources,

- (b) Special support and planned redistribution of developing manpower,
- (c) Public policy and control.

#### MINIMUM ELEMENTS OF A NATIONAL DENTAL HEALTH PROGRAM

I am certain that the committee is currently aware that no health program can be considered complete without the inclusion of dentistry. And no dental program is comprehensive without key items of service and adequate funding. These essential services include:

1. Twenty-four-hour emergency dental service for all citizens through the incorporation of dental care services as a component of all health facilities.

2. Comprehensive dental health service with special emphasis on preventive measures and patient education in the urban ghetto communities and rural areas where ill health and ignorance thrive.

3. Complete and comprehensive dental care services that are a part of the basic health package essential to the general health of the total population.

4. A clearly identifiable dental budget reflecting the special health needs and enabling correction of past destruction of human tissues and organs. This budget should be approximately 10-15 percent of the total health dollar.

Let us project the idea that a national health insurance should fund an outreach capability which will aid the prevention objective.

#### AREAS OF SPECIAL STRESS

**Manpower and Development of Human Resources.** As previously indicated, the shortage of black dental professionals and paraprofessionals is critical and as overwhelming as the existence of dental disease. This not only affects the black community but the whole Nation. Because of cultural and language barriers and differences in utilization patterns it is imperative that black resources be developed and supported. Hence, direct and positive steps must be incorporated into any national health program that gives special emphasis to eliminating this problem. The NDA recommends that it be done through the following mechanisms:

1. Increase in the numbers of black dental professionals and allied health personnel through recruitment, financial support and economic incentives to return to underserved areas. This step is essential to overcoming the massive backlog of chronic dental disease in most minority and poor white ghetto and rural communities.

2. Special Federal grants for minority student assistance associated with appropriate curriculum development in schools which train dental personnel. This effort should be combined with plans to promote community involvement in the planning, decisionmaking and delivery of dental services to community residents.

3. The training of black and other minority persons for teaching, research, and administration as well as in the delivery of dental services. This should be accomplished with special remedial programs as are adequate to insure graduation of all minority persons entering training for the dental field, who show promise for development. It should

further provide for the development of challenge, proficiency, and equivalency examinations based on ability to perform dental tasks.

4. Elimination of dead-end jobs for the allied dental health personnel through the development of basic dental care curriculums as an entry into the profession. This core of health knowledge should be embellished to incorporate needed knowledge and skills to assure long-term development and career ladders and lattices in the dental profession.

5. Special training programs in dental schools, junior colleges, and other institutions of learning that will capitalize on the previous experience and training of black and minority veterans of the U.S. armed services so as to incorporate them as quickly as possible into the dental care delivery system. Further, that they and any newly trained allied personnel be taught extended and expanded functions in the delivery of dental services.

6. Special funds be made available to institutions significantly increasing the number of black and minority students in their student body.

#### PUBLIC POLICY AND CONTROL

As a matter of public concern, the Federal Government must maintain final responsibility for the development, perpetuation, and enforcement of public policy regarding a national health system. The guidelines it establishes should give significant consideration and credence to our stated national goals of health as a "right" to all our citizens.

A national health program should by policy include :

1. Black and minority consumer representation on all dental boards, committees, and councils at the city, county, State, and National levels. Together, the dental profession and the consumer should develop common guidelines of responsibility for the practitioner and the patient.

2. Review and enforcement mechanisms to prevent discrimination against any patient who is in need of care, if that discrimination be based on restriction of access due to race, creed, color, national origin, or ability to pay.

3. The elimination of current and future discriminatory practices within the total profession on the basis of race, color, creed, or national origin. The enforcement mechanism to prevent discrimination should be funded at a level high enough to insure compliance, and members of the National Dental Association should serve on all review boards and panels.

4. The expansion of Federal support for dental facilities, with stipulations attached to all Federal funds for the construction, renovation, and expansion of dental structures; that is, for teaching, service, and experimentation which make special provision for including black and minority persons as planners, contractors, students, teachers, and supporting staff.

5. Where fee for service is the mechanism of payment for dental services, all such fees should be made public and uniform to the area served.

#### SPECIAL SUPPORT AND DISTRIBUTION NEEDS

Over and above the allocation of funds for routine implementation of a national dental health program, special funding should be made

available to promote the development of minority persons in dental health careers. Further, the examining, licensing, and distribution of these and other dental personnel should be such that if the manpower shortage can be curbed, there will be small chance of its recurring. Therefore, special consideration should be given to providing:

1. Financial incentives and encouragement to black and minority organizations and institutions for experimentation with multiple methods of delivery and financing of dental care with Federal control of enforcement and Federal guidelines for service and community participation.

2. That separate funding over and beyond regular funding be made available for the elimination of some of the backlog of oral disease within black and minority communities.

3. Universal licensure in all the United States and its possessions and territories for the dental professional, and regional boards for recertification and assurance of continuing education.

4. That any national or regional licensing body include black and other minority persons with special representation from the National Dental Association to monitor the practice of dentistry.

#### CONCLUSION

Equal opportunity for health of all our citizens as a goal of equal and social justice in America has not been realized.

I would like to quote from a presentation I made to the ADA-NDA Liaison Committee on November 6, 1970, at the ADA convention in Las Vegas, Nev. :

The NDA feels keenly the urgent need for resolution of national dental health problems, because it recognizes the massive unmet needs of 24 million socially and economically deprived black people, along with the myriads of other developing minorities of Puerto Ricans, chicanos, Indians, and white poor.

The inclusion of the above provisions with special emphasis on encouraging the reorientation of black and minority communities toward good dental health, will perform the equally important function of developing a better economic base for local self-help. There is hope that such a program will decrease dependence, encourage fuller employment, and increase motivation for achievement in underserved communities.

The full impact of a national health program, including our recommendations, which promotes maximum development of our black and minority population, will make taxpayers of tax-users, and afford the dignity, pride, and determination due a people on whose back this Nation was built. We as black Americans are proud to have had such a fundamental part in the making of America and to see the day that a people who have, in spite of adversity, grown from 500,000 slaves to a 24-million-member constituency of the greatest Nation on the face of the earth. A minority which has earned the right to a healthy life free of dental disease and disfigurement, accorded to the majority.

Mr. Chairman and gentlemen, thank you for the privilege of presenting these remarks to you.

I recognize there are several problems that have not been addressed; in the limited time, I could not present them. However, I am open for questions from the committee.

Mr. BURKE. On behalf of the committee, Dr. Webb, we wish to thank you for your fine statement here today.

I have been discussing your organization with Congressman Ralph Metcalfe, and he has informed me of the fine work that your organization is doing in some of the poorer neighborhoods of the Nation.

I would like to ask you a question. With a limited amount of money, how would we establish a priority of objectives to be accomplished through a national health program?

Dr. WEBB. Congressman Burke, I would be the first to recognize that there are not sufficient funds or manpower, as I indicated, to do all the things that we need to do.

But several things are extremely important as we evaluate any national health system, which includes dentistry. First, we must be certain to provide for the elimination of disease; second, the prevention of its recurrence; and on an equal par with the two, is the promotion of health careers among minority groups so that they may begin to participate in the rendering of health services to themselves; that is, to develop the economic base through jobs in the health field, which will allow them to participate in the fullness of American life.

I also feel very strongly that in order to attack the problem of health manpower, we must identify the great potential in the disadvantaged communities and have the working blueprint, in action, that creates the upward mobility with financial incentives. This will be an investment that will pay off within our lifetimes. If I may, I would like to give an example.

In many minority and ethnic communities, it is the Aunt Mary or Aunt Nellie that people in that community go to for advice. These individuals in these communities have some basic knowledge, often erroneous, as to what should be provided in health situations.

I believe if we can tap this resource and teach health skills to those with innate ability to deal with and relate to people, then we can attack the health manpower problem where it lies in the ghettos and in the rural communities where people need health services most.

Mr. BURKE. Would you want to make any comments on the funding mechanism?

Dr. WEBB. In reference to funding, I am not prepared to indicate any specific manner in which funding should go in order to provide adequate dental services.

But I do recognize that in any national health program, and I emphasize program, we must be very careful to avoid the kind of financing that would prevent the implementation of preventive programs or reward inefficiency or apathy. Our only hope in health is to develop strong programs for prevention in which individuals will seek services prior to critical need. In some of the mechanisms for funding that have been outlined, this might be prohibited. For instance, it would be very unlikely for an individual who has to function under a copayment system to seek preventive services. It would be equally unlikely for a person in a national health system who has to pay a deductible to seek preventive services.

If we are in fact to stress prevention, we should evaluate all health legislation in the light of what it is we are going to do and whether the legislation allows us to accomplish these tasks. I believe these are

the areas where we have to be careful. There are a number of other areas that have to be considered as far as financing is concerned.

I am aware that there are pros and cons regarding tables of allowances, capitation, and fee-for-service arrangements. But I think the public deserves complete exposure to whatever mechanisms are being used, and all the mechanisms used should reflect a program that is oriented toward stimulation of disease prevention and the development of human resources with capabilities.

Mr. BURKE. Thank you.

Are there any questions? I wish to commend you for your statement and the time you have given the committee and your testimony will be very helpful.

Thank you very much.

Dr. WEBB. Thank you.

(The following material was received by the committee:)

#### BLACK FRUSTRATION

(By Harvey Webb, Jr., D.D.S., M.P.H.\*)

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This nation has a great challenge before it. It has a moral obligation to undertake the care of all its people and it has the ability to fulfill that obligation. At this point in time, like no other before, we can extend a sincere helping hand to the Negro of this country. America is fully aware of his plight and the degree of exploitation that he has been undergoing. From his arrival in the 1600's, the Negro has been abused by the people of this country. He has developed the nation's resources, and these resources have been used to serve the white community. The opportunity to make some compensation for the past and to lay the groundwork for future human relations is now at hand. This opportunity is that of initiating meaningful, comprehensive, rehabilitative measures to relieve the stress and strain of Negro life. It is time to take stock and evaluate the true purpose of the bounty of America. This bounty must be made accessible and available to all American citizens.

The occurrences of violence and destruction are the result of pent-up frustrations coming from almost four hundred years of confinement. The violence results from the belief that there is not now, nor has there ever been, a sincere desire by white America to allow the Negro total citizenship. The rights and privileges of American go to white Americans automatically, but for Negroes these same rights must be voted on. The unrest stems from the frustration of trying to achieve in the so-called American way, (i.e., through hard work and honest labor), the fruits of success. The destructive urge emanates from the overworked philosophy of patience and rewards after death, when the Negro sees the white American reap *his* rewards now. How can the Negro be prepared for a heaven after death, when he has only known hell on this earth? He would be a "misfit" in heaven. He would not know how to respond to its pleasures and rewards.

The black American masses have come to realize that the power to build or destroy America is in their hands. They are aware that white America will only recognize and respond to economic reprisal. The destruction of the god, "money," is the only act Negroes visualize as sufficiently important to make white America recognize the error in its ways. By destroying a part of the establishment, every Negro feels some pride in being recognized. The

Negro no longer fears unjust laws or the consequences of violation. The Negro is seeking identity and revenge. He is striking back at "things" that foster the idea that money is "almighty." He is trying to make white America realize that the ill-will sown by the profit motive which has degraded the poor shall be reaped in the loss of property. He is saying "if I can not have an equal share in America, there will be none of America to share." The Negro is replying to all the injustice and inequity shown him since he was taken from Africa and made a slave to increase the wealth of white America. He is replying to the mutilation, castration, and the prostitution to which he has been subjected at the hands of white America. He feels as though he has been made the scum of American society.

He now realizes that his position on the dunghill in American society puts him in a peculiar spot. He can see that all America is vulnerable from the underside while she strives to maintain a unified front in the eyes of the world. He sees the various jobs he holds as significant pawns in his battle for recognition. He is a janitor, charwoman, warehouse helper, laborer, sawmill hand, and maid; he is the kitchen help, busboy, hotel porter, garbage man, and street sweeper. From his "disadvantage" point, as he cleans up the filth of America, the Negro has begun to evaluate his true worth to America. He has become aware of the havoc that might occur if he did not protect the warehouses and stores against fire and theft, did not remain a loyal and obedient servant, or did leave the underside of America unguarded. The attitude is not new, it has only intensified in recent years. In George Washington's day, his prime house slave and chief chef disappeared after having the best advantages a slave could expect. Numerous loyal slaves turned and fought their "good masters" during the Civil War. Many an affluent white housewife has wondered why "Willie Mae," her maid of thirty years, whom she "took care of all that time and treated as her own," left with only bitterness and disgust.

The Negro of America has been aware that he is being deprived of freedom. It is only now that he says aloud "I want respect, I want decency, I want pride, and I want equal rights." He is speaking in violent words because violence is the tongue he has been taught. He speaks with rocks and fire because these are his only resources. He speaks in crude terms because the gutter has been his home.

The horizons before America are very dim and will remain so unless we can "overcome" the stigma associated with being black in America. The onward and upward progress of our nation lies in reestablishing liaison with the people who are its foundation—the little people, the poor people and black people. The poet has appropriately said,

Open my eyes to visions  
Girt to beauty and wonder lit  
But let me always see the dirt  
And they that spawn and die in it.  
Open my ears to music  
Let me thrill to spring's first flutes and drums  
But never let me dare forget  
The bitter ballad of the slums.

America has forgotten the slums and the poor, and the black Americans that comprise these slums. Unless most Americans reassess the values by which they expect others to live, the horizons will continue to be darkened with the smoke of destruction in our cities and throughout the nation. The nation need not be deceived into believing that the National Guard or even a mighty army can protect it if the people want to destroy it.

The laws needed to prevent this destruction are already on the statute books. What black Americans need is action, not promises; food, not philosophies; and hope, not hate.

It is significant that Dr. Martin Luther King, a man of peace, fought to achieve these needs; otherwise much more destruction may have occurred. Dr. King's spirit of determination to "overcome" the hatred of man for his brother will live on in the minds of clear-thinking Americans. In addition, we who are still living in America have a wonderful opportunity to see the vision he saw, and to make the American dream come true. In order that his dream be realized, the "hearts" and "minds" of many Americans must

change. Their eyes must see the Negro as an equal part of the total American society. The Negro race can no longer be looked upon as an inferior group to be used as a stepping stone of success for other groups—neither will the Negro accept tokenism. Token acceptance is worse than nonacceptance because the Negro is able to see how he is kept divided by the very system he helps to perpetuate. Nothing less than total commitment to equal opportunity for all Americans is a satisfactory answer.

## EQUIVALENCY AND PROFICIENCY TESTING—WHERE IS JOHNS HOPKINS HEADED?

### (A School For Health Careers)

Presented at: Seminar On The Status of Equivalency Testing For Allied Health Personnel

Conducted By: Maryland Hospital Education and Research Foundation, October 19 and 20, 1971

Held at: Hunt Valley Inn, Cockeysville, Md.

Presented by: Harvey Webb, Jr., DDS, MPH, Assistant Professor; Departments—Public Health Administration and Medical Care And Hospitals, Johns Hopkins School of Hygiene, and Public Health, Research Assistant, Center For Allied Health Careers

#### I. INTRODUCTION

##### A. Real Case Studies—(names have been changed)

*Case study*<sup>1</sup> (1).—Mr. Robert Winowski, 42 year old Black male, a high school graduate with 23 years as a military corpsman. Robert attended medical training school; a special diet course; trained troops in basic care of combat wounds, and has service experience which includes: starting I.V. therapy, prescribing and administering medication, giving immunizations, assisting physicians in bone marrow biopsies, suturing, filling prescriptions, running routine lab tests, operating E.K.G.'s, giving eye tests, assisting in physical examinations, ordering medicine, and medical supplies, independent treatment of minor illnesses, serving as health officer for evaluation of water supply, and environmental problems. His civilian training includes course work in drafting, tailoring, college English, management, OJT Trainer, personal and family survival, and experiences as a laborer, orderly, and hospital attendant. He wants to develop himself in a more significant health career and obtain college credit.

*Case study*<sup>2</sup> (2).—Mrs. Barbara Jones, 34 year old white female, Barbara is a high school graduate, married with four children, ages ranging 4 to 18 years. Past work experience includes: aircraft factory mechanic, housewife, involvement in community activities, work in health field for 13 years, (11 years as a secretary, two years in a semi-supervisory capacity, and administrative assistant, unofficially). She was the behind the scenes developer, program planner, coordinator and advisor to the director of a major health clinic (she ran the show). She is excellent at relating to people and maintaining interpersonal communications. Provides guidance and training for the entire administrative staff, has good oral and written communication skills, works well in one to one or group situations, highly motivated. No other formal training or courses. She also wants to develop in the health field and obtain college credits.

It is obvious that the individuals named have backgrounds which demonstrate knowledge and skills in specific areas of allied health subject matter but are limited in their academic background and social credentials.

There are certain questions we must answer as a developing School of Health Careers.

1. How does one accurately assess the knowledge, the skill and the real life experiences accumulated by these and other individuals like them?

2. On what basis will eligibility for matriculation be determined?

3. Will there be a continuing educational process and if so what kinds of assessment mechanism, i.e. examination etc., should be used initially and periodically to ascertain their current status and insure their continued development?

<sup>1</sup> Curriculum Vitae, Johns Hopkins Hospital employee, Oct. 1971.

<sup>2</sup> Personal communication, Johns Hopkins Hospital employee, Oct. 1971.

4. Do current evaluation techniques of equivalency and proficiency testing satisfy our requirements in light of the current health manpower needs and the goals of the Johns Hopkins Medical Institutions?

### B. Goals

What are our goals at the Johns Hopkins Medical Institutions toward new health personnel?

As currently outlined we see our mission as:<sup>3</sup>

1. the maintenance of a central focus on the student with encouragement of individual growth, a high level of performance and competence and academic excellence in the Hopkins tradition,

2. the development of a high level of personal interaction of the new health professional with new and traditional personnel, and an interdependence of function with other other highly competent health professionals,

3. the development of careers for all levels of allied health personnel,

4. making an accurate assessment of a student's current level of knowledge and placement of students in an environment where maximum development can occur,

5. the establishment of curricula with a high degree of flexibility to reflect appropriate scientific responses to current social demands,

6. the creation of a continuum of training to assure the delivery of high quality health care and promote employee job satisfaction on a long term basis.

It is therefore our mission, like other,<sup>4</sup> to develop an "open, humane, efficient and innovative institution that is future oriented, service minded" with a quest for "qualitative excellence".

## II. WHAT WE LOOK FOR

The ingredients we find desirable to accurately assess an individual will of necessity include the following:

From the student:

(a) the background that the individual brings as he applies for career development in the health field; and

(b) the individual's ability to communicate effectively.

From the school:

(a) a determination of the knowledge and the skills needed in the job to be performed by the prospective worker; and

(b) an ability to provide that added knowledge and skills not possessed by the student but required to insure the future competency of the individual.

## III. HOW DO WE PROPOSE TO OBTAIN THIS DATA

### A. Job task analysis

A complete and detailed job task analysis will be needed in order to ascertain what it is we would like for the individual to know and do.<sup>5</sup> This analysis will be the keystone of our assessment process. All job tasks that are required to be performed by a worker at varying levels in his development must be broken down into their components.<sup>6</sup> The institution must assay the level of knowledge and performance demanded upon completion of its course of study.<sup>7</sup> As an institution we must be positive that the tasks outlined are those actually to be performed, and we must validate our ability to measure the applicant's competence at performing these tasks. We must be able to determine the student's task performance level, his knowledge of the task at that level, and his overall

<sup>3</sup> Carlson, D., Koch, M., et al, "A Planning Report For Education and Training In Health Services," prepared by the Center for Allied Health Careers, The Johns Hopkins Medical Institution, May 1971, revised July 1971.

<sup>4</sup> Tumelty, Robert E., Professor of Health Sciences, Information Sheet, Governors State University, Park Forest South, Ill. 60466, Dec. 1970.

<sup>5</sup> Webb, Harvey Jr., Sanders, James and Staff, Arlotti, L. and Magsamen, L., "Proposal for Better Utilization of Manpower in Out-Patient Care in the Johns Hopkins Hospital, Baltimore, Maryland" (unpublished, June 1970).

<sup>6</sup> Dunn, Margaret A., "Development of an Instrument to Measure Nursing Performance," Nursing Research, vol. 19, No. 6, Nov.-Dec. 1970, pp. 502-510.

<sup>7</sup> Rines, Alice R., "Evaluating Student Progress in Learning the Practice of Nursing," Department of Nursing Education, Teachers College Press, Teachers College, Columbia University, ch. 2, p. 9, 1963.

proficiency in knowledge of the particular subject area he will encounter as a health careerist.

### *B. Background*

Our primary focus in background review will be to seek the best candidates for successful health careers. We shall look for the candidates that have in our estimation accomplished something in life by their own merit. We shall pursue all individuals who, regardless of lousy grades, a deprived family background and being born with the "wrong" accent, religion or color have demonstrated maximum use of their inherited resources.

A thorough analysis of the individual's background must be made to assist us in confirming how much of what we request of the student has already been accumulated as past work experience or individually acquired knowledge. A systematic appraisal of the individual's work record, i.e. time on the job, manner in which he has performed on the job, the number and kinds of jobs held and the nature of independent actions for achievement he has exhibited in those positions, will reveal some signs of stability and drive in work profile.

We must also obtain information regarding past academic accomplishments that are relevant to the job we wish performed, e.g. metric system, read thermometer, electrical knowledge for E.K.G. The depth of experience the individual has had over his life span and the kinds of relationships that he has developed in gaining this experience are traditional but valid measures for predicting expected success in new fields.

In essence, we will question what has transpired with this individual in a real life situation and how hard he has tried to accomplish a given task overtime.

### *C. Communications and problem solving*

In a highly mechanized society it is essential that the student develop multiple means of communication to function in a multi-professional situation as a health career presents. The individual's ability to communicate orally and in writing, i.e. via machine, symbols or otherwise, will help determine his effectiveness in "coming across positively" to his co-workers and those with whom he will be closely associated. Evaluation from past history of his ability to consolidate the various means of communication, to recognize channels of communication other than those structured, will evoke the candidate's ability to apply the best technique to appropriate situations.

An added essential for individuals who expect to advance to positions of responsibility in health careers is the capability to solve problems. We will assess how an individual handles himself in crisis or near crisis situations or in projected interpersonal conflicts and confrontations, (e.g. create provoking situations, use staff as guinea pigs). We shall anticipate as near as is possible his expected behavior under known circumstances based on projections from past performance.

### *D. Knowledge and skills to be taught*

Finally, we must determine from the information gleaned in the answering of previous questions, what knowledge and skills must be taught so that the individual may be complemented as a total human being with health career goals. Correlation of information gained from academic sources (high school, college, training courses), work experiences, social interactions, and from methods used in problem solving in his personal as well as his work-a-day life, will provide a sum total prospective student's status. Once this has been determined we must assay to what degree and at what level reinforcement is necessary to satisfy the needs areas identified and determine at what level in the health career ladder he is prepared to fit. Careful evaluation must be made to ascertain the amount of course work necessary for him to become proficient in a given skill or to function at an acceptable level of proficiency.<sup>8</sup>

## IV. HOW WILL WE FIND IT?

We believe that depth of experience and hence, expected performance can be measured by evaluation of the sum total of the student's real life experiences.<sup>9</sup>

<sup>8</sup> Rines, op. cit., pp. 19-23.

<sup>9</sup> Personal communication, Staff of Center for Allied Health Careers, May-June 1971.

The components of these experiences will include the use of the job task analysis to assess all data collected through:

#### *A. Academic records performance*

Significant academic records from high school, college and other training programs in which the prospective student has previously engaged. All available test results will be included as background for analysis. Ingredients of past experience will be assessed in light of job task analysis and goals of the Johns Hopkins Medical Institutions.<sup>10</sup>

#### *B. Standardized test performance*

The School proposes to enroll students for the last two years of college and the College Level Examination Program (CLEP) or other standardized test will be used in assessment of their proficiency in preparation. Since CLEP's development was based on the assumption that many people know much more than their academic credentials would suggest,<sup>11</sup> it is felt appropriate to get maximum use of this established examination to measure achievement in specific subject areas. As many of the 22 currently available examinations which relate to college preparation in the health sciences will be used to allow the student to challenge subject material. The use of such a widely accepted previously validated and standardized test will allow the Center several additional advantages:

a. The newness of our budding school will have to be assessed in light of current standards and the CLEP Examination should demonstrate where our students stand in relation to other established schools and colleges.

b. CLEP Examinations will provide an evaluation mechanism for comparing the entry performance level of our students with students of other schools within the Johns Hopkins Institutions.

c. A third asset in using the CLEP Examination is the opportunity to measure the validity of CLEP or other standardized test against our own operational performance standards over a period of time (say 5 years).

#### *C. Job skill performance*

Much work has been done in proficiency and equivalency testing, but very little in the area of performance testing. In the health field performance takes a much greater significance than in other areas. i.e. there is a constant need to know, "Can the employee do the job for which he was hired". Extremely little information is available along these lines. Therefore, we propose to use the job task analysis as our baseline data and create the assessment tools necessary to evaluate the subject matter. The detailed job task analysis will provide an open forum for the review of specific skill needs, and judgmental ability required to perform given tasks at varying levels of proficiency. Problems and situations will be constructed in which demonstration of analyzed skill can be tested and measured toward established degrees of competence.<sup>12,13</sup> Procedures to be presented for performance evaluation will incorporate tasks which required low, intermediate and high skill and knowledge levels.

From the initial or entry stage we shall prepare our students to perform meaningful health related job tasks and utilize the information gained from these experiences to score his overall proficiency. Each student will be allowed to challenge as many skills as he feels he has proficiency in and will be afforded complete credit where his scores indicate a high degree of knowledge and competence. The performance examinations will involve the creation of situations, hypothetical patients, and planned crises consisting of solvable and insolvable problems with graduated degrees of complexity. They will be a test of knowledge, skills, judgmental ability and human interactions applied to real life experiences anticipated<sup>14</sup> in health careers.

<sup>10</sup> Carlson, et al., op. cit., pp. 9-11.

<sup>11</sup> "The New York College Proficiency Examination," published by the University of the State of New York, the State Education Department, Albany, N.Y., publication No. 18770.

<sup>12</sup> "Assessment of Men", selection of personnel for the U.S. Office of Strategic Service, the OSS assessment staff, Reinhart & Co., Inc., New York, N.Y., 1948.

<sup>13</sup> Hubbard, John P., M.D., Levit, E.J., M.D., Charles F. Schumacher, and Schnabel, Truman G., Jr., "An Objective Evaluation of Clinical Competence", new techniques used by the National Board of Medical Examiners, the New England Journal of Medicine, vol. 272, No. 25, June 24, 1965, pp. 1321-1328.

<sup>14</sup> Assessment of men, op. cit.

### *D. Interview performance*

One of most informative techniques for assessment of personal traits is the face to face interview.<sup>15</sup> We are convinced that a well structured guided interview can be helpful to the student who does poorly under normal testing procedures, and assessment measures. Such an encounter will be informative for an institution which must train, in the health field and for the student whose ability to handle written and oral communications is essential to his career development in a multi-professional environment. The interview will be diagnostic in its approach and analytical in its process. Educators and psychologist will be used to build on current knowledge in the development of diagnostic questions that probe the student's work history, social background, attitudes and personal motivation.

Vocalization of knowledge of specific and general background material will be only a portion of the desired outcome of the interview. More important, will be the opportunity to ascertain to what degree the student perceives the information requested of him, how he discriminates between what is salient and what is superficial and the significance of positive and negative replies he makes to inquiry. Close observation will be made of the manner in which the student listens, assimilates information and responds to what is requested. We shall attempt to ascertain the student's *modus operandi* in prior problem solving situations and determine its application in new problem situations, and personal encounters. With the use of psychologists and other specialists in human behavior we shall develop individual and group interviews with single and multiple candidates and single and multiple interviewers. These sessions will allow for the assessment of the individual's interaction and relationship with other human beings in his own peer group as well as persons in authority.

### V. SELECTION

Our final student selection will be based on a composite performance score from all possible sources. Performance score from academic records, standardized tests, past work experience, references from previous employers and performance on situational and interview-encounter sessions will be compiled individually and collectively. Each of the categories will be weighted with emphasis on individual's ability to produce under the circumstances surrounding the various assessment techniques. Those persons who demonstrate, by previous work and real-life experiences that they possess the reliability and equilibrium to accomplish a task or thought process are motivated and committed to health as a career and are academically capable of coping with the subject matter, will become prime candidates for consideration of acceptance into the program. These stabilizing characteristics must, however, be counter balanced by a selflessness in concern for others and a genuine empathy for people. Some selections will also be made on pure "gut reaction" to the individual's ability to achieve and survive in life, e.g. community organizer with leadership ability, no formal training, on panels, boards and taking a responsible role.

### VI. FOLLOW THROUGH

An integral part of the entire assessment effort must be a matrix of collaborative and cooperative learning. Initially, acceptance into the program implies a responsibility on the part of the institution as well as the students. The institution will be responsible for academic reinforcement of areas of minimal knowledge and challenge and encouragement in areas of advanced knowledge and skill. The School must learn and provide what the student requires for development. The most accelerated curriculum adaptable to the individual student will be made available to capitalize on his strong qualities and to prevent duplicate learning. On the other hand, careful counseling and enrichment shall be provided for the tutoring and support of students who need assistance. The School and the student must learn their limitations in respect to each other. Peer learning will be promoted through planned student interaction and multimedia programmed learning centers. This process will include peer learning for faculty and staff members to understand the teaching and learning phenomena.

<sup>15</sup> *Ibid.*

The student faculty ratio to be established at 8-1<sup>16</sup> will remain as low as is required for maximum student development.

When the student applies to our school he will have made the self-assessment that he has some existing competence and an interest and future tied into allied health career development. He recognizes that he has some skills and some knowledge but needs refinement, and training to develop competence and credentials. We assess him to determine what he knows and his level of performance.

In short the student knows what he knows but not what he doesn't know or what he needs. The institution on the other hand will validate this knowledge and skill level, credit him appropriately and obtain insight into what is needed to aid him in achieving his aspirations. This shall be accomplished by the use of check lists, anecdotal records and student self-reports.<sup>17</sup>

We see our role as correlating what he knows with what he does in an educational context which will integrate a program for evaluation and maintenance of professional competence. i.e. a sort of self-assessment of student and school with an ongoing review of the basis and techniques of the original assessment. We shall make maximum use of instructional technology and other educational techniques to accomplish this.

#### VII. SUMMARY

We, in a budding school for the education of Allied Health personnel have the formidable task of preserving the health profession by developing competent people quickly. We have within our own ranks persons with untapped resources for delegation of additional responsibility. How can we convert the knowledge and skills from their life experiences into competent performance to relieve the current and future health crises? We at the Johns Hopkins Institutions have decided that our goals are clear and incorporate the concepts of an open, humane, efficient and innovative student oriented institution with a view towards the future development of highly qualified service minded people. To ferret out these individuals we shall look for persons with past and present high performance records in situations that require knowledge and skill and problem resolution. We propose to accomplish this by shouldering our full portion of the responsibility to identify the jobs we expect to have done and thoroughly analyzing their relevancy to the knowledge and skill levels we expect the student to reach.

Job task analysis is the key to our assessment process. In addition, evaluation of student performance on standard test, in programmed diagnostic interviews and problem solving solutions will be incorporated into a composite score. Based on these analyses a curriculum will be developed which is adaptable to the individual student needs and provide the prerequisites for challenge and support to assure a high degree of career motivation and multiple opportunities for immediate and long term reward.

The constant analysis of whether the knowledge and skills desired are compatible with the results expected should provide our continuum of self-assessment for knowledge level and our practical review for high standards of performance. The anecdotal record, check lists and close faculty student interaction, and advanced technology are some mechanisms we plan to use.

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#### DENTISTRY'S PARTICIPATION IN COMMUNITY HEALTH PROGRAMS

Dr. Harvey Webb, Jr., Assistant Professor, Community Dentistry,  
Howard University College of Dentistry, Washington, D.C.

#### A VIEW FROM THE COMMUNITY

The time for defining and redefining the problem of dental care for the deprived is all over. We have surveyed and evaluated the poor until they shudder at the thought of another Public Health program. The time for action is now. We cannot wait. We will never have enough money. We will never

<sup>16</sup> Carlson, et al., op. cit., p. III.

<sup>17</sup> Rines, op. cit., pp. 47-54.

have enough personnel or enough facilities, because the problems of dental care have outgrown our capacity to resolve them with present techniques.

We need to take a close look at what we are doing with the existing resources, and determine if there are hidden resources which represent the untapped potential for resolving the problem of dental care for the urban poor. The solution to our problems rests not only on money, manpower or in new priorities for dental care. These things would be nice to have, but they obviously are not going to be available. We must reorient our thinking and do a better job with what we have on hand.

Some of us live in localities that have a wealth of dental resources, some in areas that have few. But, most of us come from areas where the available resources are under-used. In some instances we fail to identify other resources that could be made available.

I am proposing a plan that requires no additional money, no additional manpower, but makes better use of our current resources. It does require an open mind. The things that work we may keep, but the things that do not work, we must throw out. In the development of this plan, let us ignore no possibility for success, and let us be prepared to accept any workable concept. The aim of the plan is to organize unorganized dentistry. The time for concerted action for resolving dental problems of the urban poor is long overdue. The answer to our inaction and the fragmentation of health services lies somewhere between possessing all the time, all the money, and all the manpower needed to eradicate or prevent all dental disease and the frantic efforts we are now making to put out with water pistols the raging forest fire of dental neglect.

It would seem that dentists should long ago have consolidated forces to hold dental problems in check. If we organize and pursue a course of prevention and build a manpower reserve capable of containing dental diseases, we can soon make a realistic impact on dental care problems. Such a combining of dental efforts would allot present funds more effectively, use current personnel more efficiently, and deliver dental services more effectively without increasing costs. It would also increase the available dental manpower.

If you look at the alternatives, it becomes obvious that this can be accomplished only through what I choose to call a "Consortium for Dental Care." This consortium would bind the administration and functions of all existing dental resources and agencies into a unified program for launching a frontal and enveloping attack on dental diseases.

The Consortium shall consist of the dental schools, the hospitals, the neighborhood health centers, the private practitioners, and public health oriented dental agencies—wherever these facilities and resources exist.

The role of dental schools: Dental schools seek a supply of qualified dental students to train for the profession. These students need ample supplies of patients to fulfill their training obligations. The best resource for patients is the community. The best resource for increased public awareness of dental problems is the community. And the best arena for getting those individuals to join the profession is the community. With the opportunities presented by Federal programs for universities to initiate extensions into the community, only slight modifications in present curricula are required to establish dental training and practice clinics within the neighborhood health centers.

The maintenance of high quality care can be assured and demanded by close supervision of health center and school faculty members with joint appointments. The closer association of community and teaching institutions will enhance closer administrative and professional relationships, increase the faculty-producing mechanisms for dental schools, increase the availability of teaching material, and develop student rapport with patients by early contact with the social, economic, and environmental aspects of dental care.

The role of the hospital: The hospital dental department serves in many urban areas as a dental emergency room and the only dental facility for many urban poor families. These departments must be fully integrated into the hospital structure, and not be a second thought. A unified administrative arrangement of the hospital, the health center, dental school, and Public Health facilities will allow the channeling of patients into appropriate facilities, and afford the remaining members of the Consortium the opportunity to coordinate administrative techniques, to increase patient education, to improve patients visits, and to increase reliability of recall and follow-up procedures.

The hospital will also have an opportunity to develop internships in community dentistry. These internships will be the connecting link to all the Consortium resources. The internships may take the form of a recently approved oral surgery-community dentistry mixed internship as initiated in the Providence Hospital in Baltimore, Maryland. In this particular instance, the intern can complete a dental internship in a two-year period, and work for a Master of Public Health degree. Or, with additional time, complete an oral surgeon internship and residency leading toward Board certification. The associated dental school will provide the direct academic phase of training, and especially the specialty services which will come both from the community, the dental school and a School of Public Health. Practical experience will be gained through the hospital, the health center, the Public Health facilities and the university complex.

**The role of the neighborhood health center:** The neighborhood health centers have an inner city orientation, and are in close proximity to people having great dental need. These centers have their individual problems with which you may be more familiar than I. But, in their current state, they form an ideal focus for entry into the urban community. The neighborhood health centers present an unique situation, and an ideal setting for care. They are convenient to the people they serve. They are staffed by the community residents. They are supervised by the community dentists. They reflect the pulse of the people. They are also committed to the delivery of care in a new and innovative way. There are administrative interactions with other community organizations so the health centers can take full advantage of Federal programs and become self-perpetuating. The centers can be data-banks for useful information which can be oriented toward improvement of the delivery of care in a manner unique to the community they serve.

**The role of the private practitioner:** The private practitioner is represented through local and State dental societies, as well as through other organized groups for practicing dentists. Whether you like it or not, the private practitioner must be dealt with in this or in any other community dental health program, regardless of his lack of concern for the deprived, his inactivity in community programs, or his general independent attitude. The private practitioner must be the backbone of any dental care program. Most private practitioners are overworked or at least render as much dental service as they desire. The fundamental ingredient for success with them is their willingness and interest in community service; rendering a community service that is prestigious and pays. However, most of them are also anxious to keep abreast of latest techniques and to discuss difficult cases with their colleagues.

On the other hand, all licensing boards and the public are becoming acutely aware of the need for continuing education in the profession. The licensing boards will be in an excellent position to require that this education be obtained through university associated community health complexes. This then would provide an excellent resource for the neighborhood health center. And, it is a center which is easy to reach, it is in the ghetto—all cities have ghettos. In the Consortium the private dentist is afforded a hertofore unavailable opportunity to: a) Improve and retrench his position with his profession through laboratory work, practice clinics and classroom exercises, b) Teach dental students in the classes, in the clinic and the laboratory, c) Impart experience of practice and treatment of the whole patient, along with a step-by-step approach to care as taught to the dental students, d) Engage in the exercise of clinical or epidemiological research.

Resources for dental care, such as dental schools, Public Health centers, or hospitals will allow the private practitioner still other outlets to dental programs and newer concepts to be used in dentistry. The dental practitioner's contribution can form the foundation for continuing education and increasing the community interest in the dental profession. He will have a positive influence on the dental student. He can help the student make the transition from theoretical practice of dental schools to the real world of practitioners. The private practitioner will also be able to associate more completely with colleagues in Public Health activities and relate concerns of the dental practitioner to the hospital, the university, and the neighborhood centers.

**The role of Public Health:** The State and local Public Health officers through their national and local organizations can help enormously. Currently the United

States Public Health Service and other Federal agencies are dedicated and committed in principle to the impartial delivery of health services for the disadvantaged. The Public Health Service and State, local and territorial constituents have a challenge to make the Consortium work.

In the Consortium for dental care, your role is two-fold. In the broad sense, it is to prevent dental disease by available methods, and to organize and coordinate the implementation of the Consortium for dental care. To satisfy the first requirement, you must initiate and supervise the nationwide self-applied fluoride program for all school children in all cities. To accomplish this, you can use community workers for the asking. This effort can yield the greatest good for the greatest number for the least amount of money.

Secondly, you must evaluate your department. You have administrative knowledge, you have an organizational structure, you are aware of the social and political forces and you are the legally competent dental health body of your city, State or region, and only you possess the community awareness of the unmet needs. You must be a gadfly, an innovator and the driving force if this concept is to work.

The approach to the Consortium for dental care must be varied with the area in which you reside. This program will need top-level sanction; intermediate levels of participation and grass-roots planning. The Consortium for dental care requires the cooperation of other health and welfare agencies, as well as those included in the list of the constituents. It requires professional initiative and drive to put dentistry in its proper context relative to other health problems faced with existing unmet needs for care. The Consortium for dental care demands constant surveillance, clear lines of communication and cooperative planning. It is not a one-man show. It affords many opportunities for individual achievement, which must be exploited to make the Consortium effective.

An effective Consortium will improve the current system of delivery of care, obtaining immediate positive reaction of patients to dental practitioners, dental schools and other health professionals.

The concept of the Consortium of dental care is not new. It is a compilation of the old, and a point of view not foreign from your own. It embodied all the existing centers of treatment, accepted modalities of care, and provides a forum for developing many new techniques of service which we in Public Health have initiated.

Among its other assets are the elimination of duplication of administrative procedures, the ability to develop new and regular dental auxiliaries, the increase in scope of knowledge in all segments of the profession, the unification of methods and efforts for the common good of dentists and patients, and most of all, it will be the beginning of a national dental health care plan to fill the void created by unorganized dentistry. Unless this void is filled immediately, the traditional self-regulation of the dental profession may be lost to the dentist and placed in the hands of the consumer.

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TESTIMONY OF THE LEGISLATION COMMITTEE OF THE NATIONAL DENTAL ASSOCIATION BEFORE THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, DECEMBER 30, 1968

Mr. Chairman, members of the Board, I am Dr. Harvey Webb, Jr. Chairman, Legislation Committee, National Dental Association.

INTRODUCTION

The National Dental Association is a predominately Negro National Professional organization representing the majority of more than 5,000 Negro dentists in America. It was founded in 1900 and has continuously served a varied population with considerable experience in poverty areas. Its history is replete with activities and programs designed to alleviate pain and suffering among the population it serves. As an organization whose members serve as the primary source of dental care for most of the nearly 25 million Black people of America, we are deeply concerned for the dental welfare of all the citizens. With the enactment of title XIX (Medicaid) of the Social Security Act of 1965, the National Dental Association and Black dentists were relieved to know that

finally they would be assisted in carrying the burden of the many impoverished citizens needing care and compensated in part for their many years of benevolence.

#### *The national state of oral disease*

Oral disease is often subtle but one of the most widespread, damaging and bothersome chronic illnesses to confront medical science. It is infrequently the cause of death, but is the origin of much needless pain, suffering, loss of income and anxiety. It causes decreased function, disfigurement and if not controlled or corrected, may form foci of infection for future dissemination throughout the body. A nation-wide health examination survey found that an estimated 20 million men and women (18 in every 100) had lost all of their natural teeth and this proportion increased with age. In addition to these 20 million toothless persons, the survey found that 91 million other people had suffered from some dental disease. These persons had an average of 18 decayed, missing or filled teeth which were directly associated with family income and education. The lower the family income and education level, the less dental treatment received. Oral disease affects the aged as an added burden to the 3 or 4 other chronic diseases with which age is usually associated. The most severe and deplorable states of oral disease exists among the poor, aged and deprived and the near poor of our society. It is among these groups that caries are rampant in little children and tooth loss is early. It was among these groups that title XIX shone as a star of hope and a promise to relieve the pain and suffering of dental diseases. It was among these groups that we hoped to instill dignity and purpose by providing a comprehensive health system that was convenient and available. It was among the most needy that title XIX promised to prove for all time that health care is in fact a "civic right" of all people, not just a privilege of the affluent. Medicaid has not kept faith with the people.

#### *Deficiencies in Medicaid*

Title XIX, while setting forth some guidelines, has failed to take into account the multiple variations in state and local governments that would make the program effective. Hence, the poor continue to receive poor care and the near poor or medically indigent are not allowed the flexibility necessary to become self sufficient.

Through surveys, the Federal Government had adequate knowledge of the sites and extent of health needs. With this knowledge, states are allowed the option of accepting or rejecting title XIX while the poverty stricken people of the state suffer.

Congressional amendment in 1967 amended the open-ended reimbursement formula of title XIX so that Federal funds would *not* be available to families whose income exceeds certain percentages of the amount paid to a family of the same size under aid to families with dependent children programs. Therefore any state making an effort to improve the health care of the poor by setting medically needy income levels above unrealistic Federal limits must assume full cost of this care. One of the most recent and severe threats to the program is the Long amendment in the Senate which proposes that reduction by 50% of the funds granted the states for the medically indigent.

The Federal government has not yet effectively tapped the resource that exists in the problem areas or sought the assistance needed in its dental programs under title XIX. In the Black community, there has been an alarming scarcity of Black dentists in policy making positions throughout the country. In some states the Negro professionals have not been informed of the existence of Federally supported state programs. To solve the problems of Black people receiving dental care under title XIX, the black professional must be made the intermediary and play a major role in the planning and implementation of the programs. There is currently to my knowledge, only a handful of Black dentists in consultation or advisory positions to either HEW, State, or local governments.

The Federal government appears to be more concerned with the fiscal mechanism of funding than the quality and quantity of service rendered. It has neglected to realize that quality dental care is not a matter of buying commodities but involves rendering an effective health service and satisfying the long neglected health needs. It is difficult to put a monetary value on human misery. The Government has been unrealistic in its approach to financing dental care under title XIX. According to the Social Security Bulletin, 53 billion dollars was spent on health care in fiscal year 1967. Of this amount, 3.3 billion was

spent for dentistry. Private funds comprised 3.1 billion dollars, while public funds comprised only 151 million or only about 4%. It cannot be expected that a program such as title XIX can begin to make an impact on oral disease in this country unless an all out effort is made by both private and public institutions of health. We therefore strongly suggest that a close look be taken at the programs that exist and remold them into relevant functional dental health services of the highest quality for the maximum public good. In order that this be accomplished in the most expeditious manner, the following recommendations are proposed:

1. That a National poverty level be established that is realistic in the various states and territories where needs are greatest.

2. That dental care be included immediately as a mandatory requirement for state participation in title XIX and that an order of priority for care be established.

3. That the National Dental Association be officially designated as the organ for implementation of Government dental programs in predominantly Negro ghettos and rural areas.

4. That a plan be adopted through NDA that will include direct liaison with Negro dentists and Black communities to expedite the delivery of dental care and evaluate the quality of dental services rendered.

5. That revisions in the program be made to close the gap between allotment of funds and the benefits promised and further that a more realistic basis of cost be established in proportion with the latent dental needs that exist among the poor.

6. That all legislation proposed to suppress or curtail in any way the advantages of title XIX for the poor, be terminated.

7. That since quality care for the poor is the responsibility of the private as well as the public sector, part of the responsibility of planning be shared by the private sector. And to this end, private health insurance and professional organizations in cooperation with the DHEW develop plans for the implementation and effective evaluation of the delivery of high quality dental care through a prepaid mechanism.

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#### RECOMMENDATIONS FOR DENTAL CARE TO BE INCLUDED IN A PREPAID UNIVERSITY HEALTH PROGRAM

The Johns Hopkins University Health Service would provide considerable benefit for its patients if it included a prepaid dental plan.

The prepaid dental plan might include the following segments and ramifications:

##### I. FAMILY PREPAID DENTAL EMERGENCY PLAN

All persons in the family would be eligible for University Health Services under the plan.

Each person enrolled in the program would be given an initial cursory dental examination with mouth mirror and explorers to ascertain the extent of major dental deficiencies anticipated emergency dental conditions.

##### A. Services to be provided would include

1. Diagnostic X-ray for determining emergency dental needs.
2. Emergency extractions (as determined by the dentist).
3. I.N.D. in cases of infection.
4. Drugs to cover elimination of infection and pain.
5. Temporary treatment fillings for salvagable deciduous and permanent teeth.

##### II. An adult prepaid dental maintenance program

All persons eligible for University Health Services who are 13 years of age or older might enroll into this plan. A separate program would be established for children under 13.

Each person who enrolls in the adult prepaid dental maintenance program must have completed such initial dental work—as the Dental Director determines is required for oral health before membership becomes effective. All initial dental work needed to bring the mouth into acceptable health condition would be provided on a fee-for-service-basis.

The adult prepaid dental maintenance program would have the following conditions:

*A. Services to be provided*

1. Preventive care—

- (a) Prophylaxis (cleaning of teeth) semi-annually or as needed.
- (b) Bite-wing x-rays (2 films) semi-annually or as needed.
- (c) Full mouth x-rays (14 films) or panorex as needed.
- (d) Examination semi-annually or as needed.
- (e) Topical Stannous Fluoride or appropriate preventive medicament.

2. Treatment services—

- (a) Emergency care for relief of pain.
- (b) Restoration of individual teeth with proper amalgam (silver) resin or synthetic porcelain filling material.
- (c) Simple extractions and minory surgery.

*B. Charges*

Four to five dollars per month for each adult or child thirteen years of age or older.

*C. Conditions necessary for participation in the program.*

1. A patient is accepted into the prepaid program upon approval of the Dental Director.

2. A member or participant may be dropped from the plan upon recommendation of the Dental Director if they do not reasonably comply with recommendations regarding the care of the teeth and the securing of regular prophylactic service.

3. Most services not included under the prepayment plan may be provided on a fee-for-service basis in the Dental Center.

III

The children's Dental Health Plan may begin as early as we choose, preferably at 2 years old or as soon as the majority of the teeth have erupted.

The earlier a child is enrolled the more effective preventive measures will be. All dental care, with only minor exceptions, is provided at a cost of from three to five dollars per month per child.

Children enrolled prior to their sixth birthday will be eligible for a 25% reduction on the prevailing fees for orthodontics, if such treatment becomes necessary.

Children enrolled after their sixth birthday but prior to their thirteenth year, likewise are eligible for comprehensive care at the same monthly cost, with one exception, orthodontics services, if needed will be provided at prevailing rates. The three to five dollar rate will prove very realistic if children are started early enough. We cannot guarantee that the rate will remain the same, but experiences in similar operations indicate that it is adequate to handle this group of patients. The Dental Director is responsible for admission standards and for determining whether applicants can benefit from dental care to be provided. Correction of defects, at patient's expense, may be required prior to admission.

The Dental Director will require parental and child cooperation with respect to eating and brushing habits as well as to the schedule of required appointments. Participants may be dropped from the plan if they do not comply reasonably with recommendations regarding care of the teeth. A charge will be made for late or broken appointments, where no prior notification is given.

The following diagnostic and treatment services are offered under the children's dental plan:

*A. Preventive procedures are*

- 1. Oral prophylaxis
- 2. Dental x-rays
- 3. Clinical examination and x-ray diagnosis
- 4. Caries susceptibility tests
- 5. Fluoride treatments
- 6. Dental educational guidance
- 7. Space maintainers

*B. Restorations are*

1. Restoration of individual teeth
2. Jacket crowns
3. Temporary removable partial dentures

*C. Minor oral surgery includes*

1. Removal of teeth except bony impactions
2. Removal of residual roots
3. Removal of small cysts and tumors
4. Exposition of teeth to encourage eruption
5. Removal of tooth buds for orthodontic treatment

*D. Periodontal services includes*

1. Treatment of gingivitis, hypoplasias and stomatitis

*E. Exclusions of children's plan are*

1. Treatment of conditions not listed above
2. Treatment performed by other than Health Center dentists
3. Major oral surgery
4. Orthodontics—except space maintainers. However, children enrolled prior to their sixth birthday anniversary are eligible for a 25% reduction in prevailing fees for orthodontics
5. Conditions resulting from systemic deficiencies
6. Cosmetic procedures
7. Procedures not considered essential to good dental health, as determined by the Dental Director

All other desired dental services will be available through the plan on a fee-for-service-basis and/by consultation with necessary dental specialist.

Mr. BURKE. Our next witness is Mrs. Emiley Lamborn, representing the National Rehabilitation Association.

Will you identify yourself and your associate for the record.

**STATEMENT OF MRS. EMILEY LAMBORN, DIRECTOR, STATE-FEDERAL RELATIONS, NATIONAL REHABILITATION ASSOCIATION; ACCOMPANIED BY CHARLES ROBERTS, EXECUTIVE DIRECTOR, INTERNATIONAL ASSOCIATION OF REHABILITATION FACILITIES**

Mrs. LAMBORN. I am Emiley Lamborn, director of State-Federal Relations for the National Rehabilitation Association, and this is Mr. Charles Roberts, executive director of the International Association of Rehabilitation Facilities.

Mr. BURKE. We welcome you to the committee. I know we will appreciate your testimony.

Mrs. LAMBORN. I had a written statement which I would like to submit and summarize it and let Mr. Roberts finish up.

Mr. BURKE. Without objection, it will appear in the record in its entirety.

(The statement referred to follows:)

**STATEMENT OF MRS. EMILEY LAMBORN, DIRECTOR, STATE-FEDERAL RELATIONS, NATIONAL REHABILITATION ASSOCIATION**

**SUMMARY**

After commenting on the individualized rehabilitation process and its interdependence on the level of care of institutions and systems in the community, the characteristics of an ideal health insurance system are noted.

Attention is called to two resolutions adopted by the National Rehabilitation Association at its 1971 Annual Conference related to national health insurance: one relates to medical services to the catastrophically disabled; the other to Rehabilitation Facilities as providers of medical care and health related services.

It is urged that the needs of the catastrophically disabled be recognized as part of the total health problem of the country and it is recommended that national health insurance legislation recognize rehabilitation facilities as primary providers of medical care and health related services.

Mr. Chairman, I am Emiley Lamborn, Director of State-Federal Relations, for the National Rehabilitation Association. I am here instead of Mr. E. B. Whitten, its Executive Director, who is abroad. Mr. Charles Roberts, Executive Director of the International Association of Rehabilitation Facilities, is with me and joins me in this testimony.

The National Rehabilitation Association is a private, non-profit corporation dedicated to the rehabilitation of all handicapped persons. It has been in continuous existence since 1925 and its membership exceeds 30,000 people—doctors, therapists, counselors and others interested in helping physically and mentally impaired individuals and other disadvantaged people remove or overcome obstacles which prevent or threaten their living independent, productive, and satisfying lives.

The International Association of Rehabilitation Facilities is also a private non-profit corporation. It was formed in 1969 with the merger of two national organizations established in the mid-1950's: The Association of Rehabilitation Centers and the National Association of Sheltered Workshops. It has 650 institutional members in the United States. The majority of these institutions are already involved in the provision of medical rehabilitation services similar to those contemplated in some of the national health insurance proposals. The purpose of the International Association of Rehabilitation Facilities is to assist in developing and improving services in rehabilitation facilities.

The essence of the rehabilitation process is the evaluation of each individual's needs and his rehabilitation potential and the provision of the medical, training and supportive services he needs to reach his rehabilitation goal.

This rehabilitation process does not take place in a vacuum. The rehabilitation of any individual is closely interwoven with the whole social and economic fabric of his times. The quality and availability of the educational system, the system of medical care and that of other organizations and institutions serving human needs have a great deal to do with the extent to which an individual can be rehabilitated and become a participating, constructive member of our society. That is why the National Rehabilitation Association and the International Association of Rehabilitation Facilities are interested in the national health insurance proposals.

#### CHARACTERISTICS OF AN IDEAL HEALTH INSURANCE SYSTEM

The National Rehabilitation Association and the International Association of Rehabilitation Facilities are not supporting any particular bill. Instead they have addressed themselves to the principles that ought to underlie a national health insurance program. The characteristics of an ideal national health insurance system that have been identified by a work group are as follows:

1. The benefits of such a system should be available to everyone without regard to age, nature of health problem, or ability to pay.
2. The services should be comprehensive, that is, be broad enough in scope to meet the health needs of individuals without regard to the nature of their health problems. Another way of saying this would be that services should be unlimited, so far as they are designed to meet health problems.
3. The system should encourage early utilization and should emphasize prevention, both primary and secondary.
4. The system should define health and health related services in such a way as to encourage the delivery of comprehensive services on an interdisciplinary basis as in a rehabilitation center or other interdisciplinary health program.
5. The system should be so organized as to accomplish the goals of comprehensive health care to everyone.
6. The system should encourage innovation and experimentation in the delivery of health services. There are many innovative approaches to delivering health services that deserve try-outs on a broad basis.
7. As related to health problems for certain severely handicapped groups, the opportunity should be provided for regional approach to providing facilities and

services for such groups. These will include spinal injury, heart disease, quadriplegia, hemiplegia, renal disease, etc. It is recognized that not every community can have facilities and treatment teams competent to deal with such problems.

8. The system should make possible and encourage the development of quality controls and performance standards. Ways should be devised to determine what the results of specified treatments are in terms of their effect upon the life of the individual.

9. The system should provide for cost-quality controls.

10. The system should utilize all individuals, institutions, and facilities that meet specified quality standards. There should be no distinction between the use of facilities operated by public and voluntary organizations.

11. The system should provide cumulative confidential records which can be put on electronic tape for quick reference by treatment personnel.

12. The system must emphasize the efficient use of medical and medically related facilities.

#### RESOLUTIONS

At the 1971 Annual Conference in Chicago, Illinois, October 11, 12, and 13, 1971, the National Rehabilitation Association adopted two resolutions related to national health insurance. One of them is quoted in full below.

#### MEDICAL SERVICES TO THE CATASTROPHICALLY DISABLED

"Whereas, Congress is currently considering legislation to establish a national health insurance program, and

"Whereas, the National Rehabilitation Association is supporting such legislation in principle, and

"Whereas, it is important to the National Rehabilitation Association that such legislation be adequate to serve the health needs of the catastrophically disabled, even when these needs are greater than can be met under the basic health program: Therefore be it

*Resolved*, That the National Rehabilitation Association urge Congress in any National Health Insurance Program to make sure that the total health needs of catastrophically disabled individuals can be met under the legislation; and further

*Resolved*, That the legislation contain provisions that will assure that such disabled individuals will receive appropriate services in appropriate facilities under competent medical supervision in order that their maximum rehabilitation potential be realized."

We realize that this is a very difficult area. We are not suggesting that the health needs of the catastrophically disabled be met in lieu of those recognized as a basic health program, but we are urging that they be adequately recognized as a part of the total health problem of the country and in the health insurance system devised to meet that total health problem.

We have a small group of representatives of a number of national organizations concerned for the rehabilitation of handicapped people who are working on this problem and its solution. Some of their preliminary thinking is that certain catastrophic impairments can be identified which do not receive sufficient or thorough attention in any of the health insurance proposals. Persons with these comparatively rare physical or mental impairments may need expensive, comprehensive services on a continuing coordinated basis for a prolonger period, sometimes the lifetime of the individual. Evidence has accumulated which shows that carefully prepared interdisciplinary tailor-made regimens, using a variety of medical-social resources, can assist these catastrophically disabled individuals to attain a level of physical, economic and social functioning which would otherwise not be possible. In the United States today, such comprehensive care is provided at best on a fragmented basis involving a variety of independent professional persons, voluntary and official facilities and agencies. Coordinators rarely have the power or cooperation needed to be effective in their area. Payment of health services is unnecessarily expensive when fragmented, uncoordinated care is provided. Incentives in use reinforce the continuing provision of episodic versus goal-oriented management as a consequence, catastrophically disabled individuals are less likely to obtain levels of adjustment to their impairment which are satisfactory to the individual, his family and society.

Part of the solution may be a system which encompasses the use of a long-range management plan developed by an appropriate professional person to-

gether with the patient and approved by a panel of experts. The plan would include specific objectives for the management of the patient and the steps necessary to reach the agreed upon objective, and would be reviewed regularly and modified as indicated. Some use of regional or catchment areas would also appear to be indicated in order to avoid costly duplication of facilities and services.

#### REHABILITATION FACILITIES—MEDICARE

The other resolution related to national health insurance adopted by the 1971 annual Conference of the National Rehabilitation Association reads as follows: "Whereas, rehabilitation facilities are a major service-giving resource for treatment of the disabled, and

"Whereas, many rehabilitation facilities have been experiencing difficulties in providing services under the Medicare program since they do not fit the definitions of a hospital or extended care facility and arrangements through home health care agencies are cumbersome and often unsatisfactory, and

"Whereas, these problems will become more acute with the extension of Medicare to disabled beneficiaries under the provisions of H.R. 1: Therefore, be it

*Resolved*, That the National Rehabilitation Association support amendments to the School Security Act and related legislation in the field of medical insurance and medical care which would recognize rehabilitation facilities as primary providers of medical care and health related services."

When it came to our attention that rehabilitation facilities had been experiencing some difficulties in providing services under the Medicare program, we realized that part of the trouble is in the very nature of the rehabilitation facility which has a comprehensive approach and is a unique type of agency in the medical care of the disabled. This is not fully reflected in the Social Security Act or in the various health insurance proposals. Since rehabilitation facilities are a major service-giving resource for the treatment of the disabled, we recommend that national health insurance legislation recognize rehabilitation facilities as primary providers of medical care and health related services.

We would be happy to work with the Committee on appropriate definitions of a rehabilitation facility and its services.

Thank you very much for this opportunity to express our views.

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#### SUPPLEMENTAL STATEMENT OF CHARLES L. ROBERTS, EXECUTIVE VICE PRESIDENT, INTERNATIONAL ASSOCIATION OF REHABILITATION FACILITIES

Recent developments in the administration of existing Medicare legislation causes us to seriously question the adequacy of current health care provisions for the nation's older citizens, and equally important—adequacy of health care services as outlined in any of the proposed legislation we have reviewed.

I refer to the policy of retroactive denial of reimbursement for medical rehabilitation under Medicare. Our facilities across the country report that thousands of our older citizens who assumed they were covered under Medicare have been denied essential medical rehabilitation services. Others who were provided the services have found themselves liable for costs incurred when Medicare fiscal intermediaries have recently begun retroactive denial of payment.

The Social Security Administration assures us that their guidelines and interpretation are consistent with the law and its intent. However, this policy results in a denial of essential medical rehabilitation at the very time when it will be most effective and would also result in the greatest saving of money. Patients with long term disabilities (e.g., stroke victims) are being consigned to permanent dependency in nursing homes when they might achieve independence through medical rehabilitation. The current proposals make the same error of omission for all persons to be covered as does Medicare for the aged. It has been incorrectly assumed that Medicare coverage is adequate and could serve as a prototype of service provisions. The Long bill, for example, excludes those over 65 on the assumption that Medicare is adequate. We seem about to disregard the discoveries and tested results achieved over the past 30 years which show that early rehabilitation results in savings of both human dignity and financial resources.

IARF has appropriate data and resources to support our concern, and we would be delighted to provide any additional information to the Committee.

Mrs. LAMBORN. The first point I really wanted to make was about the rehabilitation process itself, because I think it is at the heart of the matter. In essence, it is really an evaluation of each individual's needs and his rehabilitation potential and the provision of medical training and other supportive services that he needs to reach his rehabilitation goal.

Of course this process does not take place in a vacuum. The rehabilitation of any individual is interwoven with the whole environment in which he lives—social environment, economic, and so on, so the quality and the availability of the educational system, of the systems of medical care and those of other organizations and institutions serving human needs have a great deal to do with the extent to which an individual who is disabled can be rehabilitated. That is why both the National Rehabilitation Association and the International Association of Rehabilitation Facilities are interested in the proposals for national health insurance.

We are not supporting a particular bill. We have had a group that has worked on some of the principles which we think are important and some of them have already been mentioned today. I will not list all of them, but one of them was the one just stressed by Dr. Webb on the prevention aspect. This ought to be taken into account very seriously in the development of any system.

Another is the system should be one which is available to people without regard to age, without regard to the nature of their health problem or in relation to their ability to pay. We think it should be comprehensive in nature and it should be provided on an interdisciplinary basis. We think there should be no distinction made, really, between the use of facilities that are publicly owned and those that are privately owned. That is just a capsule summary that covers some of the major things with which we have been concerned.

I also wanted to call attention to a couple of resolutions which were passed at the annual conference of the National Rehabilitation Association last month. One of them deals with medical services to the catastrophically disabled. The essence of it, if I leave out the various "whereases," was urging the Congress in the national health insurance program to make sure that the total health needs of catastrophically disabled individuals can be met under the legislation and further, that the legislation contain provisions which will assure that such disabled individuals will receive appropriate services in appropriate facilities under competent medical supervision in order that their maximum rehabilitation potential may be realized.

Of course we realize this is a very difficult area and we are not suggesting that the health needs of the catastrophically disabled should be met in lieu of a basic health program. We simply feel it is part of the total health problem in the country and it must be considered in that context and given very serious consideration.

We have had a small work group working in this area. What they have done is very preliminary but I think they have been impressed by several different factors. Even good medical care is likely to be fragmented as far as the individual patient is concerned. Probably one of things that has got to be considered is how to develop a long-range plan for this kind of catastrophic disability.

You can bring things together and get the most out of your scarce resources rather than picking here, there, and everywhere. That is one thing we wanted to talk about.

The other resolution dealt with rehabilitation facilities in relation to health insurance. You know rehabilitation facilities are really a major service-giving resource for the treatment of the disabled, and we know that they have been experiencing some difficulties under medicare since they don't fit into the definition really neatly, many of them, of a hospital, or extended care facility or nursing home.

Some of them will meet one or the other, but basically it is a different kind of animal you are talking about, and yet the approach that rehabilitation facilities are using is one that is very much needed and very effective for many of the disabling conditions in this world.

So we would like to see that there be recognition in the legislation of this kind of facility giving medical and health services as a primary provider and not just sort of squeezed under an umbrella of some sort that it really is not.

We would be very happy to work with all of you in any way we could to try to help on this, and I appreciate the opportunity of being here and speaking.

I think Mr. Roberts wants to add something on this problem I just spoke about.

Mr. ROBERTS. Thank you.

We have been helped a great deal in our recent efforts to establish good communications with the Social Security Administration, particularly by Congressman Byrnes' office. There have been some very recent developments in existing medicare which causes us to question seriously the adequacy of current health-care provisions for older citizens and probably, of more importance and concern to your committee, is the adequacy of health-care services as outlined in any proposed health-care legislation that we have seen.

I am referring to the policy of retroactive denial of reimbursement for medical rehabilitation under medicare. Our facilities all across the country report to us that thousands of our older citizens who assumed they were covered under medicare have been denied essential medical rehabilitation services and others who were provided the services found they themselves are now liable for the costs incurred when medicare fiscal intermediaries have begun retroactive denial of payment.

In a meeting last week the Social Security Administration assured us their guidelines and interpretations are consistent with the law and its intent. However, this policy results in a denial of essential medical rehabilitation at the very time when it will be most effective and would result in the greatest saving of money.

Patients with long-term disabilities, for example, stroke victims, are being consigned to personal dependency in nursing homes when they might achieve independence through medical rehabilitation.

The current proposals for national health care all make this same error of omission for all persons to be covered, as does medicare make the error for the aged. It has been incorrectly assumed that medicare coverage is adequate and could serve as a prototype of service provision.

The Long bill, for example, excludes those over 65 on the assumption that medicare is adequate. I guess the essence of what I wanted to say is that we seem about to disregard the discoveries and the tested results achieved over the past 30 years which clearly show that early rehabilitation results in a savings of both, human dignity and financial resources. We have the appropriate data and resources to support our concern and we would be delighted to supply any additional information along these lines to the committee.

Mr. ROSTEKOWSKI. Thank you.

Are there any questions?

Thank you very much for a very informative statement.

Mrs. LAMBORN. Thank you, Mr. Chairman.

Mr. ROSTEKOWSKI. The Chair now recognizes Mr. Royce P. Noland. Will you identify yourself for the record, please, and then continue with your statement.

**STATEMENT OF ROYCE P. NOLAND, EXECUTIVE DIRECTOR,  
AMERICAN PHYSICAL THERAPY ASSOCIATION**

Mr. NOLAND. Thank you, Mr. Chairman.

I am Royce Noland, executive director of the American Physical Therapy Association, the national organization representing some 17,000 active physical therapists practicing in hospitals nursing homes, home health agencies, private practices, teaching situations, and doing research.

As an increasingly important member of the health care team, the physical therapist participates in the evaluation of patients and uses therapeutic properties to help patients regain normal function. Working independently—or at the referral of a physician—the therapist treats patients with such conditions as stroke, multiple sclerosis, or Parkinson's disease. He or she applies his rehabilitative skills also to persons who have undergone major surgery, or who are crippled and handicapped by accident or by birth.

But it is not my purpose in coming here this morning to talk about the benefits of physical therapy. As a matter of fact, it is the last time you will hear that in this testimony.

Mr. Chairman, our association firmly believes that this committee is in a unique position to remove the financial barriers to care for all Americans, and to exert a profound influence on the manner in which that care is delivered. As we have learned from medicare and medicaid, the financing of care cannot be divorced from its delivery.

Mr. Chairman, at the 50th annual convention of the American Physical Therapy Association in Boston this past June, our house of delegates adopted what we believe is a far-reaching position on priorities in the health care system. It stated that, in our opinion, "Health care is second in priority only to an environment that contributes positively to human health." Our priorities embrace a partnership of public and private financing plans and health facilities which, operating together, can make comprehensive health care available and accessible to all people. We call for testing and application of new methods of delivering health care such as health maintenance organizations, for an expansion of preventive health care services, for public accountability,

including peer review and consumer participation in decisionmaking.

With your permission, Mr. Chairman, I would like to ask that the full statement of these priorities be inserted in the record at this point in my testimony.

Mr. ROSTENKOWSKI. Without objection, it will be printed in the record.

(The material referred to follows:)

AMERICAN PHYSICAL THERAPY ASSOCIATION, POSITION ON  
PRIORITIES IN THE HEALTH CARE SYSTEM

(Adopted by the 1971 House of Delegates—APTA)

In concern for the health of the American people, health care is second in priority only to an environment that contributes positively to human health.

Within health care, the American Physical Therapy Association advocates certain priorities which, if adopted by appropriate policy-making bodies, would promote the right of all persons to have equal access to and equal availability of high quality health care services.

These priorities are directed to principles and mechanisms which should pervade all elements of the health care system in the United States.

The health care system should utilize existing public and private services, facilities, and agencies in ways that will economically make comprehensive health care available and accessible to all people.

Alternatives to existing methods and organizations for delivering health care should be encouraged when they demonstrate reasonable predictability of contributing to the availability and accessibility of comprehensive health care.

Preventive health care services and public education in personal health care should be made an integral part of the health care system.

The health care system should be accountable to the public and should include effective mechanisms for peer review, multidisciplinary review, and consumer participation in policy and audit of the system.

A sufficient number and variety of health care personnel should be educated to meet continuing health care needs, and encouragement should be given to all health care personnel to provide services in areas of the nation where comprehensive health care may not be available.

The availability of health screening, preventive and early care, and timely referral for more extended care should be expanded by recognizing and enhancing the existing competencies of a variety of health care personnel.

Methods of financing the health care system should take optimum advantage of both public and private funding mechanisms to support the full scope of health care and to remove inequitable barriers to receiving necessary health care services.

Mr. NOLAND. Now, Mr. Chairman, I would like to describe a plan for financing and delivery of death care which our association's house of delegates endorsed in principle as a working guideline at the June convention. With your permission I will summarize the plan now and submit a full copy for the record to be inserted at the end of my statement.

Mr. ROSTENKOWSKI. Without objection, the summary may be inserted in the record at this point.

(The material referred to follows:)

Endorsed in principle as a working guideline by  
the 1971 House of Delegates - APTA

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#### A PLAN FOR FINANCING AND DELIVERY OF HEALTH CARE

The plan for financing of health care should be through a combination of federal support, direct individual participation, and insurance-like programs.

The plan for delivery of health care should provide for utilization of existing public and private services and facilities, and integration of alternate methods of delivery and alternate health care organizations.

All services, facilities, systems, and organizations should be subject to audit against national standards, such standards having a principal criterion of making care more accessible and increasing the quality and comprehensiveness of care.

To assure public accountability of the health care system, certain auditing units should be created.

1. A national health care commission should be created with a constituency of consumer representation being in the majority and representation from a variety of health industry personnel and facilities. The health personnel should represent a mix of disciplines and vocations. Natural groupings should be identified such as physicians, other professional nonphysician personnel, technical workers, and supportive personnel and these several groupings should be appropriately represented.

Among the functions of the commission should be those of developing policy and auditing the system from the viewpoint of service, achievement status, and fiscal reasonableness.

2. Each state should have a similarly constituted health care commission which is related to the national health care commission but independent from any state agency or governmental unit. The constituency and functions of the state commissions should be essentially identical to those of the national commission with the additional function of reporting local findings and making recommendations to the national commission.
3. Peer review and interdisciplinary review bodies should be created. These units should be as localized as possible and should receive federal guidance and some fiscal support. A specific peer review system should be genuine in the full meaning of that term. Consumers and persons providing health care should utilize these review bodies

to arbitrate matters of concern to both and the review bodies should carry major weight with other entities needing to adjudicate disputes.

The interdisciplinary bodies would supplement the peer review bodies and would serve to enhance the interaction and professional competencies of all health personnel. They could also serve in an advisory role to the state and/or national health care commission.

#### EDUCATION COST OF HEALTH PERSONNEL

If the health care system is to meet the needs of the people there is a self-evident need for additional health personnel. This would be true even in an atmosphere of optimum utilization of the existing categories and numbers of persons now in the health care system.

It is vital that the federal government take a more aggressive role in funding facilities, teacher preparation, program development, and student support to produce these needed personnel. Such funding should be the first and highest priority in any program to enhance, alter, or expand the health care delivery system. The cost of the basic educational training of health personnel should be separated from the costs of delivering health care services.

One of the major dilemmas found by both teaching hospitals and other like institutions, as well as fiscal agents, is that of absorbing education costs into service delivery reimbursement. It would be better, therefore, to have the charges for services considered in light of their specific relative value and for government to participate in the cost of training health personnel under separate funding.

#### ELEMENTS OF THE PLAN

The health care delivery system should provide three grades of health care services which vary in purpose, intensiveness, and expensiveness.

They are:

1. Preventive health services
2. Episodic health services
3. Health catastrophe services

##### 1. Preventive health services

These should include public education in personal health matters, periodic health status evaluation, and certain minimal direct services. This entire spectrum of preventive health services should be fully supported through federal resources.

Health education should be an integral part of the services of health delivery agencies and should be implemented and expanded in public and private community institutions. This education should not only include such elements as basic hygiene but should serve to increase the public's individual and collective awareness and comprehension of health service needs.

Inherent in the preventive health services program should be obligatory periodic examination, testing, or screening to produce both an individual and a national health inventory. This should be used to alert and guide individuals toward any needed care services.

There are certain services that can, at minimum cost and time, prevent disease or improve the person's health status. These can be defined and should be a significant part of preventive service. These would largely be periodic in nature and would be intended to avert morbidity.

The various preventive services should more effectively utilize nonphysician health personnel and technological advances in diagnosis and treatment.

## 2. Episodic health services

The major portion of health care service needs are episodic in nature and are intended to restore the individual to his premorbid health status. These services would include both intensive and extensive care.

It is this level of care that the individual, reinforced by an insurance-like program, would participate in payment for care.

Whether the insurance program is federally administered or is administered through nongovernmental institutions is less important than the nature of the insurance. There should, therefore, be federal standards and federal auditing of this insurance system. Coverage should include all needed health services with emphasis on out-of-hospital services. There should be both deductibles and coinsurance.

For this or other levels of service some element of choice should remain for the consumers to they might select between traditional and alternate methods of delivery. The health delivery system should not evolve into a "monopolistic public utility" as is advocated in some of the proposals for national health insurance. Time, the competitive atmosphere, adequate fiscal resources, and technological advances should be permitted to have their natural impact on synthesis of the delivery system.

## 3. Health catastrophe services

This level of service is largely protracted or prolonged in nature and is intended to restore the person to a sufficient level of his premorbid health status so as to avoid total incapacitation or minimize loss of health status. These services may include preventive measures, as well as intensive care and extensive care.

It has been estimated that less than three percent of the population has fiscal resources adequate to underwrite the costs of these kinds of prolonged and sometimes protracted care. Therefore, federal resources should be used to subsidize the full costs of this level of services. This method of funding will not only protect the fiscal solvency of persons with catastrophic health problems requiring this level of service, but will also make the costs of episodic care more predictable and economical.

#### TECHNICAL FISCAL CONSIDERATIONS

- Financing through Social Security taxes should be eliminated. The burden now being assumed by Social Security retirement benefits and Medicare are bringing this form of taxation to a point of saturation. Social Security withholding taxation has many inherent inequities, and it is now going to represent over eleven percent of earnings without any national health insurance. The concept of gaining further revenue through that source is contrary to the public interest. Social Security withholding taxation is also contradictory to the concept of graduated taxation because the poor pay just as much as the rich.
- The financing methods and systems for payment should not segregate people by age groups or otherwise. As a workable financing method emerges, such programs as Medicare and special children's programs should be phased out. Concurrently, federal and state systems serving special beneficiary groups should be integrated into the total delivery system. This should occur in an orderly fashion, however, utilizing the facilities and personnel now so involved and assuring that there be no interruption of services to these groups.
- A consistent and relevant method of payment or reimbursement should be developed and should be applicable to all levels of the program regardless of whether payment is by the individual, through an insurance carrier, or direct federal payment.
- The concept of "reasonable charge" should replace "cost reimbursement" as the principal means of payment for services. The concept of "cost reimbursement" has been one of the major problems of the Medicare program and if this were extended to the whole health delivery system for all persons it could produce chaos.

It was originally presumed that the cost reimbursement concept would act as a ceiling on costs. Actual experience has been, however, that this method forced the cost of health care up fifty percent since the inception of Medicare. A negotiated fixed reasonable charge approach for payment would be more equitable to both the provider of service and to the consumer.

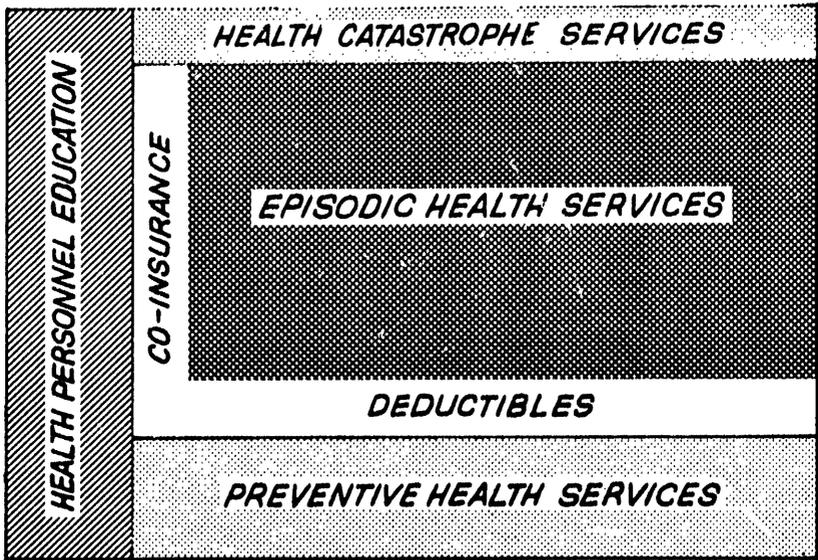
This does not imply the approach of "usual and prevailing fees" advocated by organized medicine. The reasonable charge would be a negotiated figure developed for a specific economic community. The community could be as small as a city or as large as a multi-state region and be based on general economic factors, as well as specific cost experience for health care. The resultant reasonable charges would use the principle of relative value -- both intra-and interdiscipline.

- If capitation is used as an alternate means of reimbursement, the formulas that emerge from establishing relative values, coupled with actuarial data, could be the basis for determining the capitation reimbursement.

- Support should be provided for persons unable to meet the individual financial obligations of the program. It is recognized that some segments of the population might lack the financial resources for paying the insurance premium costs or the deductible or coinsurance requirements of this plan. Federal and/or state support should be provided those persons for this purpose. This need not and should not involve any new means test that is specifically related to health care and the funding should be through a separate type federal or state program of support. The methods to accomplish this are legion, but one might be a system of Internal Revenue Service tax credits or supplemental refunds. This would eliminate the need for any unique means test, public disclosure, or new bureaucratic administrative unit. Since the IRS system has precedent for tax credits for health care costs, this could represent a simple extension of that process.

Whatever the method might be, it should ensure that economic status is not an impediment to gaining needed health care, presuming that the individual has placed reasonable priorities on his, and his dependents' health care needs.

## FUNDING SOURCES FOR HEALTH PERSONNEL AND SERVICE LEVELS



### *Sources of Funding:*

- |  |  |
|--|--|
| <p>□ Individual</p> <p>■ Insurance</p> | <p>□ Full Federal Subsidy</p> <p>▨ Major Federal Subsidy</p> |
|--|--|

Mr. NOLAND. Consistent with our health care priorities statement we believe a national health plan should combine both public and private financial and delivery resources. All health care services should be governed by national standards, which would be aimed at guaranteeing high quality care, and accessibility to all.

There are three grades of health care services in our plan, each varying in scope and financing.

#### PREVENTIVE HEALTH SERVICE

This level should include public education in personal health matters, as well as periodic health screening, and minimal direct services such as immunization. Data from periodic examinations should be used to produce both an individual and national health profile. Such data could be used not only individually, but to identify problem health areas in the Nation. Preventive services, whether provided in a physician's office or public health clinic, should utilize nonphysician health personnel and automated methods of diagnosis and treatment as much as possible.

All preventive health services should be financed through Federal resources.

The second level of care is episodic health service. This category embraces the major portion of routine health care needs which are directly tied to sickness and disability. Coverage should include the usual range of comprehensive health services, with emphasis on out-of-hospital care. Consumers should have a choice of traditional methods of care, or care provided through alternate systems such as pre-paid health maintenance organizations.

We would emphasize at this point that we firmly believe in a pluralistic system of health care and would oppose any plan which would lead health care in this country into a monopolistic public utility status. Time, the competitive atmosphere, adequate fiscal resources, and application of technology should be permitted to work their natural course on the system, with appropriate stimulation from Government.

Whether the insurance program for episodic health services is administered federally as is medicare, or is administered through non-Governmental institutions, is less important than the comprehensiveness and quality of the coverage. There should be, therefore, Federal standards and Federal auditing of the program to insure efficient administration and uniform coverage.

Financing for episodic services would be shared by the Government in the case of the poor, the employer and employee. We recommend use of deductibles and coinsurance as a brake on over utilization of services, and as one means of cutting the cost. But these could be deleted for low-income groups if they threaten to bar these individuals from obtaining health care.

The third level of care proposed in our plan is health catastrophe service. By the very name, these are lengthy, prolonged health care services usually involving long stays in the hospital, care by a variety of medical specialists, and often, the use of extremely expensive equipment. It has been estimated that less than 3 percent of the population has fiscal resources adequate to underwrite the cost of this kind of care.

Therefore we recommend that catastrophic health services be paid for entirely with Federal funds.

#### FINANCING CONSIDERATIONS

Now I would like to comment briefly on technical fiscal considerations. First we submit that national health insurance should not be financed through social security taxes. The burden now being assumed by social security retirement benefits and medicare is bringing this form of taxation to a point of saturation, and adding a further burden of national health insurance is not in the public interest. Social security withholding taxation is contradictory to the concept of graduated taxation, which we believe should be the route for Federal financing of health care.

Second, we believe the financing methods and systems for payment should not segregate people by age or other classification. As the new national health plan takes hold, other programs such as medicare and maternal and child health services should be phased into it.

Third, the method of paying providers should be consistent throughout the program—whether the payment is by the individual, the Government, or through a private insurance plan. We believe the

concept of the prenegotiated "reasonable charge" must replace "cost reimbursement" as the principal method of payment. But by "reasonable charge" we do not mean the "usual and prevailing fees" advocated by organized medicine. The reasonable charge would be a negotiated figure developed for a specific economic community. The community could be as small as a city or as large as a multistate region and the charge based on general economic factors, as well as specific cost experience for health care.

As I indicated in discussion of episodic health services, Federal and State government should help persons unable to meet the individual financial obligations of the program. The methods to accomplish this are legion, but we see merit in the tax credit route since the machinery is already in place for this through the Internal Revenue Service.

#### ADMINISTRATION

Public accountability is an estimated element of the plan I have outlined.

First, a national health care commission should be created, made up of a wide range of health industry personnel, but with consumers in the majority. This group would set the overall national policy for the plan and audit the system from the standpoint of service, achievement, and fiscal reasonableness.

Second, each State should set up a similarly constituted health care commission which is related to the national commission but independent of any other State agency.

Its responsibilities would be identical to the national body and, in addition, would report local findings and make recommendations.

Finally, groups should be set up locally to monitor operation of the program and performance of providers. These could be peer review bodies for individual classes of providers such as physicians, and multidisciplinary groups which could cover the entire local spectrum of health care delivery. These groups should get Federal guidance and some fiscal support. They could serve as arbiters in disputes between consumers and providers or between different groups of providers.

#### MANPOWER TRAINING

Now a word about education of health service personnel. There is obviously a great need for added numbers of health service personnel at all levels. Our concern is that support for the educational process not be tied to the financing of services. The Federal Government supports education of health workers as a national resource. As a general principle, therefore, we believe society at large, through general taxes, ought to subsidize the cost of training health workers, and that this cost not be made part of the cost of being sick. Costs of services then could be considered in their own relative value without being padded by costs of educating health personnel.

And so to quickly summarize. We propose that the national health plan shaped by this committee merge public and private resources and financing to provide three levels of care:

Preventive care, paid for entirely through Government funds.

Episodic care, financed privately with the consumer paying part of the cost through deductibles and coinsurance.

Catastrophic care, financed entirely by the Government.

The plan would be supervised by commissions at the State and local level with peer review and multidisciplinary groups monitoring performance of the plan at the local level.

Financing of the Federal share would be through means other than social security.

The cost of training health workers would not be financed through charges for services.

That concludes my prepared testimony. I will be happy to answer any questions which you or other members of the committee may have.

Mr. ROSTENKOWSKI. Are there any questions?

If not, thank you, Mr. Noland.

Mr. NOLAND. Thank you, Mr. Chairman.

Mr. ROSTENKOWSKI. The Chair recognizes Dr. Louis M. Aledort, medical director of the National Hemophilia Foundation.

Would you identify yourself for the record?

**STATEMENT OF DR. LOUIS M. ALEDORT, MEDICAL DIRECTOR OF THE NATIONAL HEMOPHILIA FOUNDATION; ACCOMPANIED BY DR. JAN VAN EYS; AND ROBERT LONG, MEMBER OF THE EXECUTIVE BOARD**

Dr. ALEDORT. I am Dr. Louis Aledort, medical director of the National Hemophilia Foundation and assistant professor of medicine at the Mount Sinai School of Medicine, director of the Coagulation Laboratory and the Hemophilia Clinic at Mount Sinai Hospital in New York City.

I am accompanied by Dr. Jan Van Eys, a professor of pediatrics at Vanderbilt, and Mr. Robert Long, on the executive board of the Hemophilia Foundation.

The National Hemophilia Foundation believes a national health bill must aid hemophiliacs, whether the sufferer is an out-patient, an in-patient, or on a home care program.

While the foundation is particularly interested in having coverage for hemophilia, it asks that other chronic blood diseases such as leukemia, sickle cell anemia, Cooley's anemia, and others be included, although I cannot speak directly for other health agencies. The hemophiliac, however, is the prototype of the chronic blood user and as such he has his own peculiar problems.

Hemophilia is a genetic disorder of the blood in which a clotting factor is either partially or completely missing. Hemophilia is widely known as the bleeder's disease, and it is estimated that there are 60,000 to 100,000 in the United States without regard to race, color, or creed.

Hemophiliacs are unique among chronic disease victims because they are not born crippled and can be cured if financial conditions allow them to continually purchase the missing clotting factor. Without this ongoing treatment, the hemophiliac becomes an unnecessary burden to himself, his family, and to society.

The sufferer is subject to hemorrhaging—both internally and externally. In severe cases, internal bleeding will start spontaneously—that is, with no apparent cause. A procedure as routine as a tooth extraction, for example, could become a major crisis for a hemophiliac, requiring countless transfusions and a hospital stay. With the repetition of bleeding episodes, the hemophiliac becomes crippled by his own blood.

But beyond the physical crisis, the hemophiliac is constantly threatened with uncertainty since a bleeding episode may occur without warning. Consequently, there is a tendency among family members to curb day-to-day activities for the sake of the sufferer. The psychological toll is incalculable, and in some cases devastating.

Even with optimal genetic counseling, hemophilia has an extraordinarily high rate of occurrence, and I would state flatly that it cannot be eradicated. The disease may occur spontaneously, without any previous family history, and as such, hemophilia has the highest rate of mutation of any genetic disease.

Medical advancements are providing us with materials capable of correcting the disorder by replacing the missing clotting factor. Bleeding can usually be checked with transfusions of fresh whole blood, plasma, or clotting concentrates. This procedure is known as replacement therapy; and from, 10,000 to 15,000 patients are severely enough involved to require continuous replacement therapy from birth to death.

The hemophiliac poses specific medical and financial problems

1. Replacement material is extremely costly, running from \$5 to \$30 a unit, depending on the locality where it is administered. It is not uncommon for a single hemophiliac to use 150 to 250 units a year.

2. Replacement therapy is generally carried out in an outpatient emergency room where third-party coverage is often unavailable.

3. Reconstructive surgery for correcting crippled joints is both time consuming and extraordinarily expensive, and the cost of replacing products alone, without doctor's fees or hospital costs, can be as much as \$15,000. Again, this is rarely covered by third-party payments.

4. Maintaining an outpatient clinic offering comprehensive care beyond replacement therapy—with a social worker, psychiatric, dental, and vocational assistance, is a necessary but overwhelming personal burden for the hemophiliac and his family.

5. All replacement therapy, either in the form of direct transfusion of blood or one of its components, makes a major impact on the blood banking industry in the United States. It is estimated that 27 percent of all the blood units collected is used by the 10,000 to 15,000 severely involved hemophiliacs. This blood need to combat hemophilic bleeding was the initiating force behind the creation of the National Hemophilia Foundation, which has dedicated its efforts to recruit donors.

In addition, the foundation and its 55 national chapters are making a significant contribution in identifying hepatitis carriers, a disease passed on by way of blood transfusions. After years of receiving blood transfusions themselves, some hemophiliacs have manufactured antibodies to the hepatitis virus. Using blood from these hemophiliacs, we are able to test all blood donations for the disease, and the procedure will soon be applied nationally to all blood donations.

In the past 10 years, there has been a marked increase in blood product utilization by hemophiliacs. Recognizing that the increase in blood use could outdistance the supply, we have advocated the concept of "component therapy." This means that a unit of blood is fragmented and its parts distributed according to specific needs. One type of hemophiliac, for example, needs only a small plasma portion called cryoprecipitate, another hemophiliac is able to utilize the remaining plasma, a leukemic is able to utilize the platelets derived from the same unit, while another patient, perhaps hospitalized with a bleeding ulcer, might use the red blood cells. One unit of blood, then, has met the needs of four patients.

A hemophiliac can live a useful life as long as replacement therapy is readily available. Hemophiliacs, whether they are students or employed, show a positive attendance record with continuous treatment. But the time spent waiting in hospital emergency rooms is compromising and costly.

It is for these reasons that many areas of the country have successfully started a program of "home therapy." At the onset of bleeding, a patient may give himself an infusion of the necessary blood component, which will control both pain and bleeding. This is being carried out at home, at work, and at school. Dr. Van Eys will discuss this later.

It is possible that a child born today and diagnosed as a severe hemophiliac will live a normal life without any crippling results from his disease if he is continuously treated. It is unfortunate that the majority of our adult patients were not born in an era when modern therapy existed. Nonetheless, there is no question that "home therapy" provides the most satisfactory treatment for the future hemophiliac, particularly if we believe that the aim of modern medical care is to decrease the need for hospitalization and government-dependent patients. It is vital, therefore, that in addition to inpatient coverage, outpatient and home care programs be covered in national legislation.

Essentially we face two problems. One is the rehabilitation of patients already crippled; the second is the long-range management of the newly diagnosed child. Both problems create extensive financial drains on families and communities, setting aside for the moment the emotional strain and social stigma.

With the advent of component therapy, we are utilizing our blood resources more effectively and reducing the burden for local blood banks. As home therapy techniques become more widespread, the hemophiliac will evolve from a hospital-dependent to an independent individual. The costs of outpatient replacement therapy are still beyond the normal financial capacity of the average family, and many families become medically indigent as a result—even with assistance from the Crippled Children's Service and medicaid programs. This is why coverage of replacement product costs is so desperately needed for hemophiliacs. It is important to realize that even though the initial cost of providing such coverage for outpatient replacement therapy may increase the public burden for the moment, the long-range expense to the taxpayer will be lessened as more and more hemophiliacs are able to maintain their health, become educated, work without great absenteeism, and eliminate the need for public assistance.

Again, I would emphasize that hemophiliacs can become functioning, productive members of our society if they are able to obtain

adequate therapy and financially cover costs. By a continuous replacement of the missing clotting factor, they are able to become the living dividends of the very investment I am requesting here today.

We propose that a health insurance program shoulder the costs of inpatient, outpatient, and home therapy as well as the costs of blood replacement products. Without this care program, the cost to patient, family and public service agencies will be even higher. We are confident that if such a program were established, hemophiliacs would further their efforts in blood recruitment.

The National Hemophilia Foundation proposes, then, that a national health bill include the following provisions:

1. Medical coverage will be provided for hemophiliacs and other persons with chronic blood disorders, whether they are inpatients, outpatients, or on medically approved home care programs.

2. Persons for whom the maintenance of life and health requires periodic or systematic transfusions of blood or blood derivatives will be covered for the cost of their blood product, its preparation, and its administration.

3. And third, that such payments should apply to the use of inpatient or outpatient facilities and under medically approved home care programs.

Dr. JAN VAN EYS, professor of pediatrics and biochemistry at Vanderbilt University, will present testimony regarding the value of a home therapy program in Nashville.

Dr. VAN EYS. Mr. Chairman, over the last 2-year patients afflicted with hemophilia began to participate in a home management program for self-administration of the product that can be done without having to resort to hospital visits. The impetus to this program was initially the staggering costs. I would like to give a few specific examples of such costs.

At New York's Mount Sinai Hospital in the month of August 1961, 35 hemophiliacs made 113 visits. They spent on materials alone a total of \$15,512. Each visit cost for materials alone \$115.

Another example: in Los Angeles in one hospital 254 patients got cared for for the year September 1, 1970 to September 1971. They spent on costs for materials alone an aggregate total of \$834,345.

The program at present in our area is under the guidance of physicians at Vanderbilt University School of Medicine, through telephone conversations and periodic checkups. The program in Nashville is neither the only one nor the first. Other programs are in Boston, Chicago, Fort Worth and on the west coast are in existence. The Nashville experience is representative.

Our patients have at home a low-cost especially designed freezer that makes it effective to store the blood clotting factor at home. If the patient is a severe hemophiliac, he administers the clotting factor when needed. A distinction is made to keep the blood product used at the lowest possible rate. There are a number of practical and clear results.

1. Productive time is markedly increased, the home care has made it possible for patients to attend school full-time without interruption. Others have been made to maintain their job. In one case a patient had been able to meet part of the financial obligations generated by his hemophilia for the first time because of improved job performance.

2. It has improved self-esteem of the patients to the degree that blood recruitment efforts are more intensive and productive. Often the total dependence on the hospital before the home care program resulted in dependence of whole aspects of care which included the supply of blood product.

3. Small children on home care are able to remain free of crippling because of prompt therapy. They will now face a future which should be almost normal.

4. Most importantly, home care has resulted in a net cost saving. A typical example is a 17-year-old boy who has been on home care for 18 months. His present average yearly cost of care has been placed by the parents calculated over the last one and a half years at \$7,835. The yearly average before home care came to \$10,660.

Another example of the saving: in Fort Worth, the home infusion program has resulted in a drop of the cost of clotting product from \$27.50 to \$11. This is the order of magnitude of saving through home care. It does not tell the whole story, however. Countless man-hours of medical and paramedical personnel are freed because of the home care rather than hospital-based care. Yet, it is obvious that costs are still very great. It is within the present resources of our community to be able to supply the blood needs of our hemophiliacs. If the aggressive promotion of blood component therapy will continue to yield results it has done thus far, we further expect costs to go down and available supplies to go up. However, the bulk of the cost will still lie with the cost of the blood products.

Thank you.

Mr. ROSTENKOWSKI. How soon do you think it will be before we can tell if whole blood is infected with infectious hepatitis?

Dr. ALEDORT. Approximately 25 to 35 percent of all infected units are being identified right now. The specificity of the test is still in a state where it needs further development. There are new techniques for measuring this virus as an antigen and it is assumed in the next 2 years they will probably pick up 95 percent of the infected donations. I don't know that we will ever be at 100 percent but 95 percent is estimated by the National Heart and Lung Institute within 2 years.

Mr. ROSTENKOWSKI. That is very encouraging.

Thank you very much, doctor.

Dr. ALEDORT. Thank you.

Mr. ROSTENKOWSKI. Dr. Irwin Brown.

Dr. Brown, would you identify yourself for the record and proceed with your testimony.

**STATEMENT OF DR. IRWIN BROWN, MEMBER, BOARD OF DIRECTORS, NATIONAL ASSOCIATION OF HEARING AND SPEECH AGENCIES; ACCOMPANIED BY TOM COLEMAN, EXECUTIVE DIRECTOR**

Dr. BROWN. I am Dr. Irwin Brown, executive director of the Hearing and Speech Center in Rochester, N.Y., and a member of the board of directors of the National Association of Hearing and Speech Agencies, and I have with me. Mr. Tom Coleman, who is executive director of the National Association of Hearing and Speech Agencies.

This agency, which we will shorten here today by calling it NAIISA, is a national voluntary organization which is concerned with problems in communications disorders and represents 165 different organizations devoted to this disability area as well as several hundred individuals, professionals, and volunteers who are also concerned with communications disorders.

Mr. Chairman, we have submitted a summary of our concerns and our recommendations and we feel that you will be reading this carefully, and we would like, at this time, merely to summarize our recommendations and to make some observations about the field, also supported by Mr. Coleman, who will make a statement. We would like to have this as part of the record, Mr. Chairman.

Mr. ROSTENKOWSKI. Without objection, your statement will be made part of the record.

Dr. BROWN. Thank you.

(The statement referred to follows:)

STATEMENT OF IRWIN BROWN, PH. D., NATIONAL ASSOCIATION OF HEARING AND SPEECH AGENCIES

Mr. Chairman and members of the Committee :

I. INTRODUCTION

We should like to express to you our deep appreciation for this opportunity to communicate directly with the Committee on Ways and Means at a time when you are involved with such an intricate project as designing a national health insurance program.

Our purpose here is not that of either supporting or opposing any specific national health insurance bill that has been brought to your attention. Rather, it is our intention to present to you, for your consideration as you plan and recommend a blueprint for the delivery of health and related services to people, the general needs of the millions of people in this country who are handicapped by some form of hearing, speech or language disorder.

Historically, the national leadership in health and related movements in this country has been unaware of the nature and extent of hearing/speech/language handicaps, but they must recognize the actual dimensions of the problem and the importance of this field of service. As one man put it . . . "as long as the ear was not usually the site of something that kills people, no attention was paid to speech and hearing in healthful living." Perhaps, the most recent illustrations of the limited visibility provided this important health-related field are contained in the Medicare and Medicaid programs, where only token considerations have been given to the needs of the estimated 20 million communicatively disadvantaged people of this nation.

It is our hope here today to indicate reasonably to this Committee the specific magnitude and complexity of the problems in this field which deals with hearing/speech/language disorders, including deafness.

II. THE PROBLEM

Similar to other service-to-people movements in this nation, the hearing/speech/language field has been inhibited in its activities by such problems as extremely high incidence of these handicaps in the population; severe manpower shortages and maldistribution; lack of recognition of the problem by those in power; an inadequate financial base; the absence of adequate delivery systems, and others.

A. Incidence

According to a 1969 publication of the National Institute of Neurological Diseases and Stroke entitled, *Human Communication and Its Disorders—An Overview* . . . approximately 20 million persons in this nation have communicative handicaps (hearing, speech and language disorders) which are worthy of

our concern and which create an annual deficit in the earning power of these collective individuals approximating \$1,750,000,000. Unfortunately, our surveys of hearing/speech/language service programs indicate that less than 5% of these individuals are receiving appropriate care.

Hearing/speech/language disorders spread across the human lifespan, from the cradle to the grave, and may have as their cause a developmental malformation, an injury, a disease, a functional derangement, degeneration, or perhaps some extirpative activity such as surgery. In professional terms, we might refer to these as disorders of reception (hearing problems), disorders of central processing (language development) and disorders of output (speech production problems). In more popular terms, the vocabulary would include such words and phrases as hard-of-hearing, deafness, articulation, delayed speech, stuttering, aphasia and laryngectomy, among others.

Through all of this, we are trying to indicate that while our popular terminology uses such words as hearing, speech and language . . . in reality, we are talking about a severely high incidence of health-related disorders which affect our ability to function and communicate reasonably within our social organization, our capability to learn and to develop concepts, our chances for maximum professional or vocational achievement and, ultimately, our ability to avoid the personal tragedies and social misunderstandings which communicative disorders impose on their possessors.

### *B. Financing services*

Historically, the cause of hearing/speech/language disorders has not been made popular with the general public of this nation. Thus, unlike some of the more visible crippling and terminal conditions, very little financial support has been made available to provide service in this field other than from sources such as united funds and government programs of limited scope. As stated before, limited benefits have been made available by Medicare and various Medicaid laws. Perhaps the greatest governmental support has been seen through the programming made available under the Vocational Rehabilitation Act and crippled children's programs.

Essentially, over the years, the hearing and speech movement has been financed on a deficit basis by community drives such as united funds or community chests, which in their very nature prohibit significant growth of service programs.

In recent years, through the guidance of NAHSA's educational and training programs, many agencies have put themselves on a business-like non-profit basis and through cost analysis, cost accounting, and appropriate setting of fees for services rendered have been "selling" their services at true cost, similar to other agencies and institutions providing services. Unfortunately, third parties rarely include payments for such services in their fee schedules.

There appears, at this point, to be a positive relationship between the quality and quantity of services rendered by an agency and the degree to which they have developed their non-profit practices on a business-like basis.

We currently are directing our efforts towards having benefits for hearing and speech programs included in third-party arrangements such as HMO's, private insurance carriers, and union health and welfare funds. Simultaneously, we are attempting to make appearances such as this one today in order to influence the consideration of benefits for those with hearing/speech/language disorders in any national health, rehabilitation, welfare or special education legislation.

To date, however, a sizeable percentage of services rendered in community speech and hearing agencies is on a charity basis and are essentially accomplished through the stretching of community fund support and contributions by individuals.

### *C. Manpower*

Though the hearing/speech/language handicapped population is numerically one of the largest disadvantaged groups in the nation, we have probably the most severe professional shortages within any field attempting to serve people.

In the specialties of speech pathology and audiology, we could fairly estimate that approximately 20,000 people are available to work in service, training and research programs connected with the field. As of August, 1971, the American Speech and Hearing Association indicated that its 13,741 membership included only 7,975 professionals with clinical certification in speech pathology, 925 with clinical certification in audiology and 832 with dual certification in audiology

and speech pathology. Of these clinically certified professionals in the field, only 66% actually are providing direct services to people, while the others are performing important roles in university teaching programs, administration, research and the teaching of handicapped children.

Despite the severe shortages in these two specialties, we have witnessed significant cuts in federal support of university training programs designed to increase our output of these vital specialists in this health-related field. For instance, one of the major resources for traineeships in recent years, the Rehabilitation Services Administration, in 1969 made drastic reductions in its support of training programs in the universities. This year, 1971, no new traineeships were made available. Such action has resulted in a drop of graduate trainees in hearing and speech supported by RSA from more than 600 in 1969 to less than 200 today.

It has been indicated that there are approximately 3,500 otolaryngologists and otologists considered available for practice in the specialty areas with which we were concerned in the hearing/speech/language movement. Most of these are concerned with the evaluation and management of symptomatic diseases or providing corrective surgery.

Simple arithmetic would indicate to anyone that we do not have available, nor will we in the foreseeable future, enough manpower in the professions of audiology, speech pathology or otology to provide those services needed and demanded by the huge patient load confronting us.

Unlike other health-related movements, supportive personnel with various levels of training to assist with the provisions of services to those with hearing/speech/language problems have been almost nonexistent. This situation, however, may be remedied as various federal agencies, including the U.S. Office of Education's Division of Manpower Development and Training, are beginning to assist NAHSA at its request with financial support in the development of curricula and establishment of pilot training programs for supportive personnel in hearing and speech. At this point there is reasonable indication that the use of such individuals will considerably enhance the capability of the professions by increasing the number of persons to which they can extend services.

#### *D. Delivery systems*

Traditionally, hearing/speech/language services have been provided in a variety of settings; free-standing non-profit clinics; clinics within hospitals or rehabilitation centers; state and local health or rehabilitation agencies; schools for the deaf; university clinics associated with training programs; Easter Seal Centers; school systems; physicians' offices; such business establishment as hearing aid dealerships; and other setting. Many program unfortunately have been isolated from the major health-related delivery systems. Other services also have been provided without professional guidance.

Recognizing the need for development of comprehensive systems of care, in which hearing/speech/language services would be only a part of those provided the whole individual, NAHSA through its programs has been providing educational and informational experiences which have contributed to administrative awareness of the need for affiliating with major developing delivery systems in health market areas.

Through this, the professionals within the field have begun to accept the concept of comprehensive care, including an understanding that one of its aims is to provide each individual with as much or as little service as he or she may realistically need.

The delivery system has been inhibited in many communities by the failure of the professions and businesses connected with the health field to establish a meaningful team approach that is reasonably devoid of a parochial or proprietary attitude.

Perhaps the most glaring deterrent to hearing/speech/language services involvement in comprehensive care is the absence of such systems to which we can relate our programs. Despite federal assistance for comprehensive planning at the state and regional levels in recent years, there is little to measure in terms of accomplishment as one travels on site visitation throughout the nation.

### III. SUMMARY

Just as any other responsible movement within health and related fields, we in hearing/speech/language have begun to identify and evaluate what we

believe to be the vital issues affecting the delivery of services to those who need them. Among these considerations presented here are the problems of incidence, manpower, finance and delivery systems.

However, it should be noted that we also are pursuing other subject areas not only pertinent but similarly critical to improving and increasing services for those with disorders of human communication: continuing education; quality control; concepts of comprehensive care; research; and other timely considerations such as how this field can find the balance between maintaining the initiative to grow and develop on the one hand and, on the other, avoid isolating itself from the total care systems currently developing in the nation.

As the health system progresses and becomes increasingly refined, we would like to see an extension of interest from the mere treatment and prevention of disease or disability to interest and activity in the promotion and maintenance of health. Like disease, health has its causes, and we are rapidly reaching the time when health will be subject to deliberate evaluation and management.

As we develop our concepts of comprehensive care, we would like to see included in a delivery system the inter-related services of health, rehabilitation, special education, welfare and other related endeavors.

#### RECOMMENDATIONS

In view of the (1) indicated need for providing reasonable care for the millions of individuals with hearing/speech/language disorders, and (2) the alternative negative impact on the individual as well as the nation when needed services are unavailable, the following recommendations are offered to the Committee as it considers the design of a national health insurance program:

1. That provisions be included in any proposed national health insurance legislation for equitable payment for services provided to those with hearing/speech/language disorders.

2. That consideration also be given to include appropriate provisions for financing programs to alleviate the manpower shortages, to develop adequate delivery systems, to provide continuing education, to assure quality control and to provide for miscellaneous research and studies necessary for proper and adequate development of the field as a part of the comprehensive delivery system.

#### ADDENDUM

##### A GLIMPSE OF NAHSA

Approximately five years ago, the Board of Directors and membership of the 50-year-old American Hearing Society took a historical step toward improving the plight of the millions of communicatively handicapped persons by establishing the National Association of Hearing and Speech Agencies. The new association, NAHSA, was to be a non-profit forum where lay and professional individuals and organizations could combine their interests and efforts toward solving the many problems confronting those with hearing, speech and language disabilities.

The purpose of NAHSA as simply stated was, "To assist and represent its members in the promotion of high standards of professional service and of community organization in identification, diagnosis and assessment, treatment, education and research in the various areas of communication disorders."

The following objectives and functions were established for NAHSA:

Mobilizing the efforts of professional and lay personnel who share a common concern for the welfare of the communicatively handicapped.

Promoting the interests of its member agencies and communicatively handicapped persons by maintaining liaison with government bodies including legislatures, Congress and other similarly concerned disciplines, organizations and agencies.

Stimulating research and demonstration projects and representing and assisting member agencies in the procurement of grants for such projects.

Strengthening and upgrading services through the sponsoring of institutes, conferences and workshops.

Providing a clearinghouse for the preparation and dissemination of informational and educational materials.

Providing consultant services in such areas as administration, financing, public relations, etc.

Raising the status of "service to people" within the field, and stimulating interest in working in member agencies, as well as orienting and recruiting qualified personnel for placement in member agencies.

Assisting in the extension of hearing and speech services to unserved areas. Recruiting, training and maintaining a staff to serve the unique needs of the association.

Engaging in both independent and cooperative endeavors in funding the association and individual agencies.

Such other objectives and functions as are deemed necessary by the Board of Directors, a volunteer control group responsible for its policies and fiscal performance of the staff.

Currently, NAIISA is composed of 165 member hearing and speech agencies as well as hundreds of professional and lay members.

Dr. Brown. We have a rather unique situation with our field of hearing disorders. As indicated in a publication of the NINDS a couple of years ago, it is a large disability area encompassing some 20 million people with speech and hearing disorders. At the same time, we have some concerns about the visibility of our field. The reasons for this are conjectural. Perhaps it has been the lack of direction and thrust in informing the public as to the nature of the disability area, and perhaps it is also concerned with the fact that this problems is not definitely involved with life and death as are some other health areas. Regardless, we are concerned for a very large number of people who are so affected and we also are concerned with the fact that the disability area involves a very basic aspect of the condition of life.

I think it would be very hard for anyone to disagree with the realization that hearings such as this would not be possible if some individuals were unable to vocalize and other individuals were unable to hear what is being vocalized.

We have great evidence of this impact of human communications disorders. For example, children who are defective in hearing, if they are allowed to continue without early recognition, become students who have severe emotional and educational problems. Individuals who have communications problems such as stuttering, of which we have some 1.5 million people in the United States, become people who never quite realize their human potential for functioning.

Stuttering, as an example, present in a person of obvious talents, may not permit that individual to achieve a position where he can realize those talents. We have evidence of the fact that interference with occupational achievement by hearing and speech problems in terms of actual salary loss can be estimated at the rather staggering figure of well over \$1.75 billion. So we have occupational retardation, we have educational retardation, and we have in an uncounted sense a tremendous amount of human adjustment retardation.

These are the areas with which we deal, the speech pathologist and audiologist—and I would like to take a moment to discuss the profession.

I have great concerns with the visibility of our profession and with fact that people really do not know what speech pathologists and audiologists do. My 9-year-old son asked me what I did. I said I was a speech pathologist, and he said, "What is that?" We get concerned that there are a lot of "What's that" around.

The speech pathologist and audiologist will be concerned with the early hearing loss in babies. One of our prime examples is our concern with the child who is the product of a rubella mother. If a mother contracts German measles in the first 3 months of pregnancy there is

a relative assurance that the baby will be defective, and one of the major defects is the presence of a hearing loss. The audiologist has been greatly involved in developing techniques for evaluating the extent of the hearing loss in very early infancy. Then we become involved in early management of the case and, through this, possibly preventing the exacerbation or the serious development and extension of the various symptoms of this health disability into a severe learning disability.

Insofar as adult speech problems are concerned, we have a very high incidence, of course, of cerebral vascular accident or stroke in this country. Along with CVA's there is a condition known as aphasia or the loss of the power to use words. This is so prevalent that almost everyone recognizes it as existing somewhere within his family or among his friends. The speech pathologist is very definitely concerned with the severity of this speech problem and in making recommendations for and in carrying out treatment programs for the remediation of this disability.

I give these again to you as examples of the kind of work that is being done by audiologists and speech pathologists.

Insofar as adult speech problems are concerned, we have a very spotty kind of situation which exists in this country. As one travels from State to State, he finds that the effectiveness of treating these disabilities is mediated largely by the availability of financial support for services rendered in this area of the health establishment.

In the State of Wyoming for instance we may have certain forms of support for hearing and speech problems. In North Carolina or Arkansas, it will differ. In the light of the present fiscal situation, with decreases in State aid, we find that service areas like ours are suffering serious setbacks in terms of our ability to establish, improve, or increase our assistance to the disabled population. Families, similarly, find it impossible to depend upon the present support situation and are very, very hard pressed to acquire the resources to get the proper treatment for their children or other members of the family.

We do have recommendations and our recommendations are as follows:

In view of the (1) indicated need for providing reasonable care for the millions of individuals with hearing/speech/language disorders and (2), the alternative negative impact on the individual as well as the Nation when needed services are unavailable, the following recommendations are offered to the committee as it considers the design of a national health insurance program.

1. That provisions be included in any proposed national health insurance legislation for equitable payment for service provided to those with hearing/speech/language disorders.

2. That consideration also be given to include appropriate provisions for financing programs to alleviate the manpower shortage, to develop adequate delivery systems, to provide continuing education, to assure quality control and to provide for miscellaneous research and studies necessary for proper and adequate development of the field as a part of the comprehensive delivery system.

I will now turn to Mr. Coleman who will give you additional testimony.

Mr. COLEMAN. With your permission, I would like to take just a couple of minutes here to speak to the whole problem that you are faced with in blueprinting the future in terms of comprehensive care systems.

One of our great concerns has been the seeming lack of productivity in recent years from the Federal grants made available to the States initially for comprehensive planning in rehabilitation, later in health, and I believe later in education. Unfortunately, as we travel to assist communities to put their hearing and speech and language service programs into some reasonable condition and perspective, we have thus far found no result of this planning in terms of systems to which our people can relate. We have been teaching through our education and training programs—much of this, incidentally, supported by HEW—concepts of comprehensive systems that provide full care for the whole man or woman. This is quite an involved situation. Yet we think the people in this field, the administrators and some of the professionals who are providing direct clinical care, have become aware of their need to relate to whole systems.

We believe we have developed an atmosphere where they want this. In fact many of them seek it out, but we do not find this available anywhere in the country. We know that some great thinking, some great planning of comprehensive systems has been done by individuals and groups around the country. Even in the literature are concepts of programs that could be adopted or perhaps modified and adopted by communities.

It would be our hope that you would build somewhere into your recommendations early insistence that communities, regardless of how you describe a community, complete their planning, organization and adoption of true comprehensive systems of care for people.

Mr. ROSTENKOWSKI. Thank you, Dr. Brown and Mr. Coleman.

Mr. Schneebeli?

Mr. SCHNEEBELI. Regarding speech pathologists: Is any formal education required or State licensing?

Dr. BROWN. Speech pathologists and audiologists generally pursue a minimum of 5 years of education at an accredited institution. So far as licensing is concerned, there is at present only one State in the Union which has a licensing program. Several others are considering licensing. At the present time our only stature is that we are accredited with a certificate of competence from American Speech and Hearing Association, which is our professional sister organization.

Mr. ROSTENKOWSKI. Thank you very much, gentlemen.

Dr. BROWN. Thank you.

Mr. ROSTENKOWSKI. The next witness is Dr. Elizabeth Boggs.

Welcome to the committee, Dr. Boggs. If you will identify yourself you may proceed with your testimony.

**STATEMENT OF ELIZABETH M. BOGGS, Ph. D., VICE CHAIRMAN,  
GOVERNMENTAL AFFAIRS COMMITTEE, NATIONAL ASSOCIATION  
FOR RETARDED CHILDREN; ACCOMPANIED BY JOHN COURIC,  
CHIEF OF LEGISLATIVE SERVICES**

Dr. Boggs. I am Elizabeth M. Boggs, and I am a member of the government affairs committee for the National Association for Retarded Children. I am accompanied by Mr. John Couric, who is chief

of legislative services for our organization, and as such is in charge of our small Washington office. Our main offices are in Arlington, Tex.

I don't propose to discuss at length the needs of the mentally retarded or the kinds of services they require. I am happy to pay tribute to this committee, which has in many of its other areas of responsibility, reflected in the various titles of the Social Security Act, done much to advance the cause of a heretofore neglected group.

We are here primarily to express the sincere hope that the committee, in designing what we understand will be the committee's own new health insurance proposal, will consider the special needs of the mentally retarded, and assure that this new major social thrust forward does not overlook these needs or omit them, either by design or by inadvertent oversight. The history of social programs developed to date does indicate that there is a serious risk of such inattention.

Having heard Mrs. Lamborn's testimony earlier this morning, we would like to express support for the principles that the National Rehabilitation Association set forth, and also express a caveat exactly in that context. It is easy to see that those principles apply to conditions such as stroke and quadraplegia and its is a little more difficult to see that they also apply to the chronic mental handicap represented by severe mental retardation.

I trust that our statement may be introduced in the record.

Mr. ROSTENKOWSKI. Your statement in its entirety will be included in the record.

(Dr. Boggs' statement follows:)

STATEMENT OF ELIZABETH M. BOGGS, PH. D., VICE CHAIRMAN, GOVERNMENTAL AFFAIRS COMMITTEE, NATIONAL ASSOCIATION FOR RETARDED CHILDREN, INC.

#### INTRODUCTION

Mr. Chairman: The National Association for Retarded Children, a non-profit organization with headquarters in Arlington, Texas, expresses appreciation for this opportunity to testify on National Health Insurance as it affects the lives of the mentally retarded children and adults of this country.

NARC represents some 200,000 parents, friends and professionals, nearly 100,000 young people serving in Youth-NARC, and 1,500 state and local associations in all 50 of the United States. NARC exists to promote the welfare of the mentally retarded of all ages—children and adults—by advancement of research, treatment, prevention, stressing leadership and securing services, and gaining broader public understanding and support.

I shall limit my testimony to the application of any national health insurance plan to the programs for the mentally retarded.

#### SUMMARY OF PRINCIPLE ISSUES

NARC's concerns under the heading of national health insurance fall under several general hearings:

1. *Prevention of Mental Retardation.*—Will there be incentives for the general population to utilize preventive measures during pregnancy and early childhood, and will the resources be provided in the most efficient manner?

2. *Equal Access for the Mentally Retarded.*—Will the full range of needed medical services be made available under the system to the mentally retarded regardless of their source of income, or place of residence?

3. *Coordination with Other Service Systems.*—Will the necessary social services, special education services, rehabilitation services and income maintenance programs form a cohesive continuum for the individual and will the various relevant financing mechanism be designed to leave no uncovered gaps or arbitrary exclusions of needed links in this array?

4. *Catastrophic Coverage.*—Will coverage in this category really cover the catastrophic consequences of illness and disability or will limitations written

into the act leave a few people, as now, with crushing burdens after the benefits of the system have been exhausted?

5. *Resource Development*.—Will appropriate incentives and subsidies be provided (under NHI or other cognate legislation) for the development of fiscally stable components of a truly comprehensive care system for persons with long-term disabilities, and will incentives and disincentives for use of necessary but costly services be appropriately balanced in the interest of the patient as well as the taxpayer?

#### *Surcharges*

Will patients and families be adequately protected against surcharges of various kinds imposed by providers, especially when demand exceeds supply? (Such surcharges—i.e., charges to patients above the reimbursable rate considered reasonable—are sometimes collected now under medicare and would be explicitly authorized under H.R. 1.)

In each of these areas situations can be cited in which the mentally retarded and their families have suffered special burdens. For the convenience of the Committee we have attempted to organize our views on these points under one of the nine headings used in the August Committee Print entitled *Analysis of Health Insurance Proposals Introduced in the 92nd Congress*.

### I. GENERAL CONCEPT AND APPROACH

We advocate a unified system covering the poor and non-poor alike. The general scope of coverage, with emphasis on prevention of mental retardation, is indicated in Appendix A, which is based on the deliberations of our Public Health Committee. The plan should include but not be limited to catastrophic coverage, and should stimulate efficient resource development in all shortage components.

We also advocate mandatory federalized coverage at least for the "catastrophic" component and for other unusual risks which private insurers have heretofore been unwilling to assume fully. Comprehensive plans for habilitation or rehabilitation of persons with catastrophic chronic impairments should be developed through multidisciplinary organizations responsible for coordinating and/or providing services and subject to review by peers who are specialists in handling these relatively unusual cases. Some thoughts on this subject, developed through the deliberations of a group of specialists, are presented in Appendix B.

It is sometimes held that such coverage is "too costly". Too costly for whom? Fortunately, severe chronic impairments which originate early in life and which can have a devastating cumulative effect on the individual and his family unit are relatively rare. Severe, continuing impairment among the mentally retarded (which frequently entails some other complicating physical or mental condition) probably affects something like  $\frac{2}{10}$  percent of the population, for example. It is therefore all the more important that the financial risks associated with these severe impairments be distributed through a social insurance system. Many people are unwilling to pay the extra small premium required to cover an outside chance, yet, when disaster strikes them, part of their burden tends to fall on others, through charity or taxation; thus, in a voluntary system, the provident person must pay for the improvident as well as for himself; the mandatory character of social security addresses itself to this issue. The reduction in old age assistance is one of the sources of its success.

Our position is confluent with that contained in the statement of the American Academy of Pediatrics, covering insurance against medically induced financial catastrophe: "Nearly all American families have a strongly felt need for protection against medically induced financial catastrophe defined as a maximal annual family expenditure, in proportion to income, beyond which medical expenses cannot be met without a major alteration in that family's standard of living. Therefore, the first step in a national health insurance plan should be universally required insurance against medically induced financial catastrophe, with government financing the premiums of the poor."

What constitutes a medically induced financial catastrophe? Any extraordinary and necessary cost which is regarded as a personal liability when incurred on behalf of oneself or one's dependent and which is the consequence of a disease, disorder or medically variable condition such as mental retardation.

Comprehensive care will include medically induced costs for services other than medical care. The operative words here relate to personal liability. Services

such as special education for school age children, or vocational counseling and training services offered without charge to the handicapped under federal-state programs, and, hopefully, certain social services under a new social services title to the Social Security Act, would not constitute a personal liability. However major social services such as day care for disabled adults, costs of personal care services above basic maintenance in sheltered living arrangements, and the like, for which charges to consumers are contemplated, should either be made available to all at nominal cost or considered for coverage under an insurance mechanism. Anticipating H.R. 1, which will federalize basic maintenance only, for the disabled, we fear a breakdown in delivery of such social services which are an essential component of comprehensive health care, unless some consistency is introduced between the two systems. In any case, a newly structured federal grant-in-aid program will be required to develop and maintain the necessary resources of social-rehabilitative type.

An insurance policy is intended to protect one from an unpredictable major loss or forced expenditure without regard to whether one "can afford" to sustain the loss. A national health insurance program should incorporate this feature, and in particular, should be structured so that no person or family not already in poverty should find itself forced to resort to public assistance because of a medically recognizable condition in one of its members.

#### *Need for expanded public health services*

In addition to coverage for catastrophic events, we are interested in securing inclusion of a suitable range of covered services, especially those related to prevention, early detection and early treatment. Most mental retardation originates in the earliest years of life and its long-term effects are frequently aggravated by early neglect. We have been very disappointed in HEW's failure to press for implementation of the medicaid provision initiated by this Committee in 1967 concerning inclusion of "screening, diagnosis and treatment" of eligible children for mental and physical defects. According to one recent report, only Mississippi took this mandate seriously, yet failure to implement this provision is simply storing up health costs for the future.

This failure leads us to suggest that the Committee should consider carefully whether some types of health care are not better handled under the rubric of "public health" rather than on the personal liability-insurability basis. Mass screening and immunizations seem to lend themselves to this interpretation. A flat subsidy to one PKU testing lab in a state may be less costly than having that lab charge \$1.00 per test on a third party payment collection basis, for example.

#### *Maternal and child health*

Some forms of preventive care must be individually delivered. Prenatal care is a case in point. The effectiveness of the maternity and infant care projects is now accepted. Resource development in low-income areas is still a problem. It is therefore especially important that the Committee act to prevent the demise of any viable resources.

The Administration bill to provide subsidies for capital development and startup costs for HMO's and other needed resources is not before this Committee; therefore, it might appear irrelevant to elaborate on this point. However, we believe that this Committee has an immediate obligation to consider the position of the Maternity and Infant Care, and Children and Youth projects funded under Title V, and also to consider restructuring the basic grants-in-aid to the states under Title V, so as to complement more clearly the basic health insurance program. With respect to the state aid programs, we urge that these be required to move from a purchase of care, fee-for-service basis, where this exists, to a resource development and maintenance objective. During this transition, we believe it is particularly important to maintain the MIC and C. & Y. projects which are now in operation as a result of the 1963 amendments. Authority for funding under the present arrangements terminates with current fiscal year. We urge the Committee to extend the present system of project funding at least until such time as national health insurance goes into effect. We further wish to point out that these programs are well adapted to become part of an HMO or like structure; their inclusion, where available, should be mandatory in the interests of coordination.

## II. COVERAGE OF POPULATION

We favor coverage of all U.S. residents, including all mentally retarded persons. Such persons should be eligible to receive covered services even if they are resident in an institution (public or private) which is not in itself providing a covered form of "inpatient" care.

We take particular issue with the fragmentation and partial coverage in the Byrnes bill. It is said to be "two part" but is, in fact, four part: the employed, low income families with children, the indigent aged, disabled and blind (who are especially discriminated against) and a motley assortment of people (including the nonindigent disabled) not eligible for any of the first three. The latter will grope around for an insurance pool. We believe that the mentally retarded, other than children living in their own homes, will be particularly liable to fall between the cracks of these provisions.

## III. BENEFIT STRUCTURE

We favor plans which emphasize preventive care, well baby care and maternity care without deductibles. We seek true catastrophic coverage, with major emphasis on resource development and distribution and with admission controlled through an HMO or comprehensive service system. We favor the inclusion of psychiatric care on the same basis as other forms of health care. If the Committee is convinced that individual psychotherapy represents a possible run-away risk, we suggest requiring some screening mechanisms through community mental health centers, HMO's or CHSS's.

With respect to deductibles, some plans graduate deductibles and/or co-insurance according to the patient's ability to absorb additional expenses. This is a basic departure from the principle of "insurance"—which is to protect the insured from a given risk. Moreover, the problem of determining "ability to pay" should be looked at carefully. Our membership has had a variety of unsatisfactory experiences with state agencies mandated to determine the ability of parents to pay for costs of care of children in state residential facilities or mental hospitals. We strongly urge that where only a sliding scale (of deductibles and co-insurance) can be made equitable, no new criteria for ability to pay be set up, but rather that use be made of one of the three criteria which may already have been established with respect to the individual; i.e., federal taxable income, payroll, or eligibility for welfare.

We also wish to express concern about the extent to which providers may be able in practice to charge fees above the reimbursed rate, thus creating inequities between patients and defeating the intent to cover costs within predetermined limits for everyone. Such surcharges can be disguised as excessive costs for "extras," or simply demanded as a condition of priority admission to a facility or service for which demand exceeds supply. To the extent that "free choice" is built into the system, such characteristics of the market place are likely to manifest themselves.

## IV. ADMINISTRATION

We cannot offer an opinion on the relative merits of using intermediaries. However, a national plan should have national standards and coverages; we, therefore, do not recommend involving state governments, except as sponsors of organized or institutional services where appropriate. Public agencies, both state and local, should not be discouraged from developing resources where these are scarce. Complete reliance on private providers leaves the system vulnerable to shortages, defiance of standards, etc.

## V. RELATIONSHIP TO OTHER GOVERNMENT PROGRAMS

We see medicare and medicaid absorbed into the new unified system. We see other programs affected as follows:

Covered costs for physicians services, hospital care, and home health care will be reimbursed under NHI, and not under MCH, Vocational Rehabilitation, or the new Child Development Act. However, in each of these programs (and in social services) direct grant-in-aid funds may, and should, be used to develop, and in some instances, partially sustain organized services especially components of comprehensive service systems for handicapped and disabled individuals.

*Need for resource development and maintenance through direct subsidy*

We endorse the premise found both in the Administration proposals and in the Griffiths-Corman bill that direct subsidies independent of capitation will be required to develop additional resources in a planned manner. We suggest that this principle be extended to cover part of the ongoing operating costs of some types of facilities.

In our field, organizational providers (in addition to hospitals and practicing physicians) assume an important role and must frequently deliver ongoing service to a given clientele for an extended period of time. To assure stability and continuity, such providers need not only front-end money but some continuing assured budgetary support which is not entirely contingent on capitation or fee for service. We would ask the Committee to examine the possibility of a position intermediate between the Byrnes and Griffiths-Corman bills, in that some block operating budgetary support be provided for this type of providers together with a per capita payment depending on numbers of persons actually receiving service. This system might be compared to the higher education system, where tuition reflects only a fraction of actual per capita operative cost, and income from tuitions is budgeted on top of a basic subsidy from endowment or legislative appropriation. Few universities would choose to become vulnerable to the vicissitudes of varying enrollments on a strictly proportional basis.

The experience to date in the community mental health centers, which constitute a special kind of experimental HMO, also indicates the need for this kind of approach.

We believe this financing structure may compensate for what otherwise might be a weakness in the HMO approach to "utilization". Under the current arrangements there is admittedly some incentive for overutilization. Under the proposals for health maintenance organizations or comprehensive health service systems strong deterrents are incorporated to the use of institutional and other relatively costly types of care. Under either Byrnes or Griffiths financing arrangements, these organizations will be operating under overall fiscal constraints which may well result in shortchanging patients who do indeed require multiple modalities of care and treatment over an extended period. Where the necessary facilities can receive an underlying direct subsidy from federal or state sources, the per capita fee or cost to be charged to or through the HMO could be set at less than actual per capita and thus geared to provide optimum motivation to use or not to use in the patients best interest. A "catastrophic" plan need not lack inducements for improving the system.

## VI. FINANCING

We see the need for multiple sources—e.g., payroll plus general revenues, but cannot count ourselves experts on the details.

## VII. STANDARDS

Nationwide standards are preferred. We call attention to the participation of NARC in a series of projects under the auspices of the Accreditation Council on Facilities for the Mentally Retarded (affiliated with the Joint Commission on Accreditation of Hospitals). These projects are designed to develop both standards and accreditation procedures for a wide range of programs serving the mentally retarded. We believe this system will be largely in place by the time NHI becomes operational. Monitoring of standards must include appropriate specialists in addition to physicians.

## VIII. REIMBURSEMENT OF PROVIDERS

Two principles should be observed: streamlining of paper work, especially in facilities not large enough to justify computerization, and financial stability relative to cash flow and anticipated income for organizational providers.

## IX. DELIVERY AND RESOURCES

As indicated under *Relationship to Other Government Programs*, we favor direct grant-in-aid programs to cover both start-up costs and part of operating budgets on a continuing basis for organizational providers. The amount of the ongoing subsidy would vary with the type and complexity of service being offered and the level of capitation considered desirable in the light of the incentives and disincentives to consumers, providers, case managers, and others in the total system.

## CONCLUSION

The mentally retarded are part of our society. They have general needs and special needs. Frequently in the past, social programs have been structured, intentionally or unintentionally, so as to exclude them. We earnestly hope that that mistake will not be repeated in the new national health initiatives.

## APPENDIX A

## HEALTH CARE SERVICES FOR THE MENTALLY RETARDED IN A NATIONAL HEALTH INSURANCE PROGRAM

Health care services for the mentally retarded in a national health care program should encompass comprehensive services in prevention, early detection, and treatment.

Inadequate health services have been cited as one reason for the larger number of mentally retarded in the underprivileged. Comprehensive health services should be available and accessible for all in every geographical area.

## PREVENTION

Special emphasis should be placed on the prevention of mental retardation. Prevention begins with health education of the public, the mothers and expectant mothers, and the family. Health education regarding prevention should begin at the primary school level. Health education should be a part of every phase of the health program, and each visit to a clinic should be regarded as an opportunity for a learning experience for the patient and the family. All health personnel should be concerned with health education.

Immunization programs should be given high priority; planned and designed so each person's immunizations are maintained current from early childhood throughout his life span, particularly for rubella and measles.

Prenatal care beginning early in the first trimester is most important in reducing the incidence of mental retardation by preventing premature births. A follow-up should be made to assure regular visits to the prenatal clinic or physician. The clinic should include a well planned health education program for expectant mothers that would include the care of the child in early infancy and childhood.

There should be limited use of x-ray for women of child bearing age and of the fetus. A limited and judicious use of drugs should be administered during pregnancy, labor and at delivery.

Nutrition should be stressed in the preventive phase of mental retardation—during pregnancy, early infancy, and the growth and developmental years of childhood. An adequate diet should be provided those with low incomes.

Testing and observations for lead and other heavy metals, and the presence or effects of other environmental toxins should be an integral part of the national health program, including provisions whereby information on the incidence and prevalence on the above would be forwarded on to appropriate government agencies. Programs for the prevention and treatment of lead poisoning should include screening children one to six years of age and paint analysis for lead in old maintained homes, and other buildings such as schools and institutions. Children exposed to other special local conditions involving lead hazards should be screened.

Family planning clinics should be provided under the insurance program and should include genetic counseling for parents and prospective parents.

## EARLY DETECTION

The next important activity in mental retardation which should be included in a national health care program is early detection. Early detection will provide early treatment, training and habilitation programs. In this activity the health personnel involved should have special training in the tests and examinations involved and recognition of the signs and symptoms of mental retardation; examples being:

1. PKU testing of new born infants and of expectant mothers.
2. Amino acid analysis of new born infants.
3. Testing for inborn metabolic defects.

Regular visits to the pediatrician should be provided, which would include:

1. Periodic and thorough examination during the neonatal period.
2. Periodic assessment of growth and development during infancy and early childhood (psychomotor skills, formation of teeth, eating habits, toiletting, speech and hearing and sleeping habits).
3. Periodic assessment for social adaptation and behavior patterns.
4. Frequent periodic follow-up for premature infants.
5. Tests, e.g. urinalysis, blood work and screening for parasites should be provided.

#### HEALTH RELATED SERVICES IN FACILITIES OFFERING COMPREHENSIVE PROGRAMS

Early and continuing treatment, education and training are essential to enable a maximum of the mentally retarded to function as members of society and of their families. Comprehensive care is not limited to health care.

The national health insurance program should assure the provision of health related services in:

1. Residential facilities for the seriously retarded and multi-handicapped, whether public or private.
2. Special schools and classes.
3. Day care centers for children and adults.
4. Half-way houses.
5. Sheltered workshops.
6. Work training and rehabilitation programs.
7. Interim residential programs whereby the mentally retarded are admitted on a short term basis for evaluation, care and treatment, training and rehabilitation.

The total program for the mentally retarded includes health, education, social and rehabilitation services. These services should be available and accessible according to the individual needs and funded as such. For those in residence all services should be the responsibility of the residential facility through its own or outside resources.

The insurance program should cover services provided by physicians, nurses, dentists, pharmacists, social workers, physiotherapists, occupational therapists, aides, and other ancillary personnel. Adequate staffing to provide the needed services is essential.

An ongoing system of evaluation of the mental retardation programs, as it relates to health services in general, should be funded by the national health insurance program.

#### STANDARDS

Optimal standards for residential facilities should be established, with continuous improvement and raising of the standards. There should be optimal standards for staffing with provisions for speciality training and experience in mental retardation for all health personnel providing services. The above standards should be coordinated with those standards formulated by state departments of education and rehabilitation, for health personnel considered ancillary to special education and vocational rehabilitation of the handicapped.

#### APPENDIX B

##### THE PROBLEM

Certain catastrophic impairments have been identified which do not receive sufficient or thorough attention by any of the health insurance proposals now before congress. These impairments include those caused by spinal cord injury, muscular dystrophy, multiple sclerosis, cystic fibrosis, multiple developmental disabilities (epilepsy, mental retardation and cerebral palsy) end-stage renal disease, drug addiction, alcoholism, stroke, cronic brain syndromes and the disabilities of blindness, and multiple amputations.

Persons with these comparatively rare physical and/or mental impairments may need expensive comprehensive services on a continuing coordinated basis for a prolonged period, usually the lifetime of the individual. Evidence has accumulated which shows that carefully prepared inter-disciplinary tailor-made regimens, using a variety of medical-social-rehabilitative resources, can assist individuals disabled by these impairments to attain and maintain a

level of physical, economic, social functioning which would otherwise not be possible.

Services may include immediate management at the place and time of injury or onset of disorder, diagnostic, evaluative, therapeutic, restorative, health maintenance or secondary prevention and goal-oriented counseling, guidance and training. Restorative services should be family or community-oriented, but they are often best provided on a Regional or catchment area basis as special facilities or rehabilitation centers. Health and social maintenance services and follow-up permit the individual to live as nearly independently as possible.

In the USA today, such care is provided at best as an assembly of components involving a variety of independent professional persons, voluntary and official facilities and agencies. CASE coordinators rarely have the power to command the resources needed to be effective in carrying to conclusion the optimal plan for the individual.

Payment for health and related social and rehabilitation services are unnecessarily expensive when fragmented uncoordinated care is provided. Present health insurance provisions reinforce the continuing provision of episodic versus goal-oriented management. Arbitrary discontinuities in contingencies for funding, as between health services and social services components aggravate these inefficiencies. Disabled individuals are less likely to obtain levels of adjustment to their impairment which are satisfactory to the individual, his family and society.

#### THE SOLUTION

Payment for the continuing comprehensive care of individuals with major catastrophic impairments should be covered by any new Federal health insurance or health security program.

Authorization for the initiation of comprehensive care should be based on approval by a regional *panel of experts* of a long-range *management plan* developed by appropriate professional persons together with the patient and his family, as appropriate. Panels would be established on a regional basis. The panel membership should include professional persons who are knowledgeable about the needs for services of individuals with catastrophic impairments and about the resources of the State or Region (Catchment area). The plan would include specific objectives for the management of the patient and the steps necessary to reach the agreed upon objective and the resources to be utilized. The individual's plan would be reviewed regularly and modified as indicated.

Dr. Boggs. The statement has been organized, in its main body, to reflect the system of analysis that you yourself used in the publication *Analysis of Health Insurance Proposals* in the 92d Congress and we hope this will facilitate your consideration of our proposals. I would like to speak particularly on the issues set forth on the first two pages.

In introducing this, I might say that we differentiate in our minds among (1) comprehensive care and (2) health care systems and (3) national health insurance. We believe that the health care component is an important part of but not the totality of comprehensive care and rehabilitation, as required by the mentally retarded.

On the other hand, national health insurance, properly speaking, should be considered as one of several vehicles to producing a health care system and assuring its accessibility to all, but, by its very nature, an insurance program is primarily addressed to protecting people against extraordinary financial risks for which they would otherwise have personal liability.

This is important in our conceptualization of the problem because the question of what one is personally liable for is at the crux of the issue of benefit structure. If there are services which are available without charge, for example, under a public utility system, these do not need to be covered under insurance.

In the President's plans for executive reorganization he has proposed a Department of Human Resources, in which health insurance is subsumed under the income maintenance component. No other kinds of services are included under the income maintenance portion of the reorganization. He proposes two other components: health services and human development services, along with the income maintenance component which includes present social security and public assistance, plus health insurance.

I think this is quite significant in indicating that the administration somehow has not addressed itself to issues which arise when there is a personal liability for the cost of a service which is not defined as a "health" service, and yet is, in fact, health-related or medically induced in the sense that it is an extraordinary cost which is the consequence of a disability.

We, like many other people who have testified before us, stress the importance of prevention, and would agree that any insurance system should facilitate prevention of mentally retardation, which is an extremely costly disability in a social as well as personal sense.

We would like to call your attention particularly, in that connection, to the recognized effectiveness of the maternity and infant care projects which this committee has had the responsibility for sponsoring through title IV legislation, and to point out that the legislation under which these are presently financed will expire next June 30. We hope, as part of your consideration of the health care resources system, you will address yourselves to the continuation of the present authority, for the MIC and C. & Y. projects, because the proposed transition to State financing that was expected to take place next June now seems premature. It was proposed to transfer the responsibility for support to the States, and yet, that transfer will not at present provide effective support in States with large metropolitan areas such as your own.

We would like to stress equal access for retarded. We feel the administration proposal will allow many of the adult mentally retarded to fall between the cracks because it proposes to continue the medicaid system for the disabled, blind, and aged, and this does not provide adequate insurance coverage for persons who do not happen to qualify for medicaid on the basis of very low income. Furthermore, it continues the lowest income groups under the present quite inadequate and inequitable State medicaid system, rather than bringing them into NHI.

In other words, it leaves until later a group of people who should be among the first to be considered for something called national health insurance.

We are also concerned that previous history not be repeated in that there not be any exclusion of mentally retarded individuals because they happen to be resident in an institution which is not itself a medical institution.

I call your attention, for example, to the provision in the Griffiths bill which appears to say that if a person in a psychiatric hospital, has outrun his days in that hospital, he is not covered for any kind of medical care. He is not even covered for having his appendix out. We have had this problem over and over again with the mentally retarded when they are enrolled in an institutional program which, in itself is not an eligible inpatient facility.

We are strongly in favor of universal coverage. However, in the absence of universal coverage, we would at least say that the adult dependent family member who is disabled ought to have the same coverage as a dependent child and ought to be included in any "family plan." These disabled adults are the people who get left out if they have to seek private insurance on an individual basis. A number of States have moved recently into legislation to require the inclusion of adult disabled dependent members of the family in group family coverages.

Very important—and I come back now to my remarks about the related "nonmedical" service systems—very important in our view is the way in which the health deliverers who are unequivocally recognized as health professionals and their services are related to the social educational, and rehabilitational services which frequently are defined as not "medical."

As the NRA testimony indicated, a comprehensive system of services is necessary for people with major chronic disabilities. Unless these two systems—health and social rehabilitation—interdigitate effectively we are going to have inefficiencies and greater disabilities which again is socially costly. This is, in turn, related to the issue of personal reliability.

The tendency in the administration's posture seems to be to hold people personally liable for the cost of social services above the very low-income level. We understand the administration is also going to propose that vocational rehabilitation services be means tested or be set on a fee schedule. These things mean that people above the very lowest income levels are going to be liable for personal costs, and if, in addition, a health insurance program is initiated which only covers the cost of so-called health services, these people are going to be subject to costs for essential social and rehabilitation services that are not covered; by the very fact that they are not covered and that the disabled are already paying taxes to support the health care system, it is going to be even more difficult for middle income people to accommodate these costs for noncovered "nonmedical" services. There will be undesirable disincentives to use of appropriate nonmedical service.

In that connection, I would like to encourage the committee to really come to grips with the issue of so-called custodial care. Custodial care is sometimes used as a word of opprobrium, meaning something we don't want anybody to have. It follows that it should not be supported with Federal funds. If you are talking about the type of care no one should have, it should not be allowed, let alone supported; if you are talking about necessary care other than skilled nursing home care, care which is more than board and lodging and which is worthwhile and appropriate to some human beings then the extraordinary costs of this care—above board and lodging—should be covered under a truly catastrophic insurance system, without gross limit.

Finally, we are concerned, as everybody else is, with the need to develop the resources to do all of this. We particularly refer to the organizational resources, the provider organizations which involve a number of professional people, often representing different disciplines working together. We believe that if we are really to have a comprehensive system which necessarily includes organizational procedures,

it will probably be necessary not only to provide the initial capital funding and startup costs, but also some basic continuing direct subsidy in addition to or instead of a fee-for-service or capitation payment in order that the providers of the more complex services will be in business and in place when and where they are required by the consumers.

Thank you very much.

Mr. ROSTENKOWSKI. Thank you very much.

Mr. Schneebeli will inquire.

Mr. SCHNEEBELI. Is yours the organization which represents all of the associations in the United States in the area of retarded children?

Dr. Boggs. Most of them.

Mr. SCHNEEBELI. Through you I would like to extend to your organization the gratitude of many members of this committee for the great work you are doing. This is an area of very great sensitivity.

In my area in Pennsylvania we have a school of hope in Williamsport, and they are doing a wonderful job.

Dr. Boggs. We appreciate the interest you have taken in our concerns over the years and we know you have been very helpful, as has Mr. Rostenkowski.

Mr. SCHNEEBELI. I hope you will tell the association we are very concerned about your work. And congratulate your group on your great and important progress.

Mr. ROSTENKOWSKI. The Chair recognizes Miss Frances Fischer.

Welcome to the committee.

If you will identify yourself for the record, you may proceed into your testimony.

**STATEMENT OF FRANCES E. FISCHER, CHAIRMAN, ADVISORY COMMITTEE ON LEGISLATION AND PUBLIC POLICY, AMERICAN DIETETIC ASSOCIATION; ACCOMPANIED BY MRS. ISABELLE A. HALLAHAN, PRESIDENT-ELECT**

**SUMMARY**

1. Public awareness of the importance of nutrition to health is increasing.
2. Public and private health insurance programs place too much emphasis on hospitalization and the curative aspects of health care as opposed to nutrition and other preventive health care services.
3. As Dr. Jean Meyer, Chairman of the White House Conference on Food, Nutrition and Health recently stated: "In terms of human suffering—one can well argue that every dollar spent on nutrition instruction may save tens of dollars in later medical care."
4. Nutrition should be a "covered" service in the national health insurance measure approved by the Committee on Ways and Means.

Miss FISCHER. Thank you, sir.

Mr. Chairman and members of the committee, I am Frances E. Fischer, and I serve as an associate professor at Case Western Reserve University. I am also chairman of the advisory committee on legislation and public policy of the association, and it is in that capacity that I am presenting testimony today. I am accompanied by Mrs. Isabelle A. Hallahan, who is president-elect of the association.

## NUTRITION

In the past the importance of nutrition to health was largely neglected. In recent years, however, this neglect has been replaced by concern. In 1967, the Congress approved the Health Amendments Act that authorized a national nutrition survey. Subsequently, the Senate established a Select Committee on Nutrition and Human Needs and in 1969, President Nixon sponsored the first White House Conference on Food, Nutrition, and Health. We are gratified, too, by the actions of Congress in expanding and improving the food stamp program and the national school lunch program. But much more needs to be done and that is why I am here today.

Although we have established the importance of nutrition to health, we do not provide adequately for nutrition services under public or private health insurance programs. The same situation obtains with other preventive health services. The net result, as stated by President Nixon in his health message is:

Because we pay so little attention to preventing disease and treating it early, too many people get sick and need intensive treatment.

## PREVENTIVE MEDICINE

There seems to be general agreement that some form of national health insurance is needed at this time. Although America is the wealthiest country, we are not the healthiest Nation in the world. It is our hope, therefore, that the national health insurance program that is adopted by the Congress will give adequate recognition to nutrition and other preventive health services. We believe that existing public and private health insurance programs place too much emphasis on hospitalization. Since 1960 hospital costs have risen five times as fast as the cost of living.

Under medicare, for example, there are restrictions on the role of the nutritionist as a member of the health care team. A home health agency cannot claim reimbursement for the home visits of a nutritionist no matter how essential those visits might be to the medicare patient. Such services would be available only if the patient were hospitalized. The same situation exists in the overwhelming majority of private health insurance programs.

Under medicaid the preventive aspects of health care are also neglected. An article in the Washington Post of October 24, 1971, pointed out that the 1967 amendments to medicaid that authorized "early and periodic screening and diagnosis" of children in families on public assistance has never been implemented by the Department of Health, Education, and Welfare. The article also reported that only five States are doing such screening. One of them, Mississippi, showed "the examination of 1,178 children revealed 1,301 medical abnormalities, including 305 cases of multiple cavities, 241 cases of anemia, 97 cases of faulty vision, 217 cases of enlarged tonsils, 51 cases of hernia, 48 cases of intestinal parasites, 53 cases of poor hearing, and 32 other medical

conditions requiring immediate treatment." Many of these abnormalities are closely related to malnutrition.

Dr. Jean Mayer, professor of nutrition at the Harvard School of Public Health and chairman of the White House Conference on Food, Nutrition, and Health, recently commented on the economic aspects of providing for nutrition in health programs. He said:

With government at all levels responsible for an ever increasing proportion of health expenditures, with these expenditures mounting without appreciable effect on the health statistics of the nation, it is becoming obvious that emphasis must be shifted from purely curative to prevention and rehabilitation. This means that nutrition should assume even more importance than in the past. In terms of money—as in terms of human suffering—one can well argue that every dollar spent on nutrition instruction may save tens of dollars in later medical care.

#### NATIONAL HEALTH INSURANCE

H.R. 22, the Health Security Act that was introduced by Mrs. Griffiths, specifies "nutrition" as a covered service as a part of institutional services or when furnished by a comprehensive health service organization. The American Dietetic Association urges the committee to approve this provision or a similar provision as a part of the national health insurance bill that is reported to the House of Representatives.

We also endorse the concept of the health maintenance organization that is a part of President Nixon's proposal. As he stated in his health message:

HMO's therefore have a strong financial interest in preventing illness, or, failing that, in treating it in its early stages, promoting a thorough recovery, and preventing any recurrences.

#### THE NUTRITION COMPONENT OF HEALTH DELIVERY SYSTEM

The American Dietetic Association's position is that inclusion of nutrition as a component of health care will significantly reduce the number of people requiring sick-care service and therefore, contribute directly to:

- (a) A relief of strain on the Nation's health-care delivery system;
- (b) A decrease in the escalating rate of health-care costs;
- (c) An increase in physical, mental, and social well-being of people so that they may achieve and maintain productive and independent lives.

Nutrition is a critical factor in the promotion of health and prevention of disease and in recovery and rehabilitation from illness or injury. Evidence mounts that Americans who fail to attain a diet optimal for health can be found at every socioeconomic level. The reasons are many and complex, but the impact on the health of the Nation is seen in the increased risk of complications of pregnancy in the poorly nourished woman, in the chance that her infant may be of low birth weight with accompanying risk of retarded physical and mental development; in the high incidence of overweight and underweight in

school-age children and in adults; in the debilitation of the malnourished elderly; in dental disease, widespread in the total population; and in the high incidence of chronic illnesses that require dietary treatment, monitoring, and followup. It is apparent that improvements in the nutrition of people will have a direct effect on the level of health and the resulting need for health services.

Appendix A that is attached to this statement includes a position paper on the nutrition component of health services delivery systems as adopted by The American Dietetic Association.

In concluding, The American Dietetic Association endorses the concept of national health insurance. The Association does not favor any specific bill but does urge that adequate recognition be given to nutrition and other preventive health services in the measure approved by this committee.

(Appendix A follows:)



## *The American Dietetic Association* Position Paper on The Nutrition Component of Health Services Delivery Systems

"Nutrition services under the supervision of qualified nutrition personnel should be a component of all health and health-related programs and should be designed to reach the total population with priority given to such nutritionally vulnerable groups as infants, children, and youth in the growing years, women in the child-bearing years, and the older age population." (1). The need for the Association to interpret and expand this policy statement is based on a recognition and concern that:

(a) The need and demand for quality health care by the population is not being met by, and is critically straining, the current health care delivery system.

(b) The alarming increase in the cost of medical care mandates a review and evaluation of the present health care delivery system.

*The American Dietetic Association's position is that inclusion of nutrition as a component of health care will significantly reduce the number of people requiring sick care service and, therefore, contribute directly to:*

(a) A relief of strain on the nation's health care delivery system;

(b) A decrease in the escalating rate of health care costs;

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Nutrition is a critical factor in the promotion of health and prevention of disease and in recovery and rehabilitation from illness or injury. Evidence mounts that Americans who fail to attain a diet optimal for health can be found at every socio-economic level. The reasons are many and complex, but the impact on the health of the nation is seen in the increased risk of complications of pregnancy in the poorly nourished woman, in the chance that her infant may be of low birth weight with accompanying risk of retarded physical and mental development; in the high incidence of overweight and underweight in school-age children and in adults; in the debilitation of the malnourished elderly; in dental disease, widespread in the total population; and in the high

\*Approved by the Executive Board, February 12, 1971, as Position Paper Number 0000E.

One of the main problems resulting from the lack of nutrition training in the nation's medical schools is that however much individual physicians in the federal or state planning agencies may protest their interest, nutrition almost invariably ends up being left out as a component of health-care delivery systems. Indeed, less than two years after the White House Conference on Food, Nutrition and Health, the two strongest nutrition bureaus at the state health level (New York and California) are threatened with extinction.

With government at all levels responsible for an ever increasing proportion of health expenditures, with these expenditures mounting without appreciable effect on the health statistics of the nation, it is becoming obvious that emphasis must be shifted from purely curative to prevention and rehabilitation. This means that nutrition should assume even more importance than in the past. In terms of money—as in terms of human suffering—one can well argue that every dollar spent on nutrition instruction may save tens of dollars in later medical care.

I am delighted to see that The American Dietetic Association has once again asserted its leadership in human nutrition by preparing and endorsing a position paper which outlines clearly the necessary nutrition services to be included in comprehensive health schemes. The paper also clearly describes the need for nutrition input at the planning stages if nutrition services are to be properly structured. At present, the United States Department of Agriculture is operating a gigantic (over \$3 billion) food program with what many think is much too small a nutrition component. Present indications are that the Department of Health, Education and Welfare is similarly casual about nutrition. I commend this position paper to health planners at all levels.—*Jean Mayer, Ph.D., D.Sc., A.M. (hon), M.D. (hon), Professor of Nutrition, Harvard School of Public Health, and Chairman, White House Conference on Food, Nutrition and Health.*

incidence of chronic illnesses that require dietary treatment, monitoring, and follow-up. Since it is apparent that improvements in the nutrition of people will have a direct effect on the level of health and the resulting need for health services The American Dietetic Association recommends that:

I. Nutritional care, as a component of health care, be available to all people on a continuing and coordinated basis. *Nutritional care* is the application of nutrition science to the health care of people. In its broadest sense, nutritional care is provided to the general population through studies of food consumption and nutritional health, mass education, and food assistance programs. As applied to patient care, it has the same components (assessment of food practices and nutritional status, nutrition education, and food assistance) plus dietary counseling and the service of appropriate food. These nutritional care services must be combined and coordinated to meet individual needs.

II. Nutritional care be integrated into preventive, diagnostic, curative, and restorative health services. Any contemplated health services delivery system should include a nutrition component in its preventive as well as remedial services, if the maximum benefits to health are to be achieved. The following example illustrates the application of this recommendation:

HEALTH SERVICES	NUTRITIONAL CARE
Public health service—health promotion	mass nutrition education; supplemental food assistance
Health-testing service (7)	assessment of food intake and other indexes of nutritional status
Health care service	nutrition education and counseling, food assistance, appropriate food service
Preventive, maintenance service	dietary counseling, food assistance, appropriate food service
Sick-care service	for all levels of in-patient care, appropriate food service, diet therapy, dietary counseling

III. The planning and supervision of nutritional care be under the direction of persons professionally educated in nutrition as it relates to human health needs. Dietitians and public health nutritionists, with their educated knowledge of foods and nutrition, are the health professionals who are prepared specifically to help individuals and groups improve their diets and their nutritional status. (In this paper, the term *dietitian* shall be interpreted to mean either a public health nutritionist or a dietitian who is qualified for registration in The American Dietetic Association.) Supportive personnel (dietetic technicians, dietetic assistants) extend the knowledge and skills of dietitians to greater numbers of people.

IV. Dietitians function at the planning and policy-making level of federal, regional, state, and local com-

prehensive health planning bodies to assure that an appropriate nutritional care component is incorporated into all comprehensive health care planning.

V. Comprehensive health care plans include appropriate administrative placement of the nutrition care component; staffing patterns and qualifications for personnel; identification of nature and extent of nutrition problems; standards of nutritional care; methods to be used for delivery of nutrition services; and evaluation.

VI. To assure that a supply of dietitians is available and accessible to those in need of nutritional care, steps should be taken to:

A. Support the expansion of existing education and training facilities in nutrition and dietetics and the development of new facilities.

B. Increase support available to students of education and training in nutrition by means of scholarships, loans, and other financial mechanisms.

C. Explore and establish new approaches to undergraduate, graduate, and technical education.

D. Utilize supportive dietetic personnel and improve their career development and status in the health care system.

E. Explore other means to increase the dietetic manpower supply through such mechanisms as proficiency and equivalency examinations and other recruiting efforts.

VII. Dietitians be eligible for payments as providers of health care services. Future health care legislation should stipulate dietary counseling services as an eligible service for third party payment.

VIII. Adequate funding for preventive as well as curative nutritional care services be provided. Until such time as the nation is geared to deliver comprehensive family health care, nutrition services should be supported in existing specialized programs and services, such as: health services for mothers and children; the elderly; special groups, such as migrant agricultural workers and low-income families; family planning programs; chronic disease control services; home health services, rehabilitation services for drug and alcohol addicts; and group care services in facilities such as hospitals, nursing homes, extended care facilities, day-care centers, and residential institutions; detention centers, detoxification centers, and prisons.

XI. A careful appraisal be made of the economic benefits of nutritional care in a comprehensive medical care system. Such an appraisal should also include evaluation of the effectiveness of preventive nutritional care, as well as remedial services, on such variables as cost, absenteeism, worker productivity, and so on.

X. Any national health insurance program adopted

include incentives for the development of preventive health services. Nutritional care should be identified in the legislation as an essential component of preventive health care service.

- XI. Standards for nutritional care services be included in all federal and state guidelines and regulations for health care.

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Mr. ROSTENKOWSKI. Thank you, Miss Fischer, for a very informative statement.

Are there any questions?

Mr. SCHNEEBELL. You referred to the White House Conference on Nutrition and Health. Has this action made any impact?

I realize in asking for your reaction I may be putting some individuals on the spot. I realize Dr. Mayer has been working very hard trying to make an impact. Does your group feel he has the proper support from the administration?

Miss FISCHER. I think one thing that has been the result of the White House Conference on Nutrition and Health, it has made the Nation as a whole much more aware of the problem of nutrition and malnutrition. I think that is probably a first step in developing support and in finding some solutions.

Mr. SCHNEEBELL. I judge in our present Medicare and Medicaid programs there is not much recognition of nutrition, is that correct?

Miss FISCHER. That is correct. Nutrition is not a reimbursed service under Medicare at this time.

The nutritionist—physicians cannot ask a nutritionist, let us say, or a dietitian to go to a person's home and to counsel a patient on a dietary problem.

Mr. SCHNEEBELL. I judge also your reaction is the food stamp program does not help with nutrition because it lacks guidelines and direction.

Miss FISCHER. It helps someone because it provides people with more food than they would otherwise have, but there is more need.

Mr. SCHNEEBELL. Better guidelines?

Miss FISCHER. Better guidelines and more nutrition education. It is not just for the recipients of food stamps, but people all up and down the economic levels.

Mr. SCHNEEBELL. Can't strides be made in the schools?

Miss FISCHER. Yes; but there is very little education in the schools.

Our association is supporting nutrition education in the schools, but presently there is very little.

Mr. SCHNEEBELL. Would that be done federally or through the State?

Miss FISCHER. There is money available through the school lunch program.

Mr. SCHNEEBELL. Is that in education?

Miss FISCHER. For nutrition education, 1 percent of the funds for school lunch have been designated for nutrition education. It is difficult to get a string on those funds. It is not much, but it is some. School lunch programs have not included much education.

Mr. SCHNEEBELL. They have all been pretty haphazard?

Miss FISCHER. That is correct.

Mr. SCHNEEBELL. Thank you.

Mr. ROSTENKOWSKI. Thank you, Dr. Fischer.

Mr. Durward McDaniel?

Dr. Hayes Newby?

Doctor, would you identify yourself for the record and then proceed into your statement.

**STATEMENT OF DR. HAYES A. NEWBY, ON BEHALF OF THE AMERICAN SPEECH AND HEARING ASSOCIATION; ACCOMPANIED BY RICHARD J. DOWLING, DIRECTOR, GOVERNMENTAL AFFAIRS PROGRAM**

Dr. NEWBY. Thank you, Mr. Chairman.

I am Hayes Newby, director of the University of Maryland's Division of Speech and Hearing Science, and today I am representing the American Speech and Hearing Association (ASHA), of which I am a past president. Accompanying me is Mr. Richard J. Dowling, director of the association's governmental affairs program.

We had prepared a statement which you have. I would like to request that at the conclusion of my testimony I give an amended version of that statement to go into the record.

Mr. ROSTENKOWSKI. Without objection, that may be done.  
(The statement referred to follows:)

**STATEMENT OF DR. HAYES A. NEWBY, ON BEHALF OF AMERICAN SPEECH AND HEARING ASSOCIATION**

Mr. Chairman and members of the committee, I am Dr. Hayes A. Newby, Director of the University of Maryland's Division of Speech and Hearing Science, and today representing the American Speech and Hearing Association (ASHA), of which I am a past president. Accompanying me is Mr. Richard J. Dowling, director of the Association's Governmental Affairs Program.

ASHA is a scientific and professional association of more than 14,000 members which lists these as its major objectives: The encouragement of basic scientific study of the processes of human hearing, speech, and language; the promotion of the investigation of hearing, speech, and language disorders; and the promotion of improved therapeutic procedures related to such disorders.

The work of ASHA members—speech pathologists and audiologists located in a wide variety of professional settings—is consumer-oriented. And the consumer market is a very large one indeed. Research completed in 1969 termed a population of 236,000 deaf Americans “a conservative total.”<sup>1</sup> The same study estimated that some 8,500,000 Americans have “auditory problems of one type or another which are less severe than deafness but which impair communication and hence social efficiency.”<sup>2</sup> Americans plagued by central communicative disorders (i.e., those caused by central nervous system dysfunctions or acquired neurological anomalies) were estimated at 2,100,000, and those with other kinds or speech disorders at an astonishing 10 million.<sup>3</sup>

It is true that some of these disorders are so mild as to go unperceived, and that many which are perceived go untreated. It is also true that the treatment of some of these disorders is administered by health professionals other than speech pathologists or audiologists. But the fact remains that close to 21 million Americans, about one-tenth of our national population, are in some way and to some degree communicatively handicapped. And service to these Americans is the primary mission of ASHA and its membership.

For this reason, the ASHA membership and the public it serves have a very clear stake in the development of a mechanism designed to provide increased health services of the highest possible quality to all who need them. Such a development is the purpose of this Committee's hearings. We are grateful for your concern in this important area and for the opportunity to participate in your initial deliberations.

Mr. Chairman, the American Speech and Hearing Association believes that comprehensive health care is a fundamental right in a progressive society, and that official national policy should recognize both that right and the correlative

<sup>1</sup> Report of the Subcommittee on Human Communication and Its Disorders, National Advisory Neurological Diseases and Stroke Council (NIH), *Human Communication and Its Disorders—An Overview*, Bethesda, Md. (1969), p. 11.

<sup>2</sup> *Ibid.*, p. 13.

<sup>3</sup> *Ibid.*, pp. 16–17.

duty of government to see that the means for realizing that right are provided for all. ASHA strongly endorses the development of a health-care program that is "national" in the sense that standard and uniform guidelines determine the type and degree of available services, and that these services are rendered on the basis of need and not on the accident of geography. The type program ASHA envisions will also be sufficiently broad-based to encompass all available health-care services, including the efficient and effective delivery of the full range of speech and hearing services to America's communicatively impaired.

Earlier this year, ASHA developed and adopted a position statement containing the Association's general views on the subject of national health care. I should like now to elaborate several of the principles enunciated in that statement, summarize those that remain, and request that the position statement itself be included in the record of these hearings at the conclusion of my remarks. ASHA believes that productive policy planning necessitates the recognition that health care based only on the treatment of medical disease is, at this point in our national development, incapable of meeting the needs of our citizens, and that the unaltered perpetuation of this medical treatment model in any new health-care enactments will predictably result in the maintenance of our present inadequate system on a larger scale.

It is medically unsound to treat only part of a problem. Yet, in recent years, this has been the effect of the medical model. In its traditional sense, the medical model fails to respond to the realization that health problems are experienced in a social-emotional-mental sphere, as well as in a physical sphere. We can point with justifiable pride to the continuous increase in the physical life span and physical well-being of our citizens. Unfortunately, however, we cannot point with the same degree of pride to an increase in our ability to meet the social-emotional-mental health problems which can occur with, or independent of, medical disease.

ASHA contends that any definition of health care should include consumer access to all preventive, diagnostic, remedial, and rehabilitative services that contribute to the maintenance of physical, social, emotional, and mental well-being. The Association urges a reorganization of our health delivery system in a way that will be responsive to the broad spectrum of health concerns.

Perpetuation of the traditional medical model in any new health-care enactments would mean continuation of a national health system which awards virtually all the positions of health-care responsibility for administration, decisionmaking, program development, and program implementation to a select group of professionals representing but one aspect of total health care.

A number of the proposed health-care plans pending consideration by this Congress provide for only one point of entry into health-care participation, and that way is through a physician. These proposals often specify that a physician, and only a physician, shall refer patients, prescribe treatment, approve plans for treatment, and review reports for non-medical treatment administered by non-medical professionals. Such proposals would severely restrict the delivery of total health-care services to consumers.

It may well be assumed by the proponents of these single-entry kinds of proposals that physicians are, after all, the true and perhaps even sole providers of health care. If so, these proponents should be made aware of the fact that only one-tenth of America's health-care providers are physicians. It may be that they think only physicians possess an in-depth, comprehensive knowledge of all facets of health care. If so, they should be made aware of the fact that there are more than 20 independent non-medical health-care professions, each with its own core of scientific and clinical knowledge.

Under present Medicare regulations, Mr. Chairman, speech pathology services required by elderly Americans with special problems in communication as an aftermath of strokes, cancer of the larynx, Parkinsonism, and other disease processes that have run their course and are no longer medically treatable are not now covered unless they are provided in an organized institutional setting that is directed by a physician. It matters not that the community speech and hearing center to which an elderly speech-impaired citizen takes his problem is accredited by a recognized national accrediting organization, or that its staff is professionally certified by their national professional association, or that a privately practicing speech pathologist may have a wall full of professional diplomas and certifications and be recognized as one of the leaders of his pro-

fession. Unless these institutions and practitioners are physician-directed, Medicare coverage is simply not available.

ASHA believes that this and similar examples of patients denied care from the non-medical health professions strongly commend to health-care policy planners a system that avoids the erroneous assumption of medical supremacy in all areas of health care. At the same time, they call for our adoption of a new "health-care model," one which, in addition to redefining health care as a broad and inclusive field, recognizes the need for multiple points of entry into its delivery system for both the people who need health care and the professionals who render health services; one which recognizes that more than traditional medical interests are involved; and one which makes appropriate provisions for maximizing the potential contributions of health professions which have evolved independently of medicine. Only through this model, in our opinion, can be appropriately, expeditiously, and economically dispense the quality and quantity of health care that is relevant to the broad spectrum of our nation's health needs.

Permit me, at this point, Mr. Chairman, to summarize the remaining principles recommended by ASHA for inclusion in national health-care legislation.

The Association advocates first, consumer participation in the development, implementation, and governance of health-care programs; second, protection of consumer rights regarding human dignity, privacy, confidentiality, and freedom of choice among available health-care services; third, consultation with representatives of all health-care professions, prior to the promulgation of health-care administrative regulations; and fourth, the approval of sufficient funds to provide the manpower training, public education, and research which an effective national health-care system will require.

Let me conclude my remarks, Mr. Chairman, by saying once more that the American Speech and Hearing Association gives the full support of its membership to the concept of a national health-care program that is comprehensive in scope. We urge that the primary responsibility for the delivery of the non-medical health services provided by the program be assumed by the particular profession established to manage a specific health problem, and that this responsibility begin at the formative stages of the program and continue through the final review process.

It is the Association's sincere hope that the combined creative and cooperative efforts of consumers, providers, and government will result in the development of a national health-care program that can meaningfully and efficiently meet the total health-care needs of our nation.

Thank you, gentlemen.

Dr. NEWBY. The American Speech and Hearing Association is a scientific and professional organization of more than 14,000 members, people who are working professionally in the field of speech pathology and audiology.

The gentleman who testified previously, Dr. Brown, is representing an association of agencies that provide speech and hearing services, but the individual members of those agencies are affiliated with the American Speech and Hearing Association. We are an organization of individuals rather than of agencies.

I won't bore you with all of the statistics that are in the report about the numbers of communicative handicaps that we find among our population today, except that I will say that some estimates are as high as 10 percent of the population—something on the order of 21 million individuals in our country have some form or degree of communicative difficulty.

It is with these individuals who have problems of speech, hearing, language development that we individuals in the association are concerned.

The ASHA membership and the public it serves have a very clear stake in the development of a mechanism designed to provide comprehensive health services of the highest possible quality to all who need them.

This is the reason you are having your hearings now, to develop this mechanism, and we are very grateful to have the opportunity to participate in your deliberations here.

Earlier this year, the association I am representing developed and adopted a position statement that contains the association's official point of view on health insurance.

If I may have your permission to have this statement included in the record, I will make sure that the reporter gets a copy.

Mr. ROSTENKOWSKI. Without objection, it may be included.

(The position statement referred to follows:)

#### POSITION STATEMENT ON NATIONAL HEALTH CARE

With strong concern for the needs of individuals with speech, language and hearing impairments, the American Speech and Hearing Association believes that comprehensive health care is a right to which the citizens of our nation are entitled. The Association advocates a definition of health care that is broadly based to include all available health care services. The Association supports the development of a national health care program. To this end, the American Speech and Hearing Association endorses the following principles as necessary to an effective and comprehensive health care program, including the delivery of speech and hearing services to the communicatively impaired.

1. *Comprehensive health care, by definition, includes access to all preventive, diagnostic, remedial, and rehabilitative services that contribute to the maintenance of an individual's physical, mental, and social well-being.* remedial, and rehabilitative services that co

In this principle, the definition of health care is extended to include medical treatment and all other health care services necessary to meet the total needs of the consumer. The principle also incorporates the concept of equal access to all health services. The establishment of priority rankings for health services is contradictory to the stated purposes of a *comprehensive* health program.

2. *The system of health delivery must be reorganized in a manner that will reduce fragmentation in the delivery of health services and that will be relevant to the broad spectrum of health concerns.*

Historically, health care has been conceived primarily as the treatment of pathology. Disproportionate attention has been placed upon prevention of pathology. Equally as important, only token support has been given to meeting the social and mental health needs of our citizens. Health is not merely the absence of pathology but is the state of total physical, social and mental well-being. Therefore, a health care program must provide appropriate emphasis to physical, mental and social health problems.

3. *A comprehensive health care program should be under national governance.*

Standard and uniform guidelines must be developed relative to the type and degree of health care services available under a health care program. Services must be rendered on the basis of need and not on the accident of geography. Even a cursory review of the state Medicaid regulations will quickly demonstrate that the scope of health care services provided varies widely from state to state.

4. *Providers of health care services must have full opportunity to participate in a national health care plan.*

Many proposed health care plans provide for a single point of entry into the health care system through the physician. A regulation of this type restricts the delivery of health care services to the consumer. Furthermore, the proposed regulations often specify that a physician shall refer, prescribe treatment, approve plan for treatment, and review reports following treatment in the delivery of nonmedical health care services. The assumptions underlying the concepts of single entry and physician governance of health care are three-fold: (1) that the physician is the sole provider of health care; (2) that physicians possess in-depth knowledge concerning treatment processes relative to nonmedical health

care; and, (3) that physician manpower is in sufficient supply to allow physicians to engage in extensive administrative activities. First, only 10% of all health care providers are physicians. Second, there are more than 20 independent nonmedical health care professions, each having its own core of scientific and clinical knowledge. Third, factors of critical physician shortage and over-demands on available physician care have been constantly cited in the current studies. Thus, a comprehensive health care plan cannot be based upon questionable assumptions that perpetuate the recognized deficiencies in the present health care system.

5. *Direct participation by consumers of health services is necessary in the governance of a health care program, including review bodies.*

In order to reflect consumer interests, consumer participation is necessary during the development, implementation and governance of health care programs.

6. *A health care program should protect the individual's rights in regard to human dignity, privacy, and confidentiality. Access to health care should provide the consumer with freedom of choice among the available health care services.*

7. *Prior to the passage of legislative and administrative regulations concerning the delivery of health care services, representatives of all health care providers should be consulted as to the type and mode of services rendered in order to maximize the extent and quality of health care services available to the consumer.*

Current and proposed regulations often unduly prevent the actual rendering of health care services to the consumer. For example, one proposed health care plan provides for the rendering of speech services when the service is given in a physician's office or prescribed by the physician. Since less than 0.5% of the nation's speech pathologists are employed in a physician's office and speech services are not ordinarily obtainable through physician prescription, only a small percentage of the speech handicapped population could receive speech services under such regulations.

8. *Manpower training, public education and research are necessary adjuncts to a health care program.*

Support of manpower training is mandatory in order to ensure high quality services and the continued availability of such services to the consumer. A program of public education must be instituted to inform the consumer of the availability of the vast array of health care services and the processes necessary to obtain the services. Continued improvement of health care requires support for research programs in prevention, diagnosis, remediation, and rehabilitation.

In summary, the American Speech and Hearing Association gives full support to the concept of a national health care program and emphasizes the need for such a program to be comprehensive in scope. The primary responsibility for the delivery of nonmedical health services within the plan must be assumed by the particular profession established to manage a specific health problem. This responsibility should begin at the initial planning level and be maintained through the final review process.

The combined creative and cooperative efforts of the consumer, provider and government can result in the development of a national health care program that will meaningfully and efficiently meet the total health care needs of our nation.

Dr. NEWBY. We in ASHA believe that productive policy planning necessitates the recognition that health care based only on the treatment of medical disease is at this point in our national development incapable of meeting the needs of our citizens and that the unaltered perpetuation of this medical treatment model in any new health care bills or enactments will predictably result in the maintenance of our present inadequate system but on a larger scale.

We believe it is medically unsound to treat only part of the problem, and the disease which the physician treats is only part of the problem.

We can, of course, point with pride to the accomplishments that have been made in increasing the lifespan and the physical well-being of our citizens, but we are not able to point with the same degree of pride to an increase in our ability to meet social, emotional, and mental health problems which can occur with physical disease or independent of it.

A number of the proposed health care plans that are pending consideration by this Congress provide for only one point of entry into health care participation and that is through a physician.

These proposals often specify that a physician and only a physician shall refer patients, prescribe treatments, approve plans for treatment and review reports for nonmedical treatment which have been administered by nonmedical professional personnel.

These proposals would, in our opinion, therefore, severely restrict the delivery of total health care services to consumers.

Under present medical care regulations, for example, speech pathology services required by elderly Americans who have special problems in communication as an aftermath of such physical conditions as stroke, cancer of the larynx, Parkinsonism, or other disease processes that have run their course and are no longer benefited by medical treatment are not now covered unless they are provided in an organized institutional setting that is under the direction of a physician.

It matters not that community speech and hearing centers to which the elderly might go seeking help are accredited by national accrediting agencies and that the staffs of these centers are individually certified by the American Speech and Hearing Association, or that a privately practicing speech pathologist might have his walls plastered with certifications and degrees.

Unless the institutions to which the individual under medicare goes for help are under the direction of a physician, then they are not covered.

We believe that this and similar examples of patients denied care from the nonmedical health professions strongly commend to health care policy planners a system which avoids the erroneous assumption of medical supremacy in all areas of health care.

Actually there are only about 10 percent engaged in the health professions who are physicians. We feel, therefore, that the continuation of the model that the physician must be the point of entry into the delivery system would be a mistake.

We feel that there should be participation in the planning and in the administration of any health care program, there should be participation by representatives of the various health agencies that are independent of the medical profession, but are playing perhaps not as important a role, but an important role in the total health care of the person who has handicaps.

I shall conclude my remarks, Mr. Chairman, by saying once more that we in the American Speech and Hearing Association do support the concept of a national health care program that is comprehensive in scope, and we urge that the primary responsibility for the delivery of the nonmedical health services provided through the program be assumed by the particular profession that has been established to manage a specific health problem.

In other words, speech problems should be managed by speech pathologists.

It is our association's sincere hope that the combined creative and cooperative efforts of consumers, providers, and developers will result in the development of a national health care program that can meaningfully and sufficiently meet the health care needs of the Nation.

Thank you.

Mr. ROSTENKOWSKI. Thank you, Doctor.

Mr. Schneebeli?

Mr. SCHNEEBELI. Are there any professional guidelines that must be met to qualify a speech therapist or speech pathologist?

Dr. NEWBY. At present our association, the American Speech and Hearing Association, is the only means of accrediting individuals as speech pathologists or audiologists.

Mr. SCHNEEBELI. The association qualifies them on what basis? Certain educational standards?

Dr. NEWBY. There are academic requirements.

Mr. SCHNEEBELI. Do you have graduate requirements?

Dr. NEWBY. A master's degree or equivalent amount of graduate work is one requirement.

Mr. SCHNEEBELI. I wondered if there were any scholastic requirements at all.

Dr. NEWBY. Yes, there are.

Mr. ROSTENKOWSKI. Thank you, Dr. Newby.

This concludes the list of witnesses who were scheduled to testify before us today.

The committee stands adjourned until 10 o'clock tomorrow morning.

(Whereupon, at 1:55 p.m., the committee adjourned, to reconvene at 10 a.m., Thursday, November 4, 1971.)

# NATIONAL HEALTH INSURANCE PROPOSALS

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THURSDAY, NOVEMBER 4, 1971

U.S. HOUSE OF REPRESENTATIVES,  
COMMITTEE ON WAYS AND MEANS,  
*Washington, D.C.*

The committee met at 10 a.m., pursuant to notice, in the committee room, Longworth House Office Building, Hon. Al Ullman, presiding.

Mr. ULLMAN. The committee will be in order. Our first witness this morning is Mr. L. B. Knecht.

Will you further identify yourself and your colleagues for the record and we will be happy to recognize you.

**STATEMENT OF LOUIS B. KNECHT, EXECUTIVE VICE PRESIDENT, COMMUNICATIONS WORKERS OF AMERICA, AFL-CIO; ACCOMPANIED BY IVAN SWIFT, ADMINISTRATIVE ASSISTANT TO THE PRESIDENT; AND RON STRAW, DIRECTOR, DEVELOPMENT AND RESEARCH**

Mr. KNECHT. Thank you, Mr. Ullman.

On my left is Mr. Swift, administrative assistant to President Beirne of our association.

On my right is Mr. Straw, who is director of our development and research department.

My name is Louis B. Knecht, and I am an executive vice president of the Communications Workers of America, a union which represents approximately a half-million communications and other workers. Joseph A. Beirne, our president, has asked me to appear on the union's behalf, and we appreciate being allowed to give our views to the committee.

I think we all agree that health care delivery in America today is poor. In some areas—and for some people—it is miserably poor.

President Nixon has said so.

Experts have said so.

And our members—in big cities, as well as in little towns and villages all across the country—tell us so.

Methods which would provide real improvement in health care delivery are available in pending legislation. But spokesmen for major components of the health industry—the practitioners and the insurers—are locked in an alliance to thwart legislation which would produce a health care delivery system that meets the needs of the time and the needs of the future.

The opposition is inciting a confrontation which concerns the Communications Workers of America deeply.

That confrontation is between the narrow, special interest of the health industry, and the broad, general interests of the average American.

We feel that if the narrow, special but powerful, interest is allowed to dominate the needs of the vast, working American public, a situation will result which can be even more serious than abysmal health care delivery.

That situation would be the conscious decision by American workers that whenever the worker-citizen's interest comes up against a special interest—the special interest wins. Consequently, representative government as they know it, and wish to preserve it, will not work.

The average workingman's frustration about government's ability to solve problems—and his anxiety about getting good health care delivery for himself and his family—are combining now to produce this attitude which I have described. It is the attitude Chairman Mills called "increasingly resentful," on the day that these hearings started.

Because of this attitude, and because of the merits of H.R. 22, the Communications Workers of America urges the committee and the Congress to support the Griffiths-Corman bill.

We believe that H.R. 22's concept of what health care should be—its benefit structure—its administrative procedures—its financing—its provisions concerning providers of health services—its programs for building resources to deliver health care—all answer the need which exists in America.

We also believe that it would be a serious mistake if Congress adopts half steps in the right direction.

The problem has reached the point where half steps would be little better than no steps at all.

To the people, to the workers who discuss this with us, half steps would be only another example of government generating an expectation of performance, without delivering it.

HEW Secretary Elliot L. Richardson's testimony here,, on behalf of the Nixon administration, looked to us like a clear example of the erroneous idea that a new facade of health care delivery is acceptable—but we know that a facade won't do. A new health care delivery structure is needed.

He told this committee that improvements can be made without disturbing the historic division that finds Government taking care of the health needs of the elderly and the indigent, while the private sector takes care of the rest of the people.

That just isn't working now, and it won't work anymore. We would like to ask the committee to give special attention to this comment by the Secretary, and I quote :

We believe the comprehensive health care services should be provided as rapidly as possible for the entire population. However, it will take time to develop sufficient manpower, facilities and managerial skills to fulfill this goal.

Medical and health manpower training should be expanded and streamlined, but we will fool ourselves if we think that is the way to solve the country's health care delivery problem.

The way to solve it is to pass H.R. 22, which recognizes the needs in manpower and planning and facilities, as well as the need to change

a cottage industry to a technologically efficient system and provides the methods for solutions.

The president of our union, Joseph A. Beirne, served on the National Advisory Committee on Health Manpower, and I would like to mention a recommendation made by the committee, because it helps illustrate a current aspect of the problem.

In 1967, the Advisory Committee said, and I quote:

The productivity of physicians should be increased beyond presently planned levels by a substantial expansion in the existing medical schools, and by continued expansion of new schools.

But, as recently as October of 1971, the American Medical Association testified before the House Armed Services Committee against a bill to set up a military medical academy, which would provide a supply of physicians for the military.

The AMA did not prevail—the Armed Services Committee reported the bill out unanimously.

But the AMA attitude has made it plainly obvious that this organization should no longer influence vital health legislation.

The real demands and needs of Americans should prevail.

We are aware of the fact that a national advertising campaign has been inaugurated to beat H.R. 22 and we do not question the right of any interest group to try to sell its message.

But we do not believe that the campaign will be successful.

The average working American we meet knows that something is wrong with the health delivery system, and the average working American knows those who control that system have created the problem.

They are looking to Congress to enact the solution, and Congress should enact it, in the form of H.R. 22.

Thank you.

Mr. ULLMAN. We are very pleased to have your views and those of Mr. Beirne before this committee.

Are there any questions?

Mr. Vanik?

Mr. VANIK. I would like to ask what is the present health program of the Communications Workers Union?

Mr. KNECHT. Do you mean contractually between the union and our employer?

Mr. VANIK. Yes.

Mr. KNECHT. The rates are running for an individual \$8 to \$14 a month. For two persons coverage it is \$18 to \$30. If there are two persons the rate is running \$18 to \$30. For more than two, in other words, family coverage, the rate is running \$24 to \$30 a month.

Mr. VANIK. That is almost a dollar per day for each member of the family?

Mr. KNECHT. Yes.

I would like to add one other fact. For the Bell System now and, of course, we represent many people who are not employees of the Bell System, but for the Bell System it is costing them about \$110 million a year.

Mr. VANIK. For supervisory personnel, also?

Mr. KNECHT. Yes.

Mr. VANIK. This is a total obligation of the employer as a result of the contract you have been able to develop with the companies?

Mr. KNECHT. Yes, sir.

I gave a wrong answer a minute ago, my colleagues tell me. The \$110 million is only for those people we represent, not for supervisors.

Mr. VANIK. Can you tell me what the coinsurance feature is?

Mr. KNECHT. It is 80 percent.

Mr. VANIK. In other words, the employee pays 20 percent of the medical, doctor's expenses and hospital expenses.

Mr. KNECHT. If you are talking about the catastrophic coverage; yes, sir.

Mr. VANIK. What about regular services in hospitals or noncatastrophic coverage?

Suppose a person is hospitalized for 28 days. Does he have to pay 28 percent of that cost?

Mr. KNECHT. No, sir; that is completely covered.

Mr. VANIK. For how many days?

Mr. KNECHT. I believe it is 120.

Mr. VANIK. That would be the normal Blue Cross coverage. That is 120 days of hospital care and then 80 percent of the coverage would cover that part of medical services such as doctors' bills.

Would it include outpatient services and X-rays?

Mr. KNECHT. Are you talking now about the catastrophic portion?

Mr. VANIK. I am talking about the regular noncatastrophic coverage.

Mr. KNECHT. It would include some kind of X-rays, yes, provided it was not a diagnostic thing.

Mr. VANIK. Does your plan provide for annual examinations?

Mr. KNECHT. No, sir; it does not.

Mr. VANIK. What is done under your plan to provide for preventive care?

Mr. KNECHT. Our present program is one in which the company pays the premium for what we call basic medical insurance and the company pays the premium for what we call extraordinary medical expenses, the catastrophic type of expenses.

I should say the carriers are the blues. This year we were successfully able to negotiate a change in the plan which removed the fixed fee schedules and provides for usual customary and reasonable in place of those schedules.

Does that answer your question, sir?

Mr. VANIK. I want to ask whether under your plan you cover hospital stay and doctors' services?

Mr. KNECHT. Yes.

Mr. VANIK. What doctors' services are provided?

Is there a coinsurance feature provided or is it entirely paid by the carrier?

Mr. KNECHT. I am trying to remember, sir. I don't have that with me. I believe that there is a corridor. A visit in a doctor's office is not covered.

Mr. VANIK. Does it cover psychiatric services?

Mr. KNECHT. We got that this year.

Mr. VANIK. In what form does it cover catastrophic illnesses?

Mr. KNECHT. There is a corridor of 2 percent of the annual salary of the individual involved that the individual pays.

When that corridor is pierced, then with very few exceptions it covers whatever is wrong, but it happens after the other major benefits or the basic benefits are used up.

Mr. VANIK. How would you say that program is working?

Mr. KNECHT. I should have said it is a coinsurance type of thing. I think it is working well.

Mr. VANIK. Do you feel it is the sort of thing that should be extended more broadly? As far as you can determine do the Communications Workers Union have a good plan?

Mr. KNECHT. We have what we call an average plan. We don't have a Cadillac-type plan but it is certainly better than most Americans have available to them.

Mr. VANIK. How many employees are covered by that?

Mr. KNECHT. I would guess that approximately 700-some-odd thousand but then the management is also covered.

The last time Mr. Romney spoke publicly, he indicated there were more than a million employees.

Mr. VANIK. 700,000 in your organization?

Mr. KNECHT. That is right.

Mr. VANIK. So we have a million people having a rather established program of delivery of health services and it has been working very satisfactory?

Mr. KNECHT. That is right.

Mr. VANIK. Do you have any estimate as to what the value of this program is for each one of the million employees or what it would cost for each of the million employees?

Mr. KNECHT. There are no preventive features.

Mr. VANIK. I want to compliment you on your testimony and the success you have achieved in developing a rather fine plan. It gives us a great deal of basis for developing a national program and we appreciate your testimony.

Mr. KNECHT. Thank you, sir.

I realize you have many, many witnesses, but I failed to mention that we also obtained in our negotiations this year the opportunity or the right for the employee to choose a group plan such as Kaiser for example.

Mr. VANIK. That is his option?

Mr. KNECHT. Yes, sir.

Mr. ULLMAN. Are there further questions, Mr. Corman?

Mr. CORMAN. Thank you, Mr. Chairman.

What happens, Mr. Knecht, to an employee once he leaves employment, so far as his medical coverage is concerned?

Mr. KNECHT. He loses it.

Mr. CORMAN. Then he has nothing?

Mr. KNECHT. That is right.

Mr. CORMAN. How about his dependents when they reach age 22? Are they also pushed out of the system?

Mr. KNECHT. They are dropped.

Mr. CORMAN. Do you have any idea what it would cost an employee or an adult child of an employee to buy comparable coverage if they were not a part of the acceptable group?

Mr. KNECHT. Between age 19 and 23, it runs \$8 to \$14.

Mr. CORMAN. After age 23—

Mr. KNECHT. They are not eligible.

Mr. CORMAN. Suppose an employee severed his employment but wants to continue to have the same coverage that he has under the group plan.

Do you have any idea what that would cost him?

Mr. KNECHT. I am not sure but I am advised, sir, that it would probably double the rate.

Mr. CORMAN. I am wondering if at that point they would make him ineligible for treating existing conditions?

Mr. KNECHT. Yes.

Mr. CORMAN. We heard from the Secretary that we must be very careful about extending medical care to too many people because of the shortage of resources.

It seems to me that when we say that we admit there are people who need medical care but we are not going to distribute these limited resources based on how badly you need the care but on whether or not you and the insurance company have the money to pay for it.

H.R. 22 likewise admits we have a shortage of resources.

But, under it we would apply those resources at the point where the medical need is the greatest and ignore the factor of ability to pay.

It seems to me that that may be a little more humane and make a lot more sense.

If we have limited resources we apply them where the medical need is greatest and not combine medical need plus financial ability.

Is that a reasonable approach to a delivery system?

Mr. KNECHT. I think so. Of course, really, when we talk about a delivery system, I don't think there is one today so we are, in my opinion, if you will forgive me, talking about something which is not now in existence.

Mr. CORMAN. There is a lot of evidence that if you change the method of delivery you can treat a lot more people with the same resources.

I would also assume that if suddenly everybody in the country had equal access to doctors there would be a shortage of doctors no matter how efficient they were.

If we make the criteria that of sickness or that of which groups would benefit most from good care rather than giving top priority to those who can afford it, then we would make better use of our health resources.

I thank you for your statement and your support of H.R. 22.

Mr. ULLMAN. Mr. Gibbons?

Mr. GIBBONS. I am not really impressed about there being a shortage of medical care.

There are unfunded applications amounting to \$800 million from medical schools all over the country at HEW now and there are only \$9 million to fund all of those applications and that \$9 million has been frozen by the Budget Bureau for a long time.

I think what it all adds up to is that the administration is not requesting sufficient money to train doctors and not even using the funds appropriated.

I want to get a little more of the parameters in your medical program. You say there are about 1 million people in the Bell System covered by your plan. Is that all employees?

Mr. KNECHT. If I said 1 million people were covered, I should not have limited that to 1 million because there are over a million employees and most of those have families who are also covered, so the figure would go higher than 1 million.

Mr. GIBBONS. So it would be about 3 or 4 million?

Mr. KNECHT. I would think so; yes, sir.

Mr. GIBBONS. You say it costs how much?

Mr. KNECHT. For the people we represent, it costs approximately \$110 million a year.

Mr. GIBBONS. Those are all the questions I have. Thank you.

Mr. ULLMAN. Are there further questions?

If not, we very much appreciate your testimony, Mr. Knecht.

You have been very helpful to the committee.

Our next witness this morning is our colleague, the Honorable Sam Devine from Ohio and Dr. James L. Henry. The Chair recognizes Mr. Betts for an introduction.

Mr. BETTS. I would like to take this opportunity to welcome Dr. Henry from the Ohio State Medical Association. He and my colleague from Ohio, Mr. Devine, have collaborated on a program or proposal which I think merits the attention of the committee.

I understand from Dr. Henry that Mr. Devine plans to be here any minute, but he feels in order to expedite the hearings it might be well for him to continue without Mr. Devine.

**STATEMENT OF GEORGE WOLF, LEGAL ASSISTANT TO HON. SAMUEL L. DEVINE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO**

Mr. WOLF. I am George Wolf, legal assistant to Congressman Devine. He was to be here at 10:10. He has a prepared statement about the background of this particular bill which is in essence a professional standards review organization structure.

In order to save the committee's time, we would like to have Dr. Henry describe the results of a study that was prepared in Ohio showing how this particular structure would work statistically and with the exhibits we have. If the committee will go along with us we would like to proceed on that basis.

Mr. ULLMAN. Do you want Congressman Devine's statement in the record?

Mr. WOLF. I expect him here any moment and he would like to present the statement when he arrives.

Mr. ULLMAN. We will be very happy to hear your testimony this morning.

**STATEMENT OF DR. JAMES L. HENRY, TREASURER, OHIO STATE MEDICAL ASSOCIATION**

Dr. HENRY. Mr. Chairman, in the prepared statement submitted for the record I have described and outlined the structure of a professional standards review organization, how the review councils will be chosen, and how the information gets back to the Secretary of Health, Education, and Welfare. The key to the question is the review

function itself, the use of computer data as a tool to make reasoned decisions.

The best way I can explain this function is by citing examples of how it would work. To facilitate this, we have included exhibits with our testimony that will show actual studies of disease entitled—the computer read-out phase—and how this data can be used for evaluating the quality-quantity and cost of medical care.

Let's take an obvious example to start with. If you will refer to exhibit No. 1, the exhibit reflects 1 year's experience for 41 hospitals reporting on the disease entity of cataract. You will note that only 13 hospitals have more than 20 cases per year—under medicare—and of these 13, the range of covered charges is from \$279 to \$822. The distinction is, however, that 12 are in a relative range \$500 and an average of 7 to 8 days. One hospital has an experience of \$822 and a stay of 12 days.

The obvious conclusion might be to "limit" the coverage for cataract treatment to a dollar figure of \$500 or a maximum stay of 8 days. This might be a predetermined guideline for preadmission for the disease entity, subject of course to individual review for exceptional cases. But further than this, can we establish a standard of care for abstract treatment? Look again at this exhibit and study columns No. 3, "Pharmacy," and No. 5, "Laboratory Charges."

Again, hospital No. 27 is substantially higher in each instance than the remaining hospitals. Is its "standard of care" overcare—or, in the alternative—are the remaining hospitals "under providers?" The decision then becomes a medical judgment based upon the best information about the facilities, the treatment and the results. What should the standard of care be in the case and under the circumstances? It becomes a true medical judgment. This exhibit is the tool to be used by the PSRO to point out the areas that should be reviewed initially to evaluate the quality-cost of health care.

Now let's look at exhibit No. 2, the disease entity of diabetes mellitus. This exhibit represents a greater scope of patient experience over more hospitals. Frankly, it represents a common ailment in this age group and would provide an excellent basis for standards review. It also indicates a number of areas where cost control might be a factor. For example, look at the "length of stay" column and notice hospital No. 38—a 31-day length of stay average compared with a 13-day overall average length of stay. By the same token it is not exactly fair to use length of stay as the sole criteria as hospital No. 1, showing 13 days of length of stay, and hospital No. 19, showing 13 days length of stay. Yet covered charges in hospital No. 1 are \$742 and covered charges in hospital No. 19 are \$1,244. Again, look at the pharmacy charges for hospital No. 1 at \$50 versus pharmacy charges for hospital No. 19 at \$180, or laboratory charges for hospital No. 1 at \$80 versus laboratory charges for hospital No. 19 at \$282. What should constitute a standard of care in diabetes cases for pharmacy and laboratory costs? This is a medical determination and again merely points up the areas to be examined. In both of these cases the hospitals are comparable institutions in a large metropolitan city.

Now, let's examine a small hospital, No. 14—with an average length of stay of 10 days and total covered charges of \$448. Without know-

ing the circumstances, it might be easy to conclude that this hospital is giving less than standard care and yet this is not the case. The standard of care in this institution is excellent, the cost factor is much less because of the area, help factor, income level. It cannot be compared costwise with the larger metropolitan hospitals, and yet it can be compared qualitywise. Since our purpose is to provide the best quality care at reasonable cost, the first medical determination should be directed to quality evaluation. But the quality evaluation must necessarily include cost and length of stay factors.

To illustrate the effectiveness of professional review, please refer to exhibits Nos. 3 through 17. These charts represent the average length of stay for medicare patients in extended care facilities in 29 of Ohio's 88 counties. Exhibit No. 3 is the overall length of stay average and exhibits Nos. 4 through 17 are for specific disease entities.

Notice the decline in the average length of stay in ECF's between 1967 and 1970. Exhibit No. 3 shows the overall average declined from 58 days in 1967 to 26 days in 1970. This was accomplished by the use of a professional review system understood and accepted by doctors.

In this connection, it is important to note that the quality of care has not been reduced yet substantial savings have been made in the cost of care. If the 824 patients in 1970 would have averaged 58 days as did the 333 patients in 1967 the cost in this small group alone would have over twice as much.

If we have a coordinated program statewide, the results would be even more impressive.

Medicine is not an exact science and it is not possible to treat individuals according to a given program. Certain guidelines can be established but, when we are dealing with individual problems with individual responses, we must utilize professional standards of quality to assure the purpose of health care is achieved. The medical profession can perform a valuable service in assuring the Federal Government that the beneficiaries receive the best care at the most reasonable cost.

Thank you.

Mr. ULLMAN. Without objection your statement will be inserted in the record at this point.

(Statement referred to follows:)

STATEMENT OF DR. JAMES L. HENRY, OHIO STATE MEDICAL ASSOCIATION

Mr. Chairman, Medicare and Medicaid programs—Title XVIII and XIX—have to some extent fulfilled the intent of Congress. The participants in these programs have received necessary and adequate health care. If cost is the criterion, then the quality and quantity of health care have been superlative.

The specter of abuse has been raised often. It would be fair to assume that such incidents of willful, fraudulent abuse are very minimal, but they are not nor can they be ignored. It seems more reasonable to judge that costs so exceeded anticipation because of over-utilization, which is a result of the health care providers adding religiously to the stated purpose of the legislation—adequate health care for these participants of the programs.

The Medicare-Medicaid Act recognized the need for peer review but, unfortunately, specific guidelines and policies were not delineated and activated efficiently. As a result, many utilization of peer review committees were formed for the express purpose of qualifying for Titles XVIII and XIX programs. In all candor, a significant percentage of these committees have not functioned effectively. Attempts to up-grade these committees by regulations have not been overly successful because of reluctance, ignorance and even apathy on the parts of some

providers of health care. All of these factors have caused great discomfort to beneficiaries and providers alike with retro-active denials and reduction in reimbursements.

Most of the confusion, resistance and reluctance could be eliminated by establishing a uniform system of medically directed utilization review. This Congress, and particularly this Committee, recognizes the necessity of efficient, effective peer review. The establishment of professional standards review organizations is to be recommended. Such an organization must, by constitution, create a more effective and uniform method of evaluating the quality, quantity, and cost of health care delivery. The present variances in procedure, composition and actions of peer (utilization) review programs can be eliminated by establishing regional methods based upon lengths of stay by disease entity with breakouts of charges, i.e., X-ray, radiology, laboratory, cardio-pulmonary, and other categories of physician generated charges.

Peer review, per se, deserves considerate explanation, but its basic limitations must be considered in the scope of possibilities of a professional standards review organization. Primary peer review is as old as mankind. "Johnny, wash behind your ears; stand in the corner; eat your vegetables." That is peer review—truly, but with a predictable degree of effectiveness.

Physicians have had a peer review mechanism for centuries. Individual physicians are subjected throughout their careers to stringent peer review.

Tissue, audit, review, grievance, ethics, record and many other committees concern themselves with a physician's capacity to practice medicine ethically, effectively and properly. No profession, in this country, subjects itself voluntarily to a more stringent introspective scrutiny than the medical profession. Such experienced exposure to surveillance has made the medical profession cognizant of the value of scrutiny and aware of the most effective methods of peer review.

Peer review, in itself, has been effective in areas where comprehensive coordination has been achieved. In many areas of this country, peer review has succeeded in parallel fashion to Johnny's peer review. There are many reasons for such instances of inconsistent effectiveness. Basically, the reasons seem to be predicated upon a lack of correlation; a lack of uniformity in methodology and legal limitations imposed upon hospital staffs and medical societies who attempt to act against a wayward physician. Legal agencies have reversed, untold times, actions taken by a medical group against transgressive physicians. As a result, responsible physicians are reluctant and extremely cautious in proceeding against an offending practitioner. Legal limitations have caused the labels of "white-wash" or "foxes in the henhouse" to be attached to the medical profession. Such charges are inaccurate and unfair for the most part.

Given statutory responsibility the medical profession can prove that its members are as competent in peer review as they are as medical practitioners. A professional standards review organization establishment has been proposed in many bills before Congress. As noted previously this type of legislation will create a specific correlation of all types of existing peer review programs. It is readily apparent that a professional standards review organization has great advantage over the limited, uncoordinated professional peer review committees.

In brief, the following is a prototype for the structuring of a professional standards review organization:

The entire structure of the organization should be developed within the confines of a non-profit corporation. The corporate board of directors should be composed of licensed practicing physicians, representatives of the Blue plans, insurance organizations, labor, hospitals, state health agencies, consumers and management.

This Board of Directors shall serve in an overall supervisory role, with the responsibility of fiscal management and it must serve as an appeal board to hear and adjudicate controversy. The Board shall act to carry out the chartered purposes of said corporation. The Board of Directors shall establish a Professional Standards Review Council for the express purpose of developing standards that will effectuate a professional appraisal of the quality, quantity and cost of health care.

The Professional Standards Review Council shall be composed of licensed practicing physicians who are selected from geographic-economic sectors of the

concerned area (state). Council members shall be nominated by local area medical organizations and appointed by the corporate president with the approval of the Board of Directors. The effective minimum number of councilors in an area (state) shall be eleven.

The corporate Board shall have the additional responsibility, through its president, of establishing a panel of the several medical disciplines. This panel of physicians will serve as resource and advisory personnel to the PSRO council of physicians, and, ultimately, to the corporate Board, especially in the area of appropriate scientific and financial data.

The Professional Standards Review Council shall have the primary duty of establishing the required policy guidelines to evaluate the quality, quantity and cost of medical care being delivered in the area (state). Quantity and cost could be appraised by qualified experts in the socio-economic field of care. A total comprehensive evaluation, however, must have a determination of the quality of care delivered. The interpretative analysis of related and relative scientific data—in short, quality control—is the educated responsible mission of the professional standards review council of practicing physicians. No other group is qualified to provide the necessary, meaningful background to determine the scientific standards required to assure high quality health care.

The PSRO council will determine quality professional standards of health care by disease entity. These standards will eventually be expended to include the spell of illness from hospital, ECF, out-patient and auxiliary services. This evaluation, at least at inception, must concern itself with an accurate appraisal of in-patient care provided to government subsidized health care recipients. A common knowledgeable approach is length of stay by disease entity. Within this in-patient stay physician generated charges such as laboratory, radiology, cardiology, pharmacy, must be evaluated by the council. Standards correlating length of stay, cost factors and acceptable medical scientific care must be developed by this council.

The Professional Standards Review Council will assure that a uniform data collection system is developed in all regions of the state (area). In addition, the council will develop uniform operating procedures for the several regions, including a common computerized operation. This uniformity will assure efficient operation and objective evaluation of comparative performance of the regional programs. The PSRO Council in these manners will coordinate the activities of, disseminate data and information among the several regional component organizations and other concerned organizations.

The PSRO Council, directly and through the Board of Directors, shall assist the Secretary of HEW in evaluating the performance of the component review organizations and shall make objective recommendations in the event that a qualified PSRO must be engaged to replace another component organization.

The council will further act to advise, counsel and cooperate with intermediaries and carriers in all pertinent matters. Guidelines for payment of claims may properly be established by this council in all areas relative to the professional and scientific matters.

The individual member of this PSRO council, in close cooperation with the council and corporate Board, will be responsible for the institution and operation of his regional program. It shall be his duty to involve, inform, educate, organize and assist the medical societies and hospital staffs in his region in the development of viable efficient programs of professional standards review. The councilor shall institute a uniform system with acceptable local variables under the guidelines and policies established by the area (state) council.

In the event that a hospital staff or medical society does not choose to participate, the councilor shall, through his regional resources, provide a review function for this particular territory.

The regional councilor shall serve as chairman and coordinator of the regional council or committee empowered to administer the program regionally. He shall submit periodic reports of performance of all programs and his evaluation of these programs to the area (state) PSRO Council and ultimately to the corporate board. All such reports shall be transmitted as required to the Secretary of HEW.

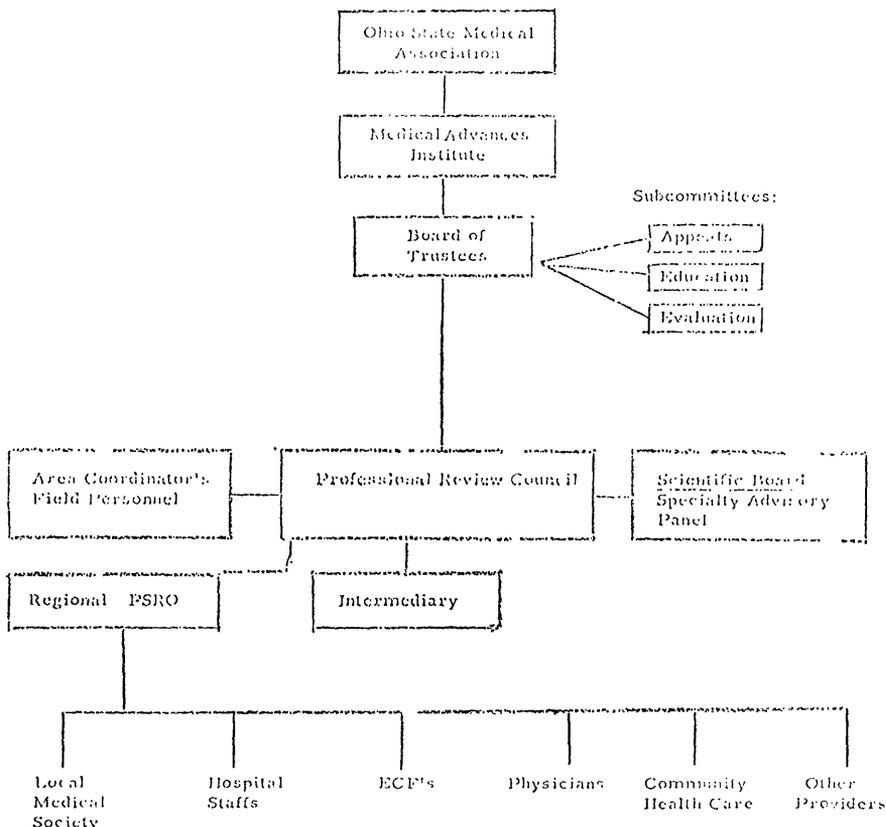
Because of limitations of time, only a broad outline of a PSRO has been included in this presentation. More detailed information will be made available upon request.

H.R. 7182—Devine, Betts—provides that physicians through already established methods will conduct professional standards review organizations to insure that an adequate control of the quality, quantity and cost of health care is effected. Any legislation that can permit multiple PSRO contracts within an area (state) must be considered very carefully. Multiple organizations dealing directly with the Secretary of HEW might well destroy unanimity and uniformity which could lead to an ineffective program in a designated area.

Area (state) wide experimental professional standard review organizations have been established in New Mexico, Colorado, Georgia, and possibly Illinois. Such action would indicate the merits of dealing within the established and familiar patterns of medical organizations. Responsible, far-sighted medical societies recognize the need and challenge of effective, successful professional review. Those that are willing to accept such responsibility should be given the opportunity. H.R. 7182 provides the opportunity for an area (state) medical society to perform PSRO functions. Then, if medicine cannot or does not perform satisfactorily, perhaps it will deserve whatever its fate may be.

This Committee has considered and enacted many historic pieces of legislation. H.R. 7182 is another historic step whereby the medical profession is enabled to establish with the Federal government a new and professional partnership unequalled in the nation's history. And the beneficiaries are the citizens you serve.

Thank you.



## EXHIBIT NO. 1

Hospital	Cases	Pharm.	Rad.	Lab.	Ph. Th.	EKG	EEG	Cov. chg.	Ave. stay
1	90	31	4	17		4		491	10
2	9	28	5	52				496	10
3	77	32	14	45				378	5
4									
5									
6	268	18		23	1	6		459	7
7	29	50	14	48	2	8		504	8
8	12	25	1	18		3		368	7
9	2	17	48	44		26		448	8
10	179	29	5	22		8		563	8
11	100	31	3	18		3		415	9
12	3	36	10	42		26		529	8
13									
14									
15	30	72	23	31	1			514	8
16	55	49	9	21		11		515	7
17	1	6	45	17		15		249	5
18	19	47	6	25		4		392	8
19	203	48	6	19		5		494	5
20									
21									
22									
23									
24	1	297	45	132		463		1,957	30
25	2	36	10	23				504	11
26									
27	69	92	24	106		17		822	12
28									
29	109	11	10	12				446	5
30									
31	2	77		27				375	6
32	3	34		12				314	8
33									
34									
35	97	58	2	16	1	1		383	8
36									
37	17	80	10	24		19		500	10
38									
39	1	3		78				195	3
40	20	10		21				279	5
41	80	37	86	29		6		462	9

## EXHIBIT NO. 2

Hospital	Cases	Pharm.	Rad.	Lab.	Ph. Th.	EKG	EEG	Cov. chg.	Ave. stay
1	86	50	42	80	4	28	12	742	13
2	37	63	20	84		2		483	11
3	47	54	50	89	7	4		800	16
4	1	42	181	170		15		735	10
5	31	56	38	50		22		598	11
6	68	48		119	4	23	8	765	14
7	11	29	63	94	3	8	3	486	8
8	21	67	18	90	7	13		723	16
9	19	86	47	94		19	6	854	15
10	49	49	59	147	4	24		848	11
11	69	50	29	48	7	28		600	14
12	20	33	56	88		22	2	446	7
13	10	46	19	39		14		464	13
14	27	65	29	63		6	1	448	10
15	58	68	40	73	3	1		619	12
16	52	106	48	133	9	17	3	976	16
17	32	36	22	30	7	14		496	11
18	28	81	15	100		10	2	642	13
19	60	180	76	232	11	30		1,244	13
20	12	98	13	118	25	65		891	16
21	25	59	23	125	6	24		611	11
22	19	96	33	118		14		934	19
23	11	103	13	57		54		561	11
24	35	77	20	126		25		622	15
25	21	81	59	160	39	36	6	934	15
26	23	33	17	75	7	10		422	8
27	48	105	145	190		24		1,020	13
28	16	51	47	130		20		624	15
29	50	70	35	79	3	4	1	621	11
30	11	37	25	86		2		419	9
31	10	38	31	46		9		443	10
32	30	76	28	68		12	2	523	12
33	35	125	22	99		1		626	14
34	11	39	69	72		29	6	603	12
35	84	80	25	51	7	16		566	13
36	17	51	52	81		10		554	12
37	15	41	10	70	1	5		326	2
38	8	256	29	100		19		1,233	31
39	36	192	33	132	14	5		926	17
40	24	48	20	67	3	12		507	10
41	59	42	45	76	10	18	4	628	12

EXHIBIT 3

Overall Average Length of Stay in Extended Care Facilities through 1970,  
based on 1,975 live discharges:

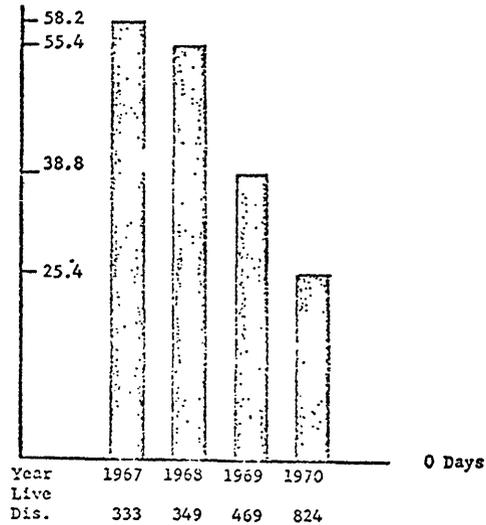


EXHIBIT 4

Average Length of Stay for Neoplasms, based on 168 live discharges:

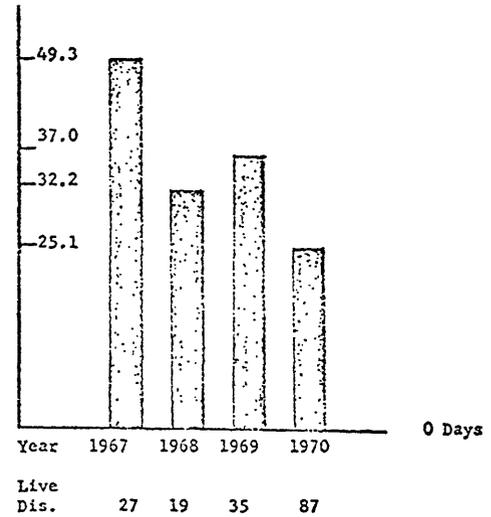


EXHIBIT 5

Average Length of Stay for Diseases of the Circulatory System, based on 943 live discharges:

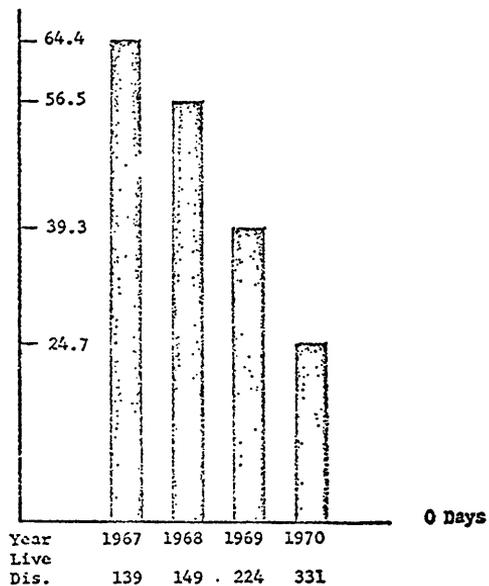


EXHIBIT 6

Average Length of Stay for Diseases of the Respiratory System, based on 56 live discharges:

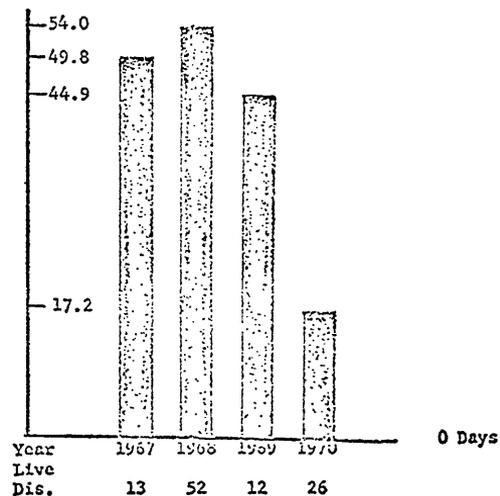


EXHIBIT 7

Average Length of Stay for Diseases of the Digestive System, bases on 93 live discharges:

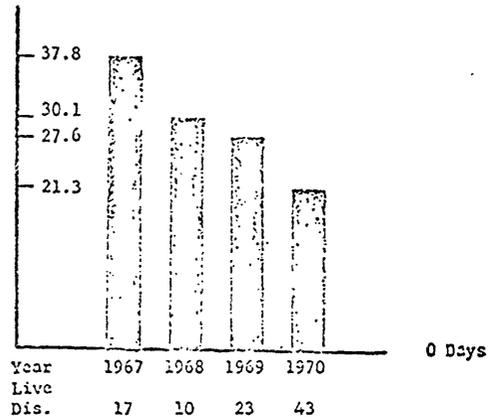


EXHIBIT 8

Average Length of Stay for Diseases of the Genitourinary System, based on 64 live discharges:

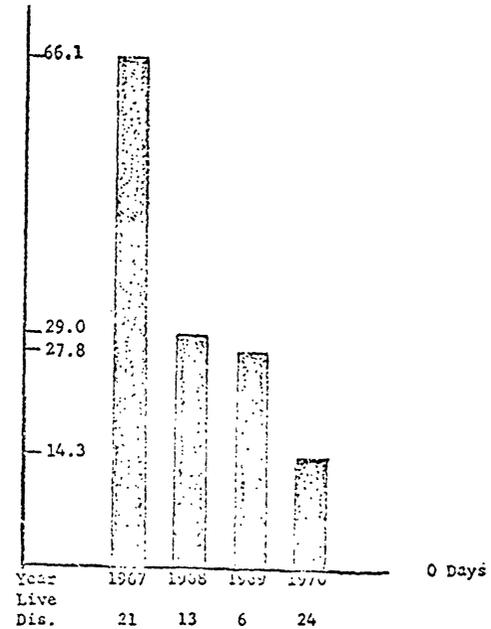


EXHIBIT 9

Average Length of Stay for Diseases of the Musculoskeletal System, based on 91 live discharges:

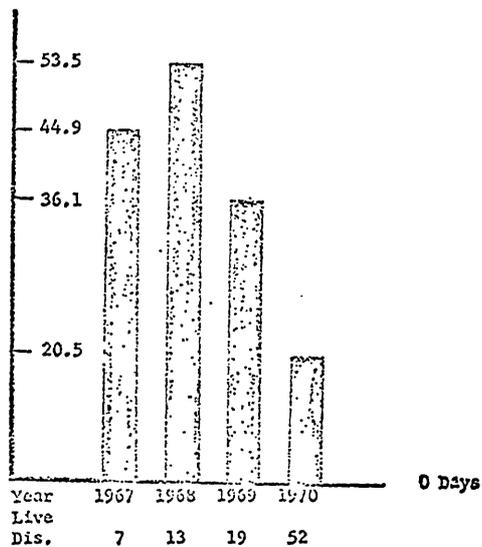


EXHIBIT 10

Average Length of Stay for Injuries and Adverse Effects of Chemical and Other External Causes, based on 415 live discharges:

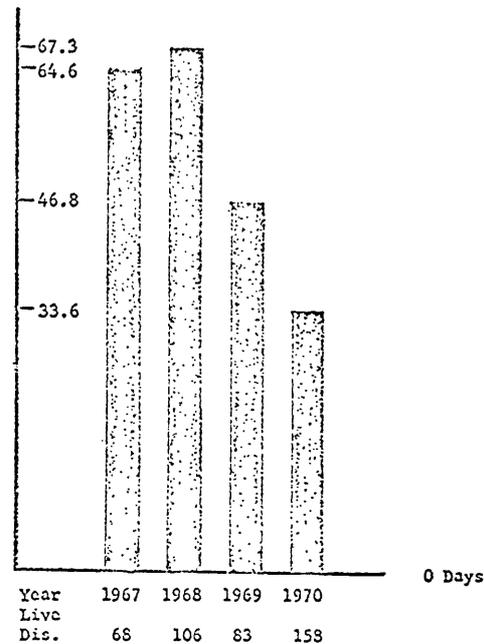


EXHIBIT 11

Average Length of Stay for Fracture of Femur other than Neck, based on 209 live discharges:

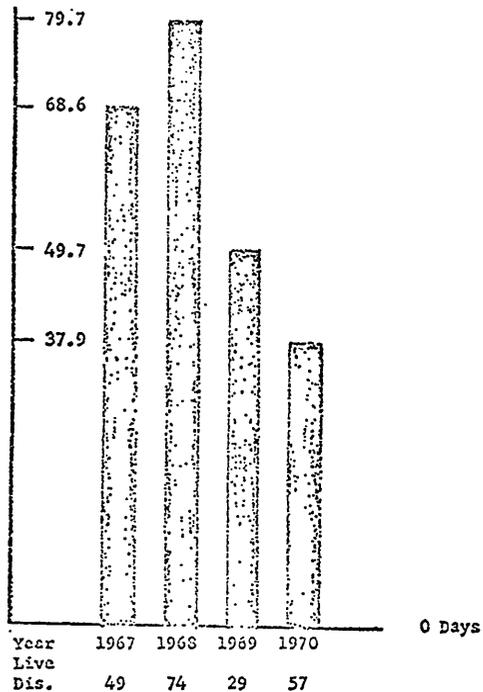


EXHIBIT 12

Average Length of Stay for Fracture of Neck of Femur (Hip Fracture), based on 87 live discharges:

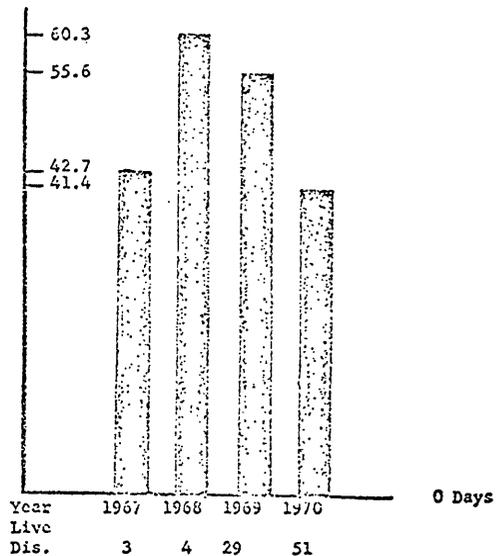


EXHIBIT 13

Average Length of Stay for Generalized Arterio Sclerosis, based on 115 live discharges:

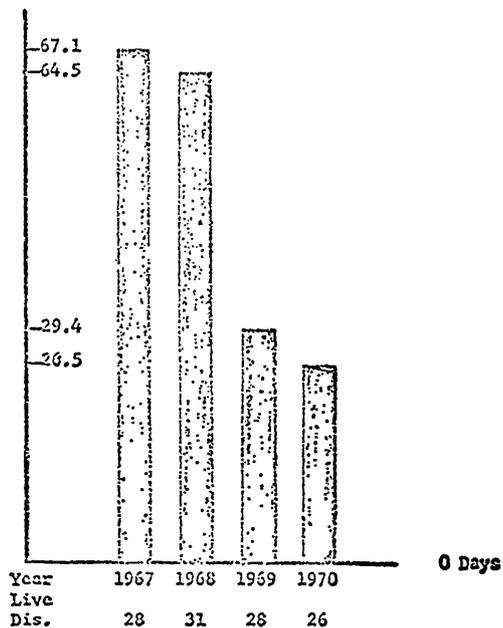


EXHIBIT 14

Average Length of Stay for Cerebrovascular Disease, based on 356 live discharges:

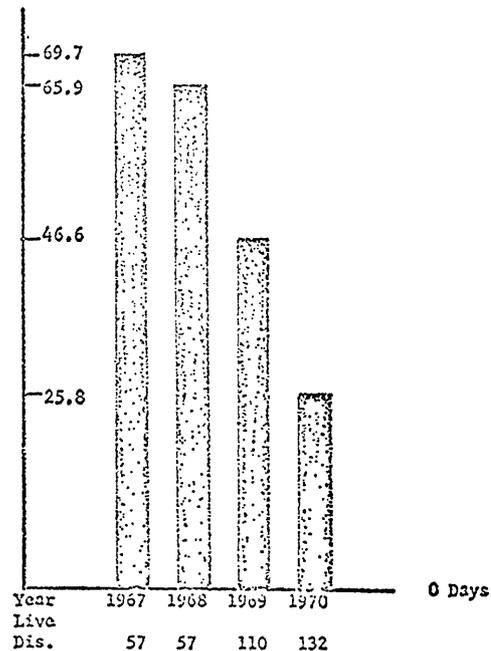


EXHIBIT 15

Average Length of Stay for Arteriosclerotic Heart Diseases, based on 158 live discharges:

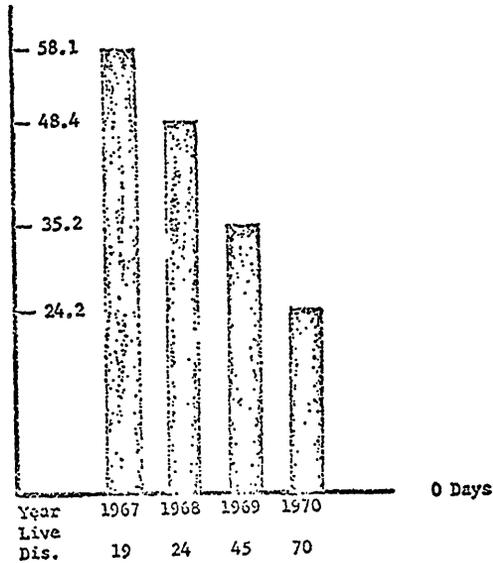
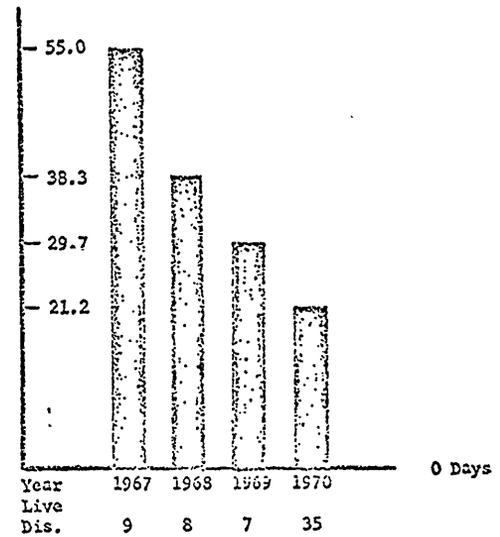


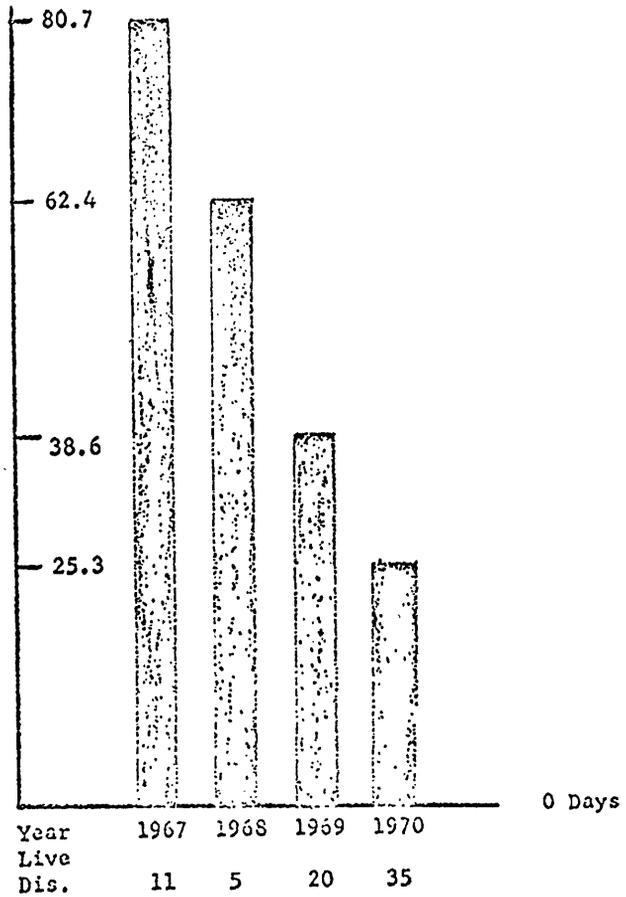
EXHIBIT 16.

Average Length of Stay for Acute Coronary Occlusion, based on 59 live discharges:



## EXHIBIT 17

Average Length of Stay for Diabetes Mellitus, based on 71 live discharges:



Mr. ULLMAN. We thank you. We understand our colleague from Ohio would like to make a statement at this point. We appreciate having you with us. The Honorable Samuel Devine.

**STATEMENT OF HON. SAMUEL DEVINE, A REPRESENTATIVE IN  
CONGRESS FROM THE STATE OF OHIO**

Mr. DEVINE. Mr. Chairman, when this committee indicated it would consider the various proposals on health care sometime ago, I began to review the bills then pending in Congress to see if I could arrive at a reasoned decision as far as an overall program was concerned. During this preliminary phase, I began to get suspicious of the statistics being used, the terms bandied about and the general impression that we had a "cottage-type industry" in operation. I also began asking the same questions many of you are asking about the quality, quantity, and cost of existing Federal programs, mainly, medicare and medicaid. The answers were somewhat vague.

My study convinced me that all the rhetoric and catchy phrases were not exactly accurate: we do not have a "second-rate system"; "cottage-type industry" is not an accurate nor fair description; and what we need most of all are facts. Specifically, what are we getting in the way of health care for the Federal expenditures?

Since the medical profession is providing a great majority of the health care in this country, I asked some doctors for their opinions on several of the pending proposals. I received a number of varied opinions, and concluded the first thing for me to do was to try to establish a basis for determining the quality, quantity, and cost of medical care under the existing system.

Among the various proposals studied was Senator Wallace Bennett's amendment to the social security bill of last year. This amendment created a program of professional standard review organization and proposed a cooperative effort between the medical profession and the Federal Government and State government. Using this amendment as a basis, we drafted H.R. 7182. To prove out the effectiveness of our concept, we decided to accumulate meaningful data for medical review using a PSRO structure.

Accordingly, a test-type computer program was developed by the local service agent for medicare and after some extensive correspondence with the Department of Health, Education, and Welfare, a modest funding grant (\$20 million) was provided. This will give us a 2-year experience for 21 disease entities covering 42 hospitals in the central Ohio area. This program was developed through efforts of Dr. James L. Henry, who is with me today. The program created a means of evaluating medical care through dollar costs per disease entity for seven major subgroups. I will let Dr. Henry describe the manner in which this data can be interpreted.

After the introduction of H.R. 7182, the changes from the Bennett amendment became the subject of constructive discussion. These differences were analyzed and discussed between staff members, and through correspondence with Senator Bennett. Briefly, they now consist of the structure of the organization and the use of statewide groups as opposed to area groups designated by the Federal Government through the Secretary of HEW.

In H.R. 7182, we contemplate using the existing structures of the medical profession as a guide and rely on statewide PSRO's as the first and preferred structure. This concept has been used in several test programs now in being—New Mexico, Colorado, Georgia, and recently Illinois—and appears to be working very well. However, our bill does create an effective program of professional standards review organizations flexible enough to accommodate the needs of specific areas. It uses the medical profession and the practicing physicians to the maximum degree. It also places the responsibility on the medical profession and organized medicine to cooperate with the Federal authorities, or in the alternative, to be subject to standards review by other agencies. Obviously, it is the responsibility of the medical profession to meet this challenge.

It is obvious to me that medical data has to be interpreted by medical personnel, and if the Government is going to get meaningful information from the computer read-out, it has to be professionally "read." A professional standards review organization composed of practicing physicians is the most practical method of accomplishing this purpose.

H.R. 7182, would provided a program whereby the Federal Government would get the best advice possible about the programs it finances; the bill would enable savings to be made in excess care cases, improvements to be made in inferior care cases, and reasoned medical judgment applied in all cases.

It will create a basis for sound judgment by Congress in considering any overall health program, by giving a comprehensive picture of the existing Federal programs and how they are working. It can be used as a basis for professional review of any newly enacted Federal health programs and provide a valid statistical base for projecting program costs. It will create a program of cooperation between the medical profession and the Federal Government.

If I can conclude and risk in oversimplifying, if we are going to have a review of the overall program, it seems to me physicians are the most logical persons to do it because they are best qualified and in a better position to give a review than a bunch of bureaucrats down in a department of the Government.

Thank you very much, gentlemen, for permitting us to testify.

Mr. ULLMAN. Thank you very much, Mr. Devine. This has been very challenging testimony. May I ask a question or two?

First, this special study was limited to medicare patients; is that right?

Dr. HENRY. Yes, sir.

Mr. ULLMAN. Under the management of whom?

Dr. HENRY. Blue Cross of central Ohio had the computer and the medical profession put in the guidelines and they broke out the medicare billing costs the way we asked them to do it.

Mr. ULLMAN. It involved computerization of all of the service and cost elements?

Dr. HENRY. We use the term doctor-generated charges, X-ray, laboratory, pharmacy, all of the things that a doctor in fact causes to be a charge factor at the billing period. We did not use per diem costs, et cetera.

Mr. ULLMAN. Did it go primarily to the length of stay in hospitals? Was this the primary point of the study?

Dr. HENRY. In the beginning we involved ourselves in length of stay with disease entity, but we found this was not a fair factor in evaluating quality and quantity. I think you have to get the breakdown as to how much pharmacy was used, how much laboratory, how much X-ray.

In the beginning, we had studies by lengths of disease entity and we refined it. Thanks to the grant, we were able to break out the various charges and we believe that is a more valuable tool.

Mr. ULLMAN. Your charts are very interesting. They present quite a challenge.

What would be your answer then to the problem?

Dr. HENRY. How, for instance, do you think we would handle the hospital with a 12-day stay charges against other hospitals that had an 8-day stay?

Mr. ULLMAN. That, of course, is the \$64 question, and you did not quite hit it head on in your testimony. You referred to it.

Dr. HENRY. I think the way you hit it head on is through a PSRO council of physicians. You get to the members of the staff of this hospital and you show them directly the computer run and you ask them two questions: Why? And do you have something nobody else has and are your results better than anybody?

Otherwise, don't you think you should conform to the standards of medical care that proved to be adequate in 11 out of the other 12 hospitals? I think there are lots of things you can say probably "in cathedral."

Mr. ULLMAN. Did you find difference in management efficiency was one of the basic differentials?

Dr. HENRY. I am sure I will probably get clobbered from behind here, but I think one of the things is you do note is that there are different techniques in administering different hospitals. Is that a very diplomatic way of saying it?

Mr. ULLMAN. I think you are being overdipomatic.

Are there further questions?

Mr. Vanik?

Mr. VANIK. I would like to ask whether or not the Ohio Medical Association supports the inclusion of psychiatric services in its proposals for a national health plan or in the medicredit plan?

Dr. HENRY. I can't speak to the medicredit plan.

Mr. VANIK. Do you advocate the inclusion of psychiatric services?

Dr. HENRY. I think, in the programs, we are attempting to devise broad guidelines for evaluating psychiatric care.

Mr. VANIK. I understand what you have done in your plan and in your proposal which has a lot of merit and which certainly should be carefully considered by this committee as a cost control device and better utilization. I want now to ask you in your capacity as a representative of the Ohio State Medical Association whether you advocate a plan of coverage which will include in a health insurance program psychiatric services?

Dr. HENRY. I think I can answer yes to that, sir.

Mr. VANIK. And nursing home care?

Dr. HENRY. Yes.

Mr. BYRNES. Would the gentleman yield?

Mr. VANIK. I yield.

Mr. BYRNES. I think we should make clear whether the doctor is representing the Ohio Medical Association or representing himself in conjunction with this particular study.

Mr. VANIK. You are a treasurer of the medical association; are you not?

Dr. HENRY. I am treasurer of the medical association.

Mr. BYRNES. Could I find out just for my own information the capacity in which the doctor appears?

Dr. HENRY. I am really appearing here because I have been involved in creating this type of a review. I am not here as treasurer of the Ohio State Medical Association. That just happens to be one of my titles but I am trying to address myself to Mr. Vanik.

Yes, we are concerned, and yes, knowing from my position of having heard the council's deliberations, yes, we are trying to involve ourselves and it involves some very eminent psychiatrists in the State of Ohio to the problem I think he is asking about.

Mr. VANIK. Now I would like to ask you under the action taken by the Ohio State Medical Association whether the association has advocated a coinsurance feature? Can you tell me that?

Dr. HENRY. We have not at this time. We have not gotten into any of this. We are trying to form an organization for the review of medical care at which time then we can be in a position to make advice available to Government and people like that.

Mr. VANIK. I am here as an Ohio representative on this committee and I would like to be guided by what the Ohio Medical Association is recommending. I have the recommendation of the AMA. I would like to know now what kind of proposal you are suggesting to the Congress in our deliberations on the great problem of a national health program.

I appreciate your suggestion as to an approach to the better utilization of hospitals. But I would like to ask you just what are you proposing with respect to a health plan for America?

Are you proposing catastrophic coverage? Do you propose outpatient care?

Mr. DEVINE. The gentleman is directing his remarks to anyone out here. He is appearing as Dr. Henry and not for or on behalf of the Ohio Medical Association nor do I feel he can state a position for them. I don't think they have taken an official position.

Mr. VANIK. I am trying to find out what my medical association is recommending on this awesome problem we have before us on the establishment of a medical program for America. I thought the treasurer of the association might have some recommendation to make or tell me on what the Ohio association is supporting, so that we can be guided in our deliberations.

Dr. HENRY. I am certainly not trying to be evasive, sir, but I can't speak to the point. I am sorry.

Mr. VANIK. You have recommended a plan for the proper utilization and peer review of hospital services.

Dr. HENRY. And ECS and a logical extension goes on into the physicians offices and outpatient services but, sir, the only data base you have that can be developed at the present time that is meaningful is the inpatient care of patients.

Mr. VANIK. Do you recommend that this be extended into a peer review of all doctors charges?

Dr. HENRY. I think this would be a logical conclusion at some time.

Mr. VANIK. Your present study only goes to hospital utilization.

Dr. HENRY. Hospital and ECS.

Mr. VANIK. That would be under part B and it would apply only to the medicare cases rather than to other insurance covered cases.

Dr. HENRY. Once you develop this, starting with the medicare data, you can go to an all-patient review. Many of the hospitals in central Ohio have a review now that extends to all patients regardless of their financial coverage in the hospital.

In other words, we have about 15 hospitals that use all patients, and even newborns are evaluated as to how much they stay and why they are overstaying.

Mr. VANIK. In Ohio, and under the canons of ethics of the medical associations, is the doctor ethically permitted to include in his bill the cost of services rendered by others, such as laboratory services, X-ray, or the consulting phase of other doctors?

Dr. HENRY. Sir, I don't think this is the normal practice. I think doctors bill for their own services and do not bill for the ancillary services.

Mr. VANIK. Is there any rule or restriction that you know of in the association which would preclude a doctor from retailing out the services rendered by a laboratory or by X-ray technicians or by any other health aid organization?

Dr. HENRY. I know in Ohio a doctor is considered highly unethical if he is involved with a pharmacy and it is frowned upon and he is slapped on the wrist. I think in laboratories they like to have the pathologist running the laboratory, to bill independently and to so recommend this as the accepted procedure.

Mr. VANIK. Is that the directive of the organization?

Dr. HENRY. It is certainly a recommendation of the organization; yes.

Mr. VANIK. Can you give me any examples of any peer review of medical fees in which any action was taken by the Ohio association?

Dr. HENRY. There is a very specific technique for reviewing fees. It is done through the local medical societies. It is done then through the State medical association in areas in which some doctors, some organizations will not review fees.

Yes, having sat on the council and having listened to the deliberations, I can tell you there are many instances in which the fee is reduced by recommendation of the Council of the Ohio State Medical Association.

The local medical societies will cause a doctor's fee to be reduced because, in their words, it is unethical to charge a fee of that proportion.

Mr. VANIK. Are there any specific examples or cases that you can refer to in which action has been taken by a State or local association?

Dr. HENRY. I could provide that for you.

Mr. VANIK. I do not need the name or specific detail, but are these proceedings public or private? Does anyone have access to such proceedings or know that they are going on?

Dr. HENRY. Yes. We have a relationship in Ohio, for instance, with the industrial commission and for many years now have been adjudicating the fees, have been considering cases in which the industrial commission considers it to be an overcharge or wants an explanation of why the fee was a given amount.

Mr. VANIK. Do you know of any single case in which a doctor in Ohio has testified in open court against another doctor on that fee issue?

Dr. HENRY. To my own knowledge, yes.

Mr. VANIK. Could you provide that for the record? That would be a public record, I presume. I have been searching and I have not been able to find a single situation in which a doctor as a professional has taken the stand to make a professional statement or give an opinion about the fee that was charged by another doctor.

(The court cases referred to follow :)

WRIGHT, HARLOR, MORRIS & ARNOLD,  
ATTORNEYS AT LAW,  
Columbus, Ohio, January 17, 1972.

Mr. HERBERT GILLEN,  
*Assistant Director of Public Relations,*  
*Ohio State Medical Association, Columbus, Ohio.*

DEAR HERB: Chuck Edgar and you have asked me to submit to you a list of cases of which I had knowledge wherein there was testimony by physicians on behalf of plaintiffs in malpractice actions against other physicians and/or hospitals.

Listed below are eight such cases in which I have, as counsel for one or more of the defendants, participated. All were tried in Franklin County Common Pleas Court and the number shown in connection with each case is the file number of the case. The cases are as follows:

- (1) Piccione v. Smith, No. 224,873.
- (2) Hays v. Slager, No. 226,530.
- (3) Soller v. St. Anthony, No. 203,071.
- (4) Klema v. St. Anthony, No. 216,161.
- (5) Calloway v. St. Anthony, No. 228,593.
- (6) Gibbs v. Sanor, No. 210,861.
- (7) Callahan v. Sanor, No. 208,631.
- (8) Jackson v. St. Anthony, No. 216,725.

In my personal experience there have, of course, been many other cases in which there was testimony by physicians in similar malpractice cases given by way of deposition before trial, but I have not included them. Also, I have limited the list above to those cases in which I was personally involved in recent years and have made no effort to list similar cases which have been handled by other defense lawyers in town handling the defense of malpractice cases on behalf of their clients.

If you desire additional information, please do not hesitate to contact me.

Sincerely yours,

JAMES E. POHLMAN.

Enclosures.

[From the Plain Dealer (Cleveland, Ohio) Nov. 7, 1963]

EYE SURGEON SUES 30 ACADEMY DOCTORS HERE

A dispute between a Shaker Heights eye surgeon and the Cleveland Academy of Medicine has landed in Common Pleas Court.

Dr. Samuel M. Kamellin, 19201 Van Aken Boulevard, with offices in the Osborn Building, 1021 Prospect Avenue S. E., is asking \$1.1 million from 30 doctors, all former officers of the academy, for alleged damages to his reputation and income.

The dispute arose in 1961, the lawsuit said, when Dr. Kamellin sued a patient for payment of a bill. The academy's mediation committee ruled that Dr.

Kamellin's charges for the patient's operation had been excessive, the latest lawsuit asserted.

The committee and Dr. John D. Osmond, Jr., then president of the academy, asked Dr. Kamellin to drop the action. He refused.

The mediation committee then referred the compliant to the academy's committee on ethics, according to the \$1.1-million lawsuit.

Dr. Kamellin contends the proceedings, which stretched from January 1961, to March, 1962, hurt his professional standing. As a result, he contends, he lost potential patients that would have been referred to him by general practitioners.

The academy released a statement yesterday saying it regretted that the lawsuit resulted from its "attempts to maintain high ethical standards for the medical profession and to arbitrate complaints of excessive fees for medical service."

The statement also said :

"In this case the medication committee of the Academy of Medicine received a complaint which it subsequently decided was justified. In the best interest of the patient, the medical profession, and the community, the committee, with the knowledge and approval of the board of directors of the academy, felt it had a duty to make its decision known to both physician and patient.

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[From the Columbus (Ohio) Citizen-Journal, Nov. 6, 1963]

#### DOCTOR SUES ACADEMY FOR \$1.1 MILLION

CLEVELAND—An eye doctor Tuesday sued 30 former officers of the Cleveland Academy of Medicine for \$1.1 million in damages as the outgrowth of a dispute over a surgery fee.

Dr. Samuel M. Kamellin charged the Academy officers had damaged his reputation, standing in the community and power to earn by their actions in connection with the fee.

The suit, filed in Common Pleas Court by Dr. Kamellin's attorney, Maurice M. Waltman, named Dr. John D. Osmond, who was president of the Academy when the dispute arose in 1961, and all others who held office at the time.

The fee was one Dr. Kamellin charged for an operation on Kenneth Cottrell, minor son of Charles Cottrell Jr. The father challenged the amount of the fee and Dr. Kamellin went to court to collect.

The suit accused Dr. Osmond of threatening retaliation by the Academy if Dr. Kamellin continued to press his claim. The suit also disputed the right of the Academy's mediation committee to intervene.

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[From the Youngstown (Ohio) Vindicator, Nov. 6, 1963]

#### DOCTORS ARE SUED IN FIGHT OVER FEE

CLEVELAND, Nov. 6—An eye doctor Tuesday sued 30 former officers of the Cleveland Academy of Medicine for \$1,100,000 in damages as the outgrowth of a dispute over a surgery fee.

Dr. Samuel M. Kamellin charged the academy officers had damaged his reputation, standing in the community and power to earn by their actions in connection with the fee.

The suit, filed in Common Pleas Court by Dr. Kamellin's attorney, Maurice M. Waltman, named Dr. John D. Osmond, who was president of the academy when the dispute arose in 1961 and all others who held office at the time.

The fee was one Dr. Kamellin charged for an operation on Kenneth Cottrell, minor son of Charles Cottrell Jr. The father challenged the amount and Dr. Kamellin went to court to collect.

The suit accused Dr. Osmond of threatening retaliation by the academy if Dr. Kamellin continued to press his claim. The suit also disputed the right of the academy's mediation committee to intervene.

## MEMORANDUM OF REVIEW OF DR. S. M. KAMELLIN CASE—MARCH 10, 1963

## NATURE AND HISTORY OF CASE

1. Under date of May 7, 1962 Dr. S. M. Kamellin, an ophthalmologist, with offices at 206 Osborn Building, Cleveland, Ohio, wrote a letter to OSMA claiming that the Chairman of the Ethics Committee of the Academy of Medicine had been guilty of an act of discourtesy in failing to answer Dr. Kamellin's letter of April 23, 1962 addressed to Dr. Middleton M. Lambright, Chairman of the Ethics Committee. Dr. Kamellin also alleged in this letter of May 7 that certain members of the Board of Directors of the Academy of Medicine of Cleveland had been guilty of certain unethical acts, to-wit: (1) The Board of Directors "with apparent malicious intent" sent a representative on November 27, 1961 to the Garfield Heights, Ohio Municipal Court to testify in a certain lawsuit brought by Dr. Kamellin to collect a fee from a Mr. Cottrell for professional services rendered by Dr. Kamellin to Mr. Cottrell's son in December, 1960; (2) Such Board of Directors "did fabricate a charge to force me to appear before the Ethics Committee for questioning about: (a) matters which had no basis in fact or evidence, but were based upon assumption only, and, (b) matters which were of no proper concern to them but were of a private nature between my patient and me". Dr. Kamellin's letter requests an investigation, "in accordance with paragraph 5, Section 4, Chapter 8 of the Constitution" of OSMA, "in order to determine which physician or physicians are guilty of the conduct" described by Dr. Kamellin. (No reference was made by Dr. Kamellin with respect to disciplinary action pursuant to Section 6 of Chapter 11 of the OSMA Bylaws; Section 6 provides for the filing and hearing by the Council of OSMA of original charges against a member of a component society in the same manner as provided in Section 4 of Chapter 11 for disciplinary procedure by a component society). This letter of May 7 is attached.

2. Enclosed with Dr. Kamellin's letter of May 7 was a copy of his letter to the Chairman of the Ethics Committee of the Academy of Medicine, dated April 23, 1962. After setting forth his answers or contentions to certain charges allegedly made by the Board of Directors against Dr. Kamellin, and which were allegedly discussed at a meeting of the Ethics Committee held on March 7, 1962, at which Dr. Kamellin and his attorney, Mr. Maurice Weltman, were present, Dr. Kamellin requested that Dr. Lambright advise him as to "the conclusions of the Committee regarding the charges of the Board of Directors, namely if I did, or did not in any way commit an unethical act as laid down by the Constitution of the Academy of Medicine of Cleveland or of any of the Principles of Medical Ethics of the American Medical Association, in the case under discussion, namely the Cottrell case." (See last paragraph on page 3 of April 23 letter, a copy of which is attached.)

3. The Council referred Dr. Kamellin's complaint to the J & P R Committee for investigation, consideration and report. Under date of August 1, 1962 Dr. Kamellin wrote to the J & P R Committee and requested an investigation of certain other allegedly unethical acts which Dr. Kamellin claims were committed by certain members of the Cleveland Academy of Medicine, as follows:

(1) Certain physicians who are members of the Ethics Committee of the Academy of Medicine of Cleveland did repeatedly fail to answer certain questions repeatedly addressed to them by me.

(2) Certain officers of the Academy of Medicine of Cleveland, acting for the Board of Directors failed to answer certain pertinent and proper questions addressed to them by me.

(3) Certain physicians, who are members of the governing body or of the committees of the Academy of Medicine of Cleveland, did in a surreptitious manner, without my knowledge and consent, and with what appears to be an attempt to delude, obtain certain private medical information in the Cottrell case.

Dr. Kamellin also requested in this letter that there be included in this supplemental investigation requested by him the act of Dr. Henry Crawford, President of the Academy of Medicine, in stating (in Dr. Crawford's letter of July 25, 1962 in reply to Dr. Kamellin's letter to Dr. Crawford of July 23, 1962) that he, Dr. Crawford, does not feel authorized to respond until the matter already before the State Association is resolved. Dr. Kamellin enclosed with his letter of August 1, 1962 copies of the following letters:

Dr. Kamellin to Dr. Lambright, June 27, 1962.

Dr. Kamellin to Board of Directors, July 11, 1962.

Dr. Kamellin to Dr. Crawford, July 23, 1962.

Dr. Crawford to Dr. Kamellin, July 25, 1962.

Dr. Kamellin to Dr. Crawford, August 1, 1962.

This supplemental complaint letter of Dr. Kamellin to the J & P R Committee, dated August 1, 1962, is attached.

4. The J & P R Committee scheduled its first hearing on this matter for October 7 but the matter was postponed by reason of the inability of Dr. Kamellin to be in attendance on that date (see Dr. Kamellin's letter to Dr. Rawling of September 21 1962). The matter was then reassigned for Sunday, January 13, 1963. On the morning of January 13 the J & P R Committee met with Dr. Kamellin, Mrs. Kamellin and Mr. Maurice Weltman, attorney for Dr. Kamellin; no representatives of the Cleveland Academy were in attendance; the Chairman permitted Dr. Kamellin to make a full statement of his complaint, which Dr. Kamellin did, consuming about two hours in the process; in the course of his presentation he read from a number of letters and documents and promised to furnish the J & P R Committee copies of all letters in his possession relating to this matter, excepting such as had already been furnished to the Committee by Dr. Kamellin or by the Academy. On Sunday afternoon, January 13, 1963, the J & P R Committee met with representatives of the Cleveland Academy; neither Dr. Kamellin nor any of his advisers or representatives were in attendance; the Academy representatives were permitted to make full presentation of their case, in the course of which they made reference to certain documents, most of which had already been furnished to the J & P R Committee months before, and a few of which they promised to furnish to the Committee.

5. Subsequently, the Committee received from Dr. Kamellin and the Cleveland Academy some additional documents referred to at the Sunday, January 13, hearings. The Committee feels that it has now received the originals or copies of all, or nearly all, the documents bearing upon the matter in dispute and copies of all these documents have been furnished to each member of the J & P R Committee.

#### STATEMENT OF FACTS

6. Inasmuch as the complaint filed with the Ohio State Medical Association on May 7, 1962, as supplemented by Dr. Kamellin's complaint filed with the J & P R Committee, dated August 1, 1962, attacks the conduct of certain members of the Cleveland Academy of Medicine in connection with certain proceedings of the Academy involving certain complaints against Dr. Kamellin growing out of his professional treatment of Kenneth Cottrell, son of Charles R. Cottrell, it becomes necessary and advisable to examine and summarize the evidence relating to the dispute between Dr. Kamellin and Charles Cottrell and that relating to the proceedings of the Academy in connection with its handling of the complaint against Dr. Kamellin lodged with it by Mr. Cottrell.

7. Under date of April 6, 1961 Charles R. Cottrell, of 11406 McCracken, Garfield Heights, Ohio, wrote a letter to the Mediation Committee of the Cleveland Academy, stating that he thought that he had been presented with an unjust medical fee and had been treated in an unprofessional manner by Dr. Kamellin in connection with Dr. Kamellin's professional services rendered to Mr. Cottrell's fourteen month old son on December 3, 1960. Mr. Cottrell states in this letter that the amount of the fee to be charged by Dr. Kamellin was not discussed at the time of the operation nor at the time of Kenneth Cottrell's discharge from the Marymount Hospital on December 15, 1960, nor at any time until Mrs. Cottrell visited Dr. Kamellin at his office on January 10; that Dr. Kamellin informed Mrs. Cottrell at that time that he would not set a definite fee until Dr. Kamellin had received payment from the hospitalization insurance that Mr. Cottrell carried; that Mrs. Cottrell then informed Dr. Kamellin that the Cottrells needed a bill to submit to Connecticut General with their notice of claim but Dr. Kamellin stated he could not give her such a bill without studying the records further and would mail a bill to the Cottrells; that the Blue Cross subsequently sent a check directly to Dr. Kamellin for the amount of \$225.00; that the last week in February Dr. Kamellin inquired of Mrs. Cottrell if the Cottrells had received payment from Connecticut General and, when informed that Connecticut General had made no payment as yet, he stated that he would perhaps temper his bill when the Cottrells brought the Connecticut General check in to his office; that Connecticut General paid Mr. Cottrell \$150.00 on March 3 in satisfaction of the claim, which sum Mr. Cottrell retained and still retained at the time of the

April 6, 1961 letter; that the Cottrells feel that Dr. Kamellin's bill of \$500.00, sent by Dr. Kamellin by registered mail on March 29, 1961, is excessive and that Dr. Kamellin is guilty of unprofessional conduct because of "his tactics in maneuvering for double insurance payment".

8. Enclosed with Mr. Cottrell's letter of April 6, 1961 were purported type-written copies of three letters, as follows:

Dr. Kamellin to Mr. Cottrell, dated March 24, 1961, stating that he was reliably informed that Mr. Cottrell had received a check from Connecticut General for the services rendered by Dr. Kamellin; that, according to his agreement with Mr. Cottrell, this check should have been forwarded to Dr. Kamellin and that he, Dr. Kamellin, expects such check, or Mr. Cottrell's personal check for an equivalent amount, to be in his office no later than Tuesday, March 28; that if he should not hear from Mr. Cottrell by that time "I will proceed to bill you for the services which I rendered to you, in an amount which I will then consider to be due me".

Dr. Kamellin to Mr. Cottrell, dated March 28, 1961, enclosing statement for services in the amount of \$500.00, less a credit of \$225.00, representing the payment by Medical Mutual, together with a cognovit note, and advising that either a check in the amount of \$275.00 "or the signed note must be in my office no later than 24 hours after you receive this letter. If not received by that time, I shall turn the matter over to my attorney for collection."

Attorney Weltman to Mr. Cottrell, dated April 5, 1961, advising that unless payment in the amount of \$275.00, or arrangement for such payment, is made within five days, legal action will be instituted by Dr. Kamellin against Mr. Cottrell for collection.

9. (At the hearing on January 13, 1963 Dr. Kamellin was requested to furnish to the Committee copies of all correspondence passing between him and Mr. and Mrs. Cottrell, and at that time he made reference to correspondence passing between him and the Cottrells bearing dates of December 18, 1960, March 24, 1961 and March 27, 1961; however, Dr. Kamellin has not furnished the December, 1960 and March, 1961 correspondence, notwithstanding that a written request for the same was made by Mr. Stichter to Attorney Weltman under date of January 18, 1963. However, in Dr. Kamellin's letter to Dr. Myron Pardee, dated April 12, 1961, Dr. Kamellin states that he wrote Mr. Cottrell insisting that he send Dr. Kamellin a check from the insurance company or his personal check and gave Mr. Cottrell several days to respond and, having received no response from Mr. Cottrell, Dr. Kamellin then billed him for his services and gave Mr. Cottrell a definite date within which to respond; Dr. Kamellin further stated in this April 12 letter that he had had no response from Mr. Cottrell and so had turned the account over to his attorney for collection. It would thus appear that the purported copies of the correspondence furnished by Mr. Cottrell to the Mediation Committee and enclosed in Mr. Cottrell's letter of April 6, 1961 are true and correct copies.)

10. On April 7, 1961 Dr. Myron L. Pardee, Chairman of the Mediation Committee, wrote to Dr. Kamellin, enclosing a copy of Mr. Cottrell's letter of April 6, and requested Dr. Kamellin to submit a written statement regarding his complaint and regarding all details of the medical care rendered to the patient.

11. On April 12, 1961 Dr. Kamellin replied to Dr. Pardee's letter of April 7; in this letter Dr. Kamellin states that subsequent to the child's discharge from the hospital the Cottrells

"\* \* \* requested a fee before the case was completed and after the second request I quoted the fee to them. They gave me the insurance papers to sign, which I did. The Medical Mutual papers which had an assignment they readily signed, and I received the money from the Medical Mutual at a later date. The other insurance paper had no printed assignment, and I told them that I would not sign the paper unless they agreed that when they received the check that they would turn it directly over to me. This they agreed also to do, without any question."

However, Dr. Kamellin does not fix the date of the "second request" or the date when he quoted the fee to them, nor does he mention the amount of the fee which he allegedly quoted. Dr. Kamellin further stated in this letter that after the lapse of more than a month following the last office visit by the Cottrells he wrote the Connecticut General Life Insurance Company and was advised that it had paid the Cottrell claim a month before, whereupon "I then wrote Mr. Cottrell that I insisted that he send me the check from the insurance company

or his personal check for the equivalent amount and gave him several days to respond. I had no response from him, so I billed him for the services rendered and gave him a definite date within which to respond." (Dr. Kamellin apparently was referring to his letters of March 24 and 28 mentioned above in paragraph 8.) Dr. Kamellin's letter of April 12 contains some description of the injury to Kenneth Cottrell and of the professional services which Dr. Kamellin rendered but contains no comment on Mr. Cottrell's complaint of an excessive fee; nor does Dr. Kamellin make any claim in this letter that the Cottrells were agreeable to paying him any sum in excess of the insurance proceeds to be received from Medical Mutual and Connecticut General.

12. On April 15, 1961 Mr. Cottrell wrote to the Mediation Committee, stating that he was enclosing copies of two other pieces of correspondence relative to the case but we are unable to identify any such correspondence. Mr. Cottrell goes on to say that "In his letter Dr. Kamellin did not acknowledge my letter of March 26"; we are unable to identify either Dr. Kamellin's letter or Mr. Cottrell's letter of March 26. None of the documents submitted to the Committee by the Academy and Dr. Kamellin answer the description given by Mr. Cottrell in his April 15 letter.

13. On May 3, 1961 Mr. Cottrell wrote the Mediation Committee advising that on April 22 he had been served with a petition filed by Dr. Kamellin, asking judgment in the amount of \$275.00.

15. On May 5, 1961 Dr. Pardee wrote to Dr. Kamellin, advising that the Mediation Committee had completed its investigation and that

"The Committee feels that your failure to establish a fee prior to learning the extent of insurance coverage was extremely poor public relations. In view of this, we feel that some revision of your fee is indicated and that you should contact Mr. Cottrell."

On the same day the Assistant Executive Secretary of the Academy wrote Mr. Cottrell, advising that the Mediation Committee had investigated his complaint and suggested that he contact Dr. Kamellin to discuss further the fee question.

15. On May 8, 1961 Dr. Kamellin wrote to Dr. Pardee stating "The fee had been established, the only question was the terms of payment, since the patient had explained to me that there was a possibility of complete insurance coverage. I was willing to wait for complete payment of my fee until after he had received the money from the insurance company. It was only after he had received the money from the company, that I billed him for the balance due me \* \* \*". (See also paragraphs 48 and 49 below with respect to the activities and proceedings of the Mediation Committee.)

16. On May 12, 1961 Mr. Cottrell wrote the Mediation Committee acknowledging receipt of the Mediation Committee's letter to him on May 5 and stating that he, Mr. Cottrell, had called Dr. Kamellin, who refused to discuss the matter with Mr. Cottrell except to inquire as to who advised Mr. Cottrell to write to Marymount Hospital and to tell Mr. Cottrell to discuss the case with Dr. Kamellin's lawyer. Mr. Cottrell also stated in his letter that he felt that "I have been abandoned in the midst of a storm".

17. On May 17, 1961 the Assistant Executive Secretary replied to Mr. Cottrell's letter of May 12, stating that the Committee desired to inform him that "you have not been abandoned by any means" and stating that the next meeting of the Committee would be on June 1, 1961.

18. On May 25, 1961 the Mediation Committee wrote Mr. Cottrell advising that it had completed its investigation of his complaint and that the Committee had suggested to Dr. Kamellin in a letter to him dated May 5 that "some revision of your fee is indicated and that you should contact Mr. Cottrell".

19. In a memorandum from L. Paris to the Mediation Committee dated June 7, 1961 it is recited that Mr. Cottrell's attorney and Dr. Kamellin's attorney are to meet to discuss settlement out of court, after which Mr. Cottrell will notify the Mediation Committee of the outcome.

20. On August 31, 1961 Mr. Cottrell wrote to Mr. Mortimer of the Cleveland Academy, advising that his attorney had filed an answer to Dr. Kamellin's petition and that the trial would probably not come up until October or November.

20(a). There appears in the file submitted by the Cleveland Academy a memorandum indicating that the Mediation Committee case No. 213—the Kamellin

case—had been referred to the Ethics Committee on November 13, 1961 by direction of the Board of Directors; there is also in the Cleveland Academy file a memorandum dated November 14, 1961 and labeled "Extracted From the Minutes of the Board of Directors" and reading as follows:

#### "V. COMMITTEE REPORTS

A. Mediation Committee—Dr. William Boukalik, Chairman requested a directive as to whether the Mediation Committee had a responsibility to determine whether and when fees in cases referred to the Mediation Committee were excessive and if the Committee did so determine, whether members of the Committee ought to be available to so testify in court if required. Mr. George Meisel of Squire, Sanders & Dempsey noted that a doctor's patient had an implied contract to pay "a reasonable fee." Whether a fee was or was not reasonable is a matter of opinion, indicated Mr. Meisel, and the opinion of the members of the Mediation Committee would certainly carry great weight in the event that a case concerning fees were referred to litigation. Motion was made that the Mediation Committee should, when possible, take a clear cut stand that a fee is or is not excessive and that members of the Mediation Committee should be willing to testify in court regarding this opinion if required. The motion being duly seconded, was passed.

In the present case now before the Mediation Committee in which a member of the Academy is in court suing for payment of a fee which the Mediation Committee had previously determined to be excessive, the Mediation Committee noted that the doctor had refused to accept the decision of the Mediation Committee. Upon motion duly seconded, the Board directed that the case be referred to the Ethics Committee."

21. Between May 8, 1961, the date of Dr. Kamellin's letter to Dr. Pardee, and February 15, 1962, the date of the letter of Dr. Lambright, Chairman of the Ethics Committee, to Dr. Kamellin, there was no communication, oral or written, between the Academy of Medicine (or the members of the Mediation Committee, the Ethics Committee or the Board of Directors) and Dr. Kamellin other than the following: An oral communication by Dr. John D. Osmond to Dr. Kamellin on the day of the trial of the case of Dr. Kamellin vs. Cottrell—November 27, 1961—and an oral communication by someone else to Dr. Kamellin to the effect that the Academy would not aid Dr. Kamellin in the case but would send a witness to testify on Mr. Cottrell's behalf. (The statements of Dr. Kamellin and of the representatives of the Cleveland Academy at the January 13, 1963 hearing support the foregoing statement.) At this hearing, Dr. Kamellin stated that the trial took place on November 10, 1961, that judgment was rendered for the full amount prayed for and that the judgment was paid in November of 1961. In his letter to OSMA of May 7, 1962 he states that the trial occurred on November 27, 1961. In any event, it is not clear whether the conversation between Dr. Kamellin and Dr. Osmond took place on the day on which the trial actually took place or at an earlier date when the case was called for trial but was continued because of the absence of the Academy's witness.

21(a). At the trial on November 27, 1961, an obstetrician who was a member of the Mediation Committee appeared as a witness for Mr. Cottrell and offered testimony that Dr. Kamellin's fee of \$500 was unreasonable but the court refused to accept his testimony on the grounds that he was not qualified to testify as to the reasonable value of services performed by Dr. Kamellin, an ophthalmologist.

22. On February 15, 1962 Dr. Middleton H. Lambright, Chairman of the Ethics Committee, wrote to Dr. Kamellin, advising that the Dr. Kamellin-Cottrell matter had been referred to the Ethics Committee "concerning your lack of cooperation with the Mediation Committee" and requested Dr. Kamellin's attendance at the next meeting of the Ethics Committee to be held on March 7, 1962.

23. On February 23, 1962 Dr. Kamellin wrote Dr. Lambright, advising that he would attend the meeting of the Ethics Committee on March 7 and requesting that there be sent to him immediately "further specific information as to the matter concerning the alleged lack of cooperation with the Mediation Committee".

24. On February 26, 1962 Dr. Lambright wrote Dr. Kamellin, stating that the specific information concerning Dr. Kamellin's lack of cooperation could be found in the Mediation Committee's letter to Dr. Kamellin of May 5, 1961 and Dr. Kamellin's letter of May 8, 1961, addressed to Dr. Pardee, and stating further

that "It probably would be best to review all of the facts of this case at this time".

25. In the Cleveland Academy file appears a memorandum labeled "Ethics Committee Meeting March 7, 1962". This memorandum recites the various persons present, including Dr. Kamellin and his attorney, Mr. Weltman; it further recites that a portion of the minutes of such meeting is as follows:

"Upon motion duly made and seconded the Committee determined that formal procedures involving S. M. Kamellin, M.D. be terminated at this time and within this Committee. In a separate motion duly made and passed the Chairman was instructed to write a letter to Dr. Kamellin indicating the displeasure of the Committee with his handling of the situation involving Mr. Charles Cottrell and his lack of cooperation with the Mediation Committee. This letter is to be circulated among the Committee for complete agreement and to carry the means of the entire Committee".

This memorandum does not disclose whether Dr. Kamellin or his attorney was or was not present when the foregoing motions were passed; nor does this memorandum indicate what witnesses were heard or what documents were offered and considered at the hearing. (See also paragraphs 48 and 49 below with respect to the activities and proceedings of the Ethics Committee.)

26. There is also a memorandum in the file of the Cleveland Academy purporting to be an excerpt from the minutes of the Board meeting of March 13, 1962 and reading as follows:

"B. Ethics Committee—Dr. Middleton H. Lambright, Chairman, reported action in a case referred from the Mediation Committee in which the Mediation Committee has ruled a fee excessive and the doctor involved had refused to alter his fee, but had taken the patient to court and won a suit for collection of the fee. Upon motion only seconded, the Board directed that the name of the doctor involved be revealed to the Board. Dr. Lambright thereupon announced the name of the doctor involved. Dr. Lambright indicated that the Ethics Committee wished to send a letter to the doctor criticizing his handling of this particular case and refusal to reduce fee charges. Mr. George Meisel indicated that from a legal point of view, the Ethics Committee was within its rights in so writing.

"Dr. Lambright then proposed that the By-Laws be amended by adding a provision under "discipline of Members, Article I, Section 5 of the By-Laws, stating that failure to cooperate with a Committee of the Academy of Medicine is contrary to the spirit of the Principles of Medical Ethics, it is a violation of the Provisions of the Constitution and By-Laws of the Academy of Medicine, and constitutes grounds for disciplinary action. This suggestion is referred to the Committee on Constitution and By-Laws for consideration and recommendation."

27. On April 11, 1962 the Ethics Committee wrote to Dr. Kamellin, advising of the decision of the Ethics Committee; this letter bears the signature of Middleton H. Lambright and lists the names of the members of the Ethics Committee. This letter reads as follows:

"The Ethics Committee wishes to thank you for your courtesy in appearing with your counsel at the last meeting of the Committee in an effort to bring forth the facts in this case necessary to properly adjudicate it. There were several of these facts which were brought out to indicate that inconsistencies were noted.

"First of all, the total income of the family of the patient as reported by the father and as judged by you showed a considerable variation.

"Second, there is no proof that you billed this patient before taking the action which you did. According to the records, your bill was not sent out until after the insurance benefits were discovered by you. Furthermore, the amount of the bill was also changed.

"The Committee felt that your action in ignoring the recommendations of the Mediation Committee was not in keeping with the high standards of the Academy of Medicine of Cleveland.

"Based on the consideration of the services rendered and the ability of the patient to pay, the Committee has considerable doubt as to the reasonableness of the fee charged.

"Furthermore, the Ethics Committee wishes to endorse the principle that all members of the Academy of Medicine must stand firm on proper ethical behavior without deviation in any direction."

(There is also in the Cleveland Academy file what purports to be an earlier draft of the Ethics Committee's report and which bears the following notation

at the top: "This is the letter that will be sent to S. M. Kamellin, M.D. from the Ethics Committee. If you approve of the letter in its present form please call Miss Paris by Tuesday, March 13th. If you do not approve of it and wish to make changes, make them on this copy and return it to Miss Paris by March 13th.")

(The circularizing of this draft may account, in part at least, for the delay in communicating to Dr. Kamellin the results of the action taken by the Ethics Committee on March 7 and the action taken by the Board of Directors on March 13.)

(While the letter of the Ethics Committee is dated April 11, 1962, Dr. Kamellin stated at the hearing on January 13, 1963 that he did not receive it until after May 8 and that the envelope containing the April 11 letter also contained another letter from Dr. Lambricht, dated May 8, referred to below.)

28. On April 23, 1962 Dr. Kamellin, not having received the Ethics Committee's letter of April 11, wrote to Dr. Lambricht requesting that he be advised of the conclusions of the Ethics Committee. In this letter Dr. Kamellin details the discussions which he claims took place at the March 7 hearing on the charges that (1) he failed to cooperate with the Mediation Committee, (2) that his fee was too high, and (3) that he predicated his fee on the basis of the insurance payments. This is the letter that Dr. Kamellin enclosed with his original complaint of May 7, 1962, addressed to the Ohio State Medical Association. A copy of Dr. Kamellin's letter of April 23, 1962 is attached. It will be noted that the sole request made in this letter is contained in the next to the last paragraph of the letter; it is also set forth in paragraph 2 of this memorandum.

29. On April 25, 1962 Dr. Kamellin wrote OSMA requesting a copy of the Constitution of OSMA.

30. On May 3, 1962 Dr. Kamellin wrote to Dr. John D. Osmond, President of the Cleveland Academy, requesting that the Academy office make available for his inspection at the office the minutes of the Board meetings held in the 13-month period from April, 1961 to April, 1962, both inclusive.

31. On May 7, 1962 Dr. Kamellin wrote his complaint letter to OSMA and on the same date sent a copy thereof to the Board of Directors of the Cleveland Academy. A copy of the May 7, 1962 complaint letter is hereto attached.

32. On May 8, 1962 Dr. Lambricht, Chairman of the Ethics Committee, wrote Dr. Kamellin as follows:

"The Ethics Committee is aware that there has been some delay in writing you after your appearance at the March 7, 1962 meeting.

"This is because the enclosed letter was referred to the Academy Counsel for a recommendation prior to sending it to you."

(The "enclosed letter" mentioned in the May 8 letter is no doubt the April 11, 1962 letter mentioned in paragraph 27 above.)

33. On May 14, 1962. Dr. Kamellin wrote Dr. Lambricht, acknowledging receipt of an envelope enclosing the April 11, 1962 letter and the May 8, 1962 letter mentioned in paragraphs 27 and 32 above, and posing a number of questions as to who dictated the April 11 and May 8 letters, whether the signatures thereon are those of Dr. Lambricht or someone else duly authorized to sign the same, as to whether the other members of the Ethics Committee concur in the statements set forth in the April 11 letter and as to who typed each of such letters.

34. On June 1, 1962 Dr. Kamellin wrote a three-page letter to Dr. Lambricht, complaining of Dr. Lambricht's failure to reply to Dr. Kamellin's letters of April 23 and May 14 and making a number of comments regarding the April 11, 1962 letter sent by the Ethics Committee to Dr. Kamellin (see paragraph 27 above) and questioning the correctness of the action taken by the Ethics Committee, and criticizing the attitude manifested by the members of the Ethics Committee. Dr. Kamellin again demanded "a straight-forward communication answering the questions which I have asked in my previous letters to you".

35. Among the papers in the Academy's file is an undated memorandum from Mr. Donald A. Mortimer to Attorney George Meisel, reading as follows:

"The Ethics Committee has decided to ignore the enclosed letter.

"If you have any comments about this decision or questions about anything in the file, call me."

There is no indication as to whether the letter referred to is the April 23 or the May 14 or the June 1 letters written by Dr. Kamellin, or some other letter.

36. On June 11, 1962 Dr. Kamellin wrote to Robert Lang, Executive Secretary, requesting a copy of Mr. Cottrell's original complaint to the Mediation Committee and on June 13 Mr. Lang sent such copy to Dr. Kamellin.

37. On June 15, 1962 Dr. Kamellin wrote the Board of Directors, complaining of the failure of Dr. Lambright, Chairman of the Ethics Committee, to answer Dr. Kamellin's communications of April 23, May 14 and June 1 and charging that this was an "inexcusable discourtesy" and failure on the part of Dr. Lambright to perform his official duties; Dr. Kamellin concludes this letter as follows:

"I am therefore at this time requesting that you direct Doctor Lambright to answer the questions in my letters described above, answer them yourselves, or, preferably request Dr. John Osmond Jr. the former president of the Academy of Medicine, to answer them, by mail, to me, since the matter under discussion represents unfinished business during his term of office.

"Failure of a response by either of the above mentioned sources will leave me with but one conclusion; and that is that the Board of Directors of the Academy of Medicine of Cleveland, do not intend to extend to me the courtesy and cooperation which they expect and require from me and the other general members of the Academy of Medicine of Cleveland."

38. On June 19, 1962 Dr. Lambright wrote to Dr. Kamellin a letter of explanation for the delay in answering Dr. Kamellin's letters of April 23, May 14 and June 1; in this letter Dr. Lambright answered certain questions posed by Dr. Kamellin in the three letters already mentioned. A copy is attached.

39. On June 27, 1962 Dr. Kamellin wrote to Dr. Lambright again charging him with "gross discourtesy" and complaining that Dr. Lambright has not fully answered the various questions posed in Dr. Kamellin's letters of April 23, May 14 and June 1 and demanding "specific, concise, straightforward answers" to eight questions, as follows:

"(1) Did the Ethics Committee which met on June 13, 1962 consist of the same persons as those who were members of the Committee on March 7, 1962? If not, please name the full committee as of June 13, 1962 and designate those who were present at, and those who were absent from the meeting.

"(2) On what date following the meeting of the Ethics Committee on June 13, 1962 did you write the contents of the letter dated and typed June 19, 1962 and why was it not typewritten and forwarded to me until after the Board of Directors received my letter to them dated June 15, 1962?

"(3) Are you now acting in this matter for the present Ethics Committee and the present Board of Directors or for the Ethics Committee and the Board of Directors as constituted on March 7, 1962?

"(4) On what date did the members of the Ethics Committee read and approve the letter dated April 11, 1962?

"(5) In your letter of June 19, 1962 you stated that you signed one of the letters mailed May 8, 1962, but you did not specify which letter. Please do so. What is the name of the person who signed the other letter for you and was this person specifically authorized by you to do so?

"(6) Did or did not Miss Laurel Paris type the letter dated April 11, 1962 and the letter dated May 8, 1962?

"(7) What is the conclusion of the Ethics Committee regarding the charges by the Board of Directors; namely, did I or did I not in any way commit an unethical act as laid down by the Constitution of the Academy of Medicine of Cleveland or by the Principles of the American Medical Association, Code of Ethics, in the case under discussion, namely the Cottrell case?

"(8) Do the Ethics Committee and the Board of Directors wish to arrive at the truth in this case, regardless of who is involved in it? Or do they wish to leave it in its present unresolved state, in spite of the evidence which I gave to the Ethics Committee on March 7, 1962 and information in my letter of June 1, 1962, that further conclusive proof of my statements is available in my files, if and whenever it is wished?"

40. On July 5, 1962 Mr. Mortimer wrote Dr. Kamellin, advising that copies of his letter of June 27 had been mailed to members of the Ethics Committee and that Dr. Lambright, Chairman, was out of town and would return about July 9.

41. On July 11, 1962 Dr. Kamellin wrote the Board of Directors complaining that on July 10, 1962 Mr. Mortimer, Assistant Executive Secretary of the Academy, had obtained from the Marymount Hospital a photostatic copy of a portion of the medical record of Kenneth Cottrell, this data having been released by the hospital pursuant to the written consent of Mr. Charles Cottrell but without the consent of Dr. Kamellin; Dr. Kamellin characterized this action of Mr. Mortimer as a "surreptitious method of obtaining private medical information which was desired by certain officers of the Academy of Medicine is highly unethical and I believe it to be illegal".

42. On July 12, 1962 Mr. Mortimer advised Dr. Kamellin that Dr. Kamellin's letter of July 11 had been received and distributed to the officers of the Board and the Committee involved.

43. On July 16, 1962 Attorney George Meisel of the firm of Squire, Sanders & Dempsey in Cleveland wrote Dr. Kamellin expressing the legal opinion that inasmuch as Mr. Cottrell had properly authorized Mr. Mortimer to inspect the hospital records of Kenneth Cottrell, the release of these records by the hospital is not illegal.

44. On July 23, 1962 Dr. Kamellin wrote to Dr. Henry A. Crawford, President of the Cleveland Academy, complaining that Dr. Kamellin had had no answer from Dr. Lambright to Dr. Kamellin's letter of June 27 and complaining again of the action of the Academy of Medicine in securing a copy of the medical record of Kenneth Cottrell with Dr. Kamellin's consent. Dr. Kamellin then poses fourteen questions to which answers are requested of Dr. Crawford. Copy of this July 23 letter is attached.

45. On July 25, 1962 Dr. Crawford, President of the Cleveland Academy, wrote Dr. Kamellin as follows:

"This will acknowledge receipt of your letter of July 23, 1962. As of May 7, 1962, charges were preferred by you to the Ohio State Medical Association alleging unethical conduct on the part of the Board of Directors of the Academy of Medicine of Cleveland and Cuyahoga County Medical Society. Until this case is resolved, I do not feel authorized to enter into any further discussion of these matters with you."

46. On August 1, 1962 Dr. Kamellin wrote to the J & P R Committee of OSMA his supplemental letter of complaint, copy of which is attached. On this same date he wrote to Dr. Crawford, enclosing a copy of his, Dr. Kamellin's, letter to the J & P R Committee.

47. There is also in the file submitted to the J & P R Committee certain hospital records on the Kenneth Cottrell case. There is also in the file a number of letters written by Dr. Kamellin to OSMA subsequent to the lodging of Dr. Kamellin's supplemental complaint of August 1, which need not be commented on here for the reason that they contain little, if any, pertinent factual matter bearing upon the charges of unethical and discourteous acts set forth in Dr. Kamellin's letters of complaint of May 7 and August 1. These subsequent letters consist in the main of arguments advanced by Dr. Kamellin in previous letters to the Academy, of suggestions as to how the J & P R Committee and the Council of OSMA should conduct the investigation and hearing of the charges and listing numerous questions which Dr. Kamellin desires answered by OSMA.

48. At the hearing on January 13, 1963 Dr. Kamellin, in presenting his case, devoted most of his time to the reading of correspondence. With perhaps two or three exceptions, copies of all the letters read by Dr. Kamellin or referred to by him at the hearing have been furnished to the J & P R Committee by either Dr. Kamellin or the Cleveland Academy. At the hearing on January 13 Dr. Kamellin stated that he had put a "stopper" on Kenneth Cottrell's hospital records because of a statement that Mr. Cottrell allegedly made some months prior to July 10, 1962 (the date on which Mr. Mortimer secured a photostatic copy of Kenneth Cottrell's hospital record), which statement of Mr. Cottrell was to the effect that he was going to sue Dr. Kamellin for malpractice. Dr. Kamellin further stated that the written authorization by Mr. Cottrell was dated July 9, 1962 and directed the hospital to furnish a copy of the records to the Mediaion Committee. This authorization was presented to the hospital on July 10, 1962. Dr. Kamellin also stated at the hearing that he had not treated Kenneth Cottrell after the month of January, 1961; that he, Dr. Kamellin, never met the Mediation Committee, all communication with it being solely by telephone or by correspondence; that in August, September or October of 1961 Dr. Kamellin's lawyer and Mr. Cottrell's lawyer reached an agreement as to the amount of the fee at a total figure somewhat less than \$500.00, but Mr. Cottrell refused to go through with a settlement on this basis; that he met with the Ethics Committee on March 7, 1962, this being the only meeting with that Committee or any other committee or body of the Academy; that he submitted to the Ethics Committee at the hearing on March 7 opinions by Dr. M. Paul Motto and Dr. M. E. Gans that the fee of \$500.00 charged by Dr. Kamellin was reasonable and not excessive and that he was quizzed at the Ethics Committee meeting on March 7 as to certain previous statements he had reportedly made, indicating that his fee might be \$450.00

and that he had admitted making these statements. Near the end of his presentation Dr. Kamellin stated he wants to have the "air cleared"; that he wants to know if he was unethical or if the Academy members were unethical.

49. At the afternoon hearing on January 13, 1963 the representatives of the Cleveland Academy stated that the Mediation Committee had information that Mr. Cottrell was "brushed off" by Dr. Kamellin on several occasions when inquiry was made by Mr. Cottrell as to what his fee would be; that the Mediation Committee consider but one question, namely: Was the \$500.00 fee charged by Dr. Kamellin excessive?; that the Mediation Committee, on the basis of the description of the surgery given by Dr. Kamellin, the financial standing of Mr. Cottrell, the letter of Mr. Cottrell of April 6, 1961 (and its enclosures), Dr. Kamellin's letter to Dr. Pardee of April 12, 1961, and the opinion of an ophthalmologist, concluded that the \$500.00 fee was excessive; that despite repeated efforts by the Mediation Committee and Mr. Cottrell to effect a revision of Dr. Kamellin's bill, Dr. Kamellin sued and secured judgment; that the Mediation Committee took up with the Board of Directors the matter of testifying for Mr. Cottrell and securing the necessary authorization to do so and that a Mediation Committee member, who is an obstetrician, volunteered as a witness but was not permitted by the court to give an opinion; and that following the trial the matter of Mr. Cottrell's complaint was referred to the Ethics Committee. They further stated that Dr. Motto had repudiated, or was willing to repudiate, his opinion referred to in his opinion letter (referred to in paragraph 48 above) as to the reasonableness of Dr. Kamellin's fee and also that the Academy has no record or documentation of the happenings or proceedings before the Mediation Committee or the Ethics Committee except the partial minutes already furnished to the J & P R Committee.

WAYNE STICHTER,  
*Legal Counsel, Ohio State Medical Association.*

#### OSMA STAFF ADDENDUM

NOTE.—Dr. Kamellin's suit never came to trial. He moved to California where he died in 1969. Also, he never substantiated before the Judicial and Professional Relations Committee, OSMA, his complaint against the Academy of Medicine of Greater Cleveland.

Dr. HENRY. I can think of a specific case in which there was a doctor in a town near you, sir, who had one of the greatest systems of fee billing I have ever seen. He had a stable of patients in which one day he treated them on the industrial commission charge, the next day on a medicare charge and the next day on a welfare charge. I am sure he had all types of systems of billing, and it was brought to the attention of the local medical society that acted. It was brought to the attention of the State that acted, and I can only tell you that this gentleman is no longer practicing in the State of Ohio.

We had prepared testimony, and when we came to the point of going into court, the gentleman decided to withdraw from the practice of medicine so we never really got into court, but there is a case where it happened.

Mr. VANIK. If I remember the case you refer to, that would be a public-related case in which the compensation was paid by the State or Social Security Administration so the development of the information on the man came not through private sources, but through the public records which were searched to discover these activities.

Dr. HENRY. I think in this particular situation the Government agencies came to the medical profession and asked them to make judgments and we did, in fact, make judgments, sir.

Mr. VANIK. Let me ask you this: If a citizen of my community or any community in Ohio should have a disagreement with the billing charge that is made by his doctor, what procedure could he follow,

legitimately and properly, in order to have the matter directed to the attention of the proper authorities in the medical bureaucracy?

Dr. HENRY. You are from Cuyahoga County?

Mr. VANIK. Yes.

Dr. HENRY. The way it is done in Cuyahoga County, it is referred either directly from the patient or it can be from the third-party carrier. I think there is a fee review organization in Cuyahoga County through their medical society that does in fact review all of these cases. They then, if there is an appeal, they then refer to the Ohio State Medical Association and we hear the case. In fact, I think our next docket does have in fact several cases from your county right now in which we are reviewing the fees, and the reduction in fee as was recommended by your local medical society.

Mr. VANIK. As a matter of physical utilization of a doctor's time, how much of a professional's time or how many medical man-hours are used in this kind of work, in peer review, in hearing these complaints? Do you have any estimate of that? You say doctors ought to do it, but every time we put a doctor on a job like this he is not able to look at patients.

Dr. HENRY. I am not sure most doctors consider it a loss or waste of time. I have done it for many years and I think of it as an obligation not only to my profession but to my community.

Mr. VANIK. You feel you want to do it?

Dr. HENRY. I think most doctors feel the same way.

Mr. VANIK. I am very disturbed about the delivery of health services to our senior citizens in Ohio. Ohio's life expectancy at age 65 is lower than the average in the United States. Is there any explanation for that? Why do we die sooner? I am talking about all of Ohio. The national average life expectancy at age 65 is 14.59 years and the Ohio average is 14.18. It is even lower in the nonwhite areas.

Dr. HENRY. Sir, I do not know anything about these figures. That is the first time I have ever heard them.

Mr. VANIK. They come out of the NIH records. It is for the period 1959 to 1961—the latest figures available. I am quoting directly from the NIH records. Given these figures, is it possible we don't have enough doctors and health personnel in the State to provide adequate health services?

Dr. HENRY. I am sure we need more doctors and more health personnel in the State of Ohio. As you know, in Ohio there is another medical school in Toledo, classes at Ohio State University have been increased, and there is a contemplated medical school in northeastern Ohio to be in addition to Western Reserve, so I think we are directing ourselves to the shortage of medical personnel in the State of Ohio.

Mr. VANIK. We have 10 less doctors per 100,000 people than the U.S. average. Is there any reason why our climate for doctors can not be improved other than by programs before the Ways and Means Committee?

Dr. HENRY. I know, being a general practitioner and still trying to do all of this, I see more patients now than I did 20 years ago. I don't know if I am better or the patients are worse, but I am still seeing a heck of a lot of patients.

Mr. VANIK. We have only three of the 108 medical schools, not counting—

Dr. HENRY. We have four schools now.

Mr. VANIK. Yes; a new one. I think there are more than 108 in the country. That was the latest figure I have. We have 5 percent of the Nation's population and 207 percent of the medical schools, and only 3.7 percent of the students.

What is the Ohio Medical Association doing to stimulate the development of more doctors in the State?

Dr. HENRY. We are working with a manpower group out at Ohio State University. We are deeply involved with the Toledo Medical School. We are working with the deans of all medical schools. We have several high-level study committees in trying to improve the efficiency of the program.

As you know well, the programs have been reduced to 3 instead of 4 years. We have given them a lot of advice which they have accepted, and some which they have rejected.

Mr. VANIK. In my community of Cleveland the average consumer price index for medical care is 143.5; whereas for the United States it is 130.4. It is 13 points above the national average.

Could you give me any reason why there might be this discrepancy in costs in our community? We feel very much burdened by these escalating costs which are 13 percent above the national average.

Dr. HENRY. I do not know the reasons because I do not have the figures, and have not studied them. I think one of the answers in your community, Congressman, you have a very progressive medical organization which is involved in this type of thing, and I think possibly we can have a more in-depth evaluation of your problems if we can get uniform data.

One of your problems is no place in the United States reports things the same way, so, if we can get some uniformity, I think we can develop some statistics that, maybe, will give you answers that you are looking for. Right now I can give you answers, maybe, in Van Wert County but I can't for Cuyahoga County.

Mr. VANIK. What about the problem of assignments? How many doctors in your association refuse to take medicare assignments?

Dr. HENRY. At one time I think the number was as high as 87, but I think it has dropped considerable in the last 4 years. I don't know what the number is. I have heard it but I don't remember, but I think it is a tremendously less amount now.

Mr. VANIK. The figure I have is that 31.2 percent of Ohio's doctors accept medicare assignments. Nationally it is almost double that rate. I was wondering what there was about the State of Ohio that made medical assignments so much out of line with the national practice, because if this is true, the studies which you have made are really not complete. This goes to one of the really critical problems of our community. We can't get doctors to handle the medicare assignments.

Now, why is it that Ohio should have one of the poorest records among the 50 States in medicare assignments?

Dr. HENRY. The beauty is in the eye of the beholder. Maybe those doctors think because they have 31 percent they are more effective and doing a better job. I don't have your source of statistics so you have me at a disadvantage. Ohio State traditionally was a direct-billing or-

ganization. We tried to maintain a direct doctor-patient relationship and one of the ways was on the billing thing, so we spent a lot of time and energy trying to maintain a direct billing. In Ohio this is why you have a lower percentage.

Mr. VANIK. Didn't the association take some aggressive action in urging its members not to take assignments?

Mr. HENRY. Yes.

Mr. VANIK. When was that?

Dr. HENRY. Possibly 1966.

Mr. VANIK. Does that mandate still continue today?

Dr. HENRY. It was not a mandate; it was a recommendation.

Mr. VANIK. Here was a State association recommending to its members that they do not take medicare assignments upon which so many of our senior citizens depend for their health care. What have you done to change that position, if you have changed it?

Dr. HENRY. At one time it was 87 percent that did not and now 31 percent are. There is one little problem here. At no time did the Ohio State Medical Association's members refuse to take care of those patients. They took care of them strictly as though they were one on one. It was not a question of not taking care of the patient. This was merely a billing technique. I don't see that this reduces the quality of medical care one iota.

Mr. VANIK. Here is what has happened: Patients have little to do about who the doctor is when they have a grave illness. They go to a doctor and get cared for. Then they get a bill and pay the bill, and then they can't collect their money because the doctors refuse to say anything more on the bill than "\$185 medical services." That does not satisfy medicare, so we have millions and millions and millions of dollars of bills that have been paid by the patient that are not readily recoverable through medicare, because of the refusal of the physician to fill out the application for the patient after he has received his money.

Dr. HENRY. I am sure what you say is true, but I do not have any knowledge nor have we officially had any knowledge, and we have committees working with Blue Cross in all of the Ohio and certainly with Nationwide and OMI. If this is a problem, it has not been brought to the attention of the medical society.

Mr. VANIK. If almost 70 percent of your doctors are not taking medicare assignments, have you endeavored to at least make available to the public the list of doctors who do not take medicare assignments so the public can be guided as to who does and who does not take medicare assignments?

Dr. HENRY. No, sir.

Mr. VANIK. The patient who has to rely on medicare could then pick a doctor who is going to take an assignment rather than one who is not. He might have a chance to exercise some discretion in selecting a doctor and avoiding one who does not take a medicare claim. This would eliminate that doctor from having a case which he does not want anyway. It would save the patient the money that he otherwise would be paying for his own medical services under a covered program.

Dr. HENRY. I will report this back to the medical society and I am sure through President Robichek you will get an answer and maybe we can satisfy your problem.

Mr. VANIK. It is a serious thing. We have almost 200,000 people in my community who are depending on medicare services. This gives me as many problems as anything else in my community. Somehow the Congressman, as Mr. Devine knows, gets all of the complaints and these complaints keep coming back about the failure or the refusal to take assignments.

Mr. Chairman, I would like, at this point, to place in the record a specific problem that occurred in my community in August, and, after the record is printed, doctor, I would appreciate it if you could go into this problem. This is another manner in which you could be of tremendous help on peer review. We had several cases where tetanus shots would run as high as \$35 to \$40 in hospitals in my community.

If there is no objection, Mr. Chairman, I would like to place this article of the Cleveland Press, dated August 30, in the record.

The CHAIRMAN. Without objection, it will be included.

(The newspaper article follows:)

[From the Cleveland Press, Aug. 30, 1971]

#### TWO 40-CENT TETANUS SHOTS PRICED AT \$34

(By Georg Mann and Joe Collier)

Clevelanders are finding out that the smallest medical service can be a costly matter. Take the case of Mrs. Joyce Merz of 16330 Richard Dr., Brook Park.

She has discovered that there can be a 4000% markup in the cost of an anti-tetanus shot that the hospital she visited paid only about 40 cents for.

Mrs. Merz and her young son on the same day accidentally punctured their skin with nails and she decided they must have anti-tetanus vaccine. Because their own doctor was not available, they went to the nearest hospital, Southwest General.

The wounds were slight and were cleaned at home with soap and water. No surgery, or cleaning out or other preparation were done at the hospital. Nothing was needed but a swipe of merthiolate, the shots, and an adhesive bandage each.

Each was charged \$10 for the use of the emergency room, billed by the hospital. The administering of each shot was \$7, done in each case by a hospital nurse, but billed separately by the doctor.

So far as Mrs. Merz was concerned she was charged for the doctor's office (the emergency room), the work was done by the nurse, and the doctor, who merely looked at each wound and left, had no overhead and minimal duties.

"Of course," Mrs. Merz said, "my husband's union health coverage paid the \$34, but we pay the insurance and the rates are going up."

Mrs. Merz' experience will be nothing new to many Greater Cleveland families. The hospitals themselves point out that their emergency rooms are more and more being substituted for the emergency home visits that most doctors no longer make.

The hospitals say the business was uninvited and at first unexpected. They were unprepared, and many of them say that the cost to them is more than they bill.

Brand new medical economics have evolved and as usual are more costly to the patient.

All or nearly all of the hospitals here and elsewhere charge for the use of their emergency rooms, which serve as doctors' offices. Many hospitals contract with a group of doctors to man the rooms.

Other hospitals bill patients for the services of their own staff doctors. Others bill for some services, not for others. A patient, in more serious emergencies, can also be billed for lab tests, X-rays and other special investigations a doctor may order.

Occasionally a patient will receive still another bill for a roentgenologist he has never seen, talked to or had a report from. The roentgenologist will have read the X-rays the next day to see whether a medical mistake has been made. His report goes only to doctors.

More and more insurance contracts are written to pay for emergency room visits, or some of them with an increase in rates.

The Press talked to a number of Cleveland hospitals and prepared the following table of basic costs of a visit to some of the hospital emergency rooms in Cleveland.

Hospital	Charge for room	Charge for doctor
University.....	\$30	(1)
Metropolitan General.....	10	(1)
St. Luke's.....	(2)	\$8
St. Vincent's Charity.....	25	(3)
Mt. Sinai.....	15	8
Suburban.....	17	(1)
Fairview.....	17	7
Lakewood.....	18	9
Southwest.....	11	7
Parma Community.....	15	(1)
St. Alexis.....	15	(1)
Marymount.....	18	8
Euclid General.....	10	8
Lutheran.....	20	10
St. John's.....	8	10
Polyclinic.....	16	(1)
Huron Road.....	17	10
Cleveland Clinic.....	25	(1)

<sup>1</sup> None.

<sup>2</sup> \$10 medical; \$14 surgical.

<sup>3</sup> None, if seen by an intern; otherwise, \$8.

<sup>4</sup> Varies.

The doctor's fees in the table are base fees, for minimum service.

Where no doctor's fee is indicated, the service is provided by interns, residents or house doctors, and is included in the hospital's fee.

In spite of the charges for the emergency room, two Cleveland hospitals indicated that the actual cost to them of an emergency room visit ranged from \$29 to \$35.

Mr. VANIK. I think the plan you suggest is fine. I would like to see part B included in the peer review. Presently, it is doctors reviewing doctor's fees. I think if that feature could be added to the proposal you have, and I think it could be rather quickly done, it would probably provide a format for providing a peer review system that would be satisfactory to the doctors and the medical profession. At the same time it would perform a great service to the community.

I want to congratulate Mr. Devine and Mr. Betts and you for outlining this approach to a very difficult problem.

The CHAIRMAN. Are there any further questions of Dr. Henry?

Mr. BYRNES. I want to say to the doctor, and to Mr. Devine, that I think they made a splendid contribution to the work of this committee because they came here pointing up a basic problem which we all know we have. They addressed themselves specifically to getting uniform data and analyzing that data from a medical standpoint in order to determine whether it gives the patient the appropriate care, and at appropriate charges.

I think you are to be congratulated on the public service you are performing. You have a practice to take care of, but your willingness to get into this area is commendable.

There is a mechanism for trying to assure that people get the medical care to which they are entitled at reasonable cost.

It is incredible. More or less by inferences, you have been taken to task because you do not have the answers to all of our medical problems.

I think your presentation has been most helpful. As one member I want to express my sincere appreciation for your coming here, and for the work you have done.

The CHAIRMAN. Mr. Corman.

Mr. CORMAN. Doctor, could you tell me the reason why the Medical Association initially discouraged doctors from taking assignments? Was it because of a fear of disrupting the normal client-patient relationship, or was it because you did not want a bureaucrat fixing doctors' fees?

Dr. HENRY. I think it was a philosophical question dealing with the interposition of somebody between the doctor and his patient. I don't believe it was a slap, sir, at the bureaucracy at all. I don't believe that for a minute. In Ohio we have Blue Shield and that type of thing for a long time. We were familiar with that. I don't really think that was it.

Mr. CORMAN. As I understand it, most private insurance companies have policies that provide for copayment just as medicare provides for copayment. The difference is that under medicare the fees are fixed if one takes an assignment, whereas with the insurance companies it is normally pretty much open ended as to what the doctor can charge.

Dr. HENRY. For a long time in Ohio the Blue Shield forms had no mechanism on them for direct physician assignment by the patient. This was the wish of the medical profession. It was only after the advent of medicare that there could be an assignment even in the Blue Shield in Ohio. It was a long time in coming. Maybe I am confusing you. I am not trying to.

Mr. CORMAN. It did not seem to disrupt the client-patient relationship so long as there was no maximum fee the doctor could charge, but when medicare came in and suddenly there is some fee fixing, then they were reluctant to rely on this patient-client relationship being 20 percent.

Dr. HENRY. Having sat on peer review committees, doctors are meaner and nastier to each other than they are to anybody else. In speaking to Mr. Vanik, I have seen some pretty horrible things done and said. We may be united on the outside but on the inside we get pretty violent at times.

Mr. CORMAN. I agree with Mr. Byrnes. You have made a substantial contribution in highlighting a very difficult problem. The normal free enterprise system is not applicable in the medical field. The consumer does not go out and shop for bargains in the medical field and we get to the very difficult problem of whether the profession is going to regulate itself as to fees as well as professional standards, whether the Government is going to do it or should it just not get done. I am not comforted by the fact that we seem to be creating some systems for those people whose bills are paid for by the Government. I am worried about the poor fellow who has to dip into his pocket and pay the bill.

Dr. HENRY. So am I. I think a reasonable expansion of this system gives you the controls you are looking for. I don't like the word controls but it gives you the parameters you are looking for.

Mr. CORMAN. Thank you very much.

The CHAIRMAN. Before yielding to Mr. Collier, let me suggest, Dr. Henry, it would be a great service to each and every Member of Congress if they would take the opportunity to sit with a peer committee looking over their shoulders and listening to their discussion of some of the fees that are charged by the doctors that are deemed to be excessive by the peer committee.

I did that for some hour and a half or 2 hours in August in Little Rock with a group that meets once a month to review these cases that the computer or some individuals throw out as being somewhat out of line. I agree with you. I never thought doctors would talk about each other as they do. But they really talked about some of these unnamed doctors which they said charged too great an amount for a particular service rendered. There was one case of an operation, it is a two-part operation but it is performed at the same time, and this surgeon had billed for separate operations. One of the doctors said either he is an intern or just past the stage of being an intern. Had he ever been a resident he would have known this is one operation so we want to talk to him. And they were going to get his name and talk to him about his billing as two separate operations, this two-part operation. They allowed him a fee which was less, as I recall, than either of the two fees that he had set up for the two parts. One of them was \$750 and the other was \$500, and as I remember, they said the normal fee for the entire operation was about \$400, so they cut it back to that. I was amazed at the way they scrutinize these things.

On that peer commission sat a doctor who is an expert in each specialty of the medical profession, as well as the general practitioners, and they would yield to the one who is a specialist in this particular phase of medicine to give his version first. If the other doctors did not like his thinking they would vote him down and cut under what he thought, so I think these peer committees do a wonderful service in holding down costs.

I don't know how many of these cases escape the notice of the computer or the individual who brings it to the attention of the peer commission, but there were tremendous savings in the fees that day that were being charged. Frankly, I felt sorry for some of these doctors.

Dr. HENRY. Doctors are strange animals.

The CHAIRMAN. I mean I felt sorry for some of the doctors they were judging.

Mr. Collier.

Mr. COLLIER. First I would like to echo the remarks made by Mr. Byrnes. I think the type of proposal you discuss here is certainly a meaningful approach to one very important aspect of dealing with a national health program on a sound, commonsense basis.

Then a comment in line with the suggestion made by my colleague from Ohio with regard to issuing a list of doctors who will not take medicare assignments, I think it would make a great deal more sense if such a list is compiled to list those who will primarily, because if one needs the service of any kind he seeks to find out those who will

offer it. That is probably why the classified section of the telephone directory does not list those who do not perform the services because it would not be half as much help as listing those who do.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Brotzman.

Mr. VANIK. Would the gentleman yield?

Mr. COLLIER. Yes.

Mr. VANIK. That would be a more effective way, I agree.

Mr. BROTZMAN. I just wanted to tell you, Dr. Henry, and say to my colleague, Congressman Devine, how valuable your testimony is because it becomes readily apparent to me if there is anything we must be wary of on this committee it is that when we come out with legislation, if that particular plan detracts from the quality of medicine, then we have actually done the people of this country a great disservice instead of trying to help them. This is something we really have to look at and test all the way.

The fact that you had experience in this particular area is particularly valuable. I note in Congressman Devine's testimony he alludes to his bill, and the fact that other States have PSRO's in existence. I wanted to merely state that we are doing this in Colorado.

I have talked to Dr. Kenneth Platt, who will testify before the committee. I would agree with your comment, Congressman Devine, that it is working very well. I believe the record is going to disclose that it has saved money—first of all, costs to the patient, to the State of Colorado, and it would save the Federal Government money.

In addition to that, they have had a good record out there in my State as far as reducing the time that patients spend in hospitals. I don't want to anticipate Dr. Platt's testimony, but I have a recollection that they brought it down substantially by virtue of this kind of peer review.

Dr. HENRY. I think it is almost 4 days for hospital admission which is really fantastic.

Mr. BROTZMAN. I was amazed, and I think Colorado is working under a similar type of pilot funding under HEW. So I, too, want to echo what has been said. I think you have made a very valuable contribution to show us actual experience as distinguished from pure theory. Thank you.

The CHAIRMAN. Are there any further questions? If not, Dr. Henry and our colleague from Ohio, we appreciate your statements and the contributions you have made to our work.

Thank you very much.

Our next witness is Dr. Eileen M. Jacobi, executive director of the American Nurses Association.

We appreciate so much having you with us this morning and we are pleased to recognize you.

**STATEMENT OF DR. EILEEN M. JACOBI, EXECUTIVE DIRECTOR,  
AMERICAN NURSES ASSOCIATION; ACCOMPANIED BY CON-  
STANCE HOLLERAN, DIRECTOR, GOVERNMENT RELATIONS**

Dr. JACOBI. I am Dr. Eileen M. Jacobi, executive director of the American Nurses Association. Accompanying me is Constance Holleran, director of our government relations department. The associa-

tion is 75 years old this year and is the professional organization of registered nurses in the United States. It has constituent associations in all 50 States, the District of Columbia, Guam, and the Virgin Islands. Registered nurses in Puerto Rico may join the national association directly as may members of the Armed Services Nurse Corps and civilian nurses working abroad.

The purposes of the association are: To foster high standards of nursing practice, promote the professional and educational advancement of nurses, and promote the welfare of nurses to the end that all people may have better nursing care.

The American Nurses Association has supported the provisions of the Social Security Act and extensions and improvements in the system since its adoption. It was the first organization in the health field to lend support to proposals to provide health insurance coverage for the aged through the social security mechanism.

As one of the professional groups deeply concerned with providing health care for the American people and as the largest single group of professional persons giving the care, we welcome this opportunity to present our views and comments on the subject of national health insurance.

The association is committed to the position that health care is a basic right and that the benefits of modern medical science and of technology should be available to all citizens of this country. We believe that most people now consider that the achievement of health, a state of complete physical, mental, and social well-being should be the national goal of highest priority.

If an optimum or near optimum state of health is to be reached the national health care program must be comprehensive and include preventive, health maintenance, diagnostic and treatment, restorative and protective services. A piecemeal approach to meeting health care needs will in the long run be more costly, will not meet the public's expectations and will result in frustration of both the providers of services and their clients.

Health insurance in this country, whether provided through public or private mechanisms, has encouraged the use of the most expensive facilities and providers resulting in an overutilization of these and contributing to inflationary costs. Additional public and private financing of health care services alone will not guarantee that these will be available, acceptable and assessable to all people. If health care benefits are not comprehensive the consumer will be further encouraged to seek care only in crisis situations.

We are opposed, therefore, to proposals for national health insurance that address themselves merely to providing more public funding to meet the costs of care. While we agree that serious illness and/or injury can lead to financial disaster we do not believe that protection solely against the catastrophic costs of care is in the public interest at this time. Such protection should be a part of the comprehensive health care program.

With multiple benefits provided for in the program emphasis should shift from the use of expensive facilities to the imaginative use of ambulatory services, clinics, out-patient departments, the home, neighborhood health centers, the physician's office, and the home. Such a

program should encourage the use of preventive and health maintenance services which have been largely ignored under the present system.

Some of the proposals for national health insurance before this committee ignore entirely the needs of the mentally and emotionally ill.

In our country an estimated 17 million persons, 10 million under the age of 25, suffer from some form of psychological disturbance. Attempts to provide more scientific and humane care for the mentally ill have occurred periodically over the years without tangible evidence of improvement. It is only in recent years that psychiatric care has become available for the patient within his community. Generally the emotionally disturbed among us are either untreated or inadequately cared for. The mentally ill of our communities have endured for too long public and professional rejection and isolation.

The quality and quantity of services available has been determined largely on the basis of socio-economic status. Effective treatment has been the exception, not the rule. Any health insurance plan which does not provide for sufficient and comprehensive care for the millions of mentally troubled and acutely and chronically disturbed individuals would continue this pattern of inadequate treatment.

No longer can we abide this disparity of health care for the mentally ill. We urge you to support an aggressive plan which will enable us to reduce mental illness, and provide that individuals have access to care by all professionals in the mental health field, the psychiatrist, the psychiatric nurse, the psychiatric social worker and the psychologist.

These professionals are assisted in their work by a large group of dedicated psychiatric aids and licensed practical nurses.

For the record, we would like to state that we believe home health benefits under the medicare program have been over-controlled. Intermediaries have made very arbitrary and questionable decisions with respect to the nursing care they will approve for payment. To be sure their decisions are based on regulations of the Social Security Administration that are perhaps interpreted rigidly.

If crutch-walking is taught by a nurse, this is not paid for. On the other hand, the limitations on home health services need to be reconsidered. Agencies providing these services have a long history of controlling their activities and unnecessary visits by nursing staff have been discouraged. Supervision of staff is of a high caliber. Case conferences on patient needs and evaluation of the service provided is a long-established practice in these agencies. Since less than 1 percent of medicare expenditures have been used to pay for home health services, there is some justification in believing the agencies are not given over to visiting for the sake of the medicare dollar. It is our opinion that the nursing administration is in the best position to determine the need for services in the home, with adequate utilization review.

We trust that ample provisions will be made for home health services under a national health program. Nursing in the home, home-maker/home health aide and social work services can maintain individuals in their own homes, and keep families together avoiding crisis

situations and serious breakdowns that lead to the need for the most expensive care in nursing homes and hospitals.

For example, a homemaker service can be provided for an elderly couple with some mental health problems and they can be maintained in the home and therefore avoid hospitalization or nursing home care for two individuals.

We firmly believe that under a national health insurance program provision must be made for true cost accounting of the nursing service rendered.

Nursing service budgets in many institutions and agencies may include a variety of charges that are more related to institutional services other than nursing.

To insure that comprehensive health care is available, acceptable and accessible to all people a structure or structures needs to be devised that promotes coordination of services in a given area. We believe that such an integrated system should be developed through the comprehensive health planning mechanism.

During the 1960's legislation to promote comprehensive health planning was enacted by the Congress. Its purpose was to promote a partnership between Government and the private sector, consumers and providers to determine health care needs, ways to meet identified needs for services and health manpower and insure against needless duplication of services and facilities.

There is general agreement that there needs to be greater coordination of the services provided, whatever the geographic area. Failure of communication and planning among facilities and agencies providing services and among groups of health workers providing care militates against comprehensive care and the accessibility to consumers of appropriate care. We recommend increased Federal funding and greater authority for the planning agencies.

In the planning process there should be active participation of consumers in identifying health needs and as a system evolves, continuing opportunity for consumers to evaluate its effectiveness in meeting needs.

There is widespread dissatisfaction with the present system of delivering health care. To inaugurate a new program without public involvement could lead to public resistance. A selling job will have to be done to convince people that care received under a new delivery system is of better quality, more readily available and less costly. Consumers who have participated in planning such services would be the best salesmen.

Any corporate structure, arrived at through the planning process, for coordinating and delivering health care should have an overall board composed of consumers and providers of services. It should not be dominated by any one institution or agency or group of professional practitioners.

There is considerable interest now in developing health maintenance organizations. The concept of the health maintenance organization is not new. Group practice programs have been in existence in the United States all of this century with the greatest growth of these occurring in the 1930's. However, they provide health services for a relatively small proportion of the population.

Promotion of the health maintenance organizations as a provider of health care has increased in the last few years because of mounting costs and the unavailability of health care in an organized system; the American Nurses' Association supports and encourages such a development.

Here again we state our belief that consumers and all providers of health services should be involved in planning the organization.

The nursing profession is ready to cooperate in every appropriate way in the development of an organized, integrated health system.

Nurses are the largest group of practitioners in the health field. They must be involved in identifying areas of need and participating in policy decisions as plans are made to reform the health care system.

We are aware that health care services are lacking in rural and inner city areas. The thrust of legislation before the Congress is to establish health maintenance organizations in these deprived areas. We agree that a major effort must be made to reach out to those who have been denied health care for economic, social, or geographic reasons.

We would hope this would not result in and perpetuate a separate system for the poor and the underprivileged. For too long they have been isolated from quality services. We favor a one-class system in which all sectors of the population would be covered and in which services of high quality would be available to all.

Whatever programs in health maintenance are developed, we believe they should be under public or nonprofit auspices. Profitmaking in the health field is not likely to be acceptable to the American people already greatly concerned about the ever-increasing costs of health care and who are suspicious of profiteering in the field.

A national health program should provide payment for nursing services. Nursing is an essential component of modern health care and must be available if the benefits of medical science and technology are to be provided. Beneficiaries of the insurance program should have protection against the cost of essential private duty nursing services and against the costs of public health nursing services at home as well as against the costs of hospitalization, medical care, and nursing home care.

For the seriously ill, especially in smaller hospitals without intensive care units, the care provided by the private duty nurse is often essential to recovery. Increasingly, in the past several years, insurance carriers have included private duty nursing as a covered benefit in their major medical expense programs. Any national health insurance program should also make provision for such service.

Overutilization can be avoided by establishing safeguards that require utilization review committees and certification of need by the physician and the director of nursing services or her delegates.

In the delivery of health care more recognition should be given to the primary care role of the nurse. Nurses have been engaged in providing preventive services and in promoting good health practices in schools, industry, the home, and in neighborhood health centers but this role has had less recognition than the role played in crisis related situations in hospitals. Increasingly they are assuming a primary care role, especially in pediatrics, in maternity care, and in the mental health field. We submit that increased involvement by nurses in pri-

mary care and greater emphasis on the primary care role of the nurse can result in helping people enter the health care system: before there is evidence of serious pathology.

The responsibilities of the registered nurse include the following which undergo a continuing evolution and expansion:

Maintaining and assisting in restoring such body functions as respiration, elimination, nutrition, locomotion, rest, sleep, relaxation, circulation, and communication.

Observing, recording, and reporting changes in the condition of the patient.

Determining an individual's need for care.

Providing safe and effective administration of medications and medically prescribed treatments.

Health teaching about diet, hygiene, rest, disease process, prevention of disease.

Providing emergency measures in such situations as hemorrhage, fractures, prescriptions, delivery.

Followup visits to patients to evaluate compliance with medical regime and the need for assistance in achieving activities of daily living, health teaching, and so forth.

Primary care can be described as being health oriented rather than illness oriented. More and more, education for nursing practice concentrates on maintenance of health and prevention of illness. Traditionally, education for medical practice has focused on pathology and the treatment of disease. These are complementary roles and appropriate to achieving the overall societal goals of keeping people well and curing the ill.

Thus we see the nurse expanding her practice in the area of health care, assuming responsibility for monitoring the growth and development of children, providing antepartal, intrapartal, and postpartal health, and screening and treating minor illnesses, following guidelines in normal pregnancies, counseling regarding physical and mental lines established collaboratively by physicians and nurses.

One health maintenance organization reports that of 4,500 visits made to its center, 65 percent were related to the upper respiratory problems, minor trauma, muscle pain and need for psychological support. Their experience indicates that 70 percent of these incidents can be handled by the nurse alone without sacrificing quality care and with full patient acceptance and approval.

For individuals with chronic illness guidance and supervision is essential to maintain a degree of health so they can remain at home in the community and out of the hospital. The nurse is the appropriate health professional to provide these services. A striking example of this type of nursing care and what can be accomplished is the case of an 18-year-old diabetic who in an 8-year period was never out of the hospital for longer than 4 months. She was hospitalized 124 times. Later, under nursing supervision for 7 months, she has had no in-hospital admission and only one visit to the emergency room.

A national health program will tax the health manpower resources of the Nation unless providers of services enter into a collaborative examination of the manner in which present health workers are re-

cruited, educated, utilized and compensated and make recommendations for modifications and the means for instituting change.

Optional utilization of the nurses' skills and expansion of her functions can be a very positive influence in a national program of health care. This is also true of other workers in the field. No single profession can meet all the needs for health services of all the people in the country.

While promoting the proper utilization of present health manpower and the expansion of the functions, it must also be recognized that to provide health services for over 200 million persons, there will need to be a very substantial increase in the number of workers in the health field.

Achieving an increase in health manpower calls for an expansion of existing schools and the creation of new programs with large-scale Federal financing of schools and student. The Congress has recently passed legislation that would provide such aid for nursing programs and their students. Appropriations to implement the provisions of the Nurse Training Act of 1971, and at a level authorized, are essential and institutional support is especially urgent in view of the possible early initiation of a national health insurance program.

As health manpower roles are modified there will be need for continuing education and additional education to keep practitioners abreast of changes. This will require enlarged governmental investment of funds.

It is our conviction that basic education, continuing education, and additional education of health personnel should be supported through general tax funds. Since these are for the broader public good, they should have a broader base of support. We believe the insurance fund should be separate and distinct and pay only for the health services people require and receive.

There are many areas of the country where the health manpower shortage is especially acute. We believe financial incentives—loan forgiveness, grants, higher compensation—to bring about redeployment of health manpower to those areas where there is a scarce supply, can have some impact.

However, health workers, like other people in our society, have professional, intellectual and social needs as well; and all of us must give some thought to how these needs can be met; to the end that all people will have equal access to health care.

The Federal Government should establish national standards governing health insurance coverage so that each citizen is assured equal benefits.

Further, providers who fail to meet quality standards or who are reluctant to do so should not be permitted to participate in a national health insurance program. When the Social Security Amendments of 1965 were enacted, with provisions for medicare and medicaid, Congress did indicate its intent that health services of high quality be provided to all. However, there has been a continuing effort to dilute standards for nursing service, especially the requirement for registered nurses in nursing homes. We submit that a facility without a registered nurse is not providing skilled nursing care.

The development of standards of nursing services and of nursing care is the nursing profession's responsibility and we trust the Fed-

eral Government would look to the profession for advice and counsel as it implements a national health insurance program.

We support the utilization review of services as a means of determining proper utilization and believe there should be a participation by nurses, with other providers, in determining the setting in which a consumer's health care needs can best be met at any given time.

Multidisciplinary utilization review in just one major hospital in the country was able to cut the average hospital stay from 17 to 12 days. Peer review of the quality of care is supported as a means of determining the effectiveness of care and should be required ongoing process. Each profession within the health field should have the responsibility, and be accountable, for developing standards of care. No one profession should be charged with the assessment of the quality and totality of care. Rather this should be a collaborative effort of all the disciplines involved.

The American Nurses' Association believes there should continue to be a system of State license for the practice of nursing. There has been increasing concern about State licensure of health personnel and demands that the system be reformed. It is charged that the varying requirements for licensure among the State inhibits the mobility of practitioners and contributes to shortages of health personnel in certain sections of the country.

While this may be a factor influencing the maldistribution of some health professionals, it would not be true in the case of nurses. We have a national examination and all nurse candidates for licensure take this examination. Nurses, therefore, have been able to move with relative ease from State to State, the original license being endorsed by States they may subsequently wish to practice in.

#### SUMMARY

The American Nurses' Association has based its comments today not on any specific proposal for a national health insurance program now before the Congress, but rather to what it considers are the essential elements of a health care system. These I will list for you and we urge your serious consideration of them as you develop this important and significant legislation:

1. Health care is a basic right of all people.
2. Government has responsibility for assuring through appropriate legislation the accomplishment of this goal just as Government has responsibility for assuring that other requirements for physical, mental, and social well-being of people are met, such as an adequate income, housing, food, and education.
3. There should be a partnership between the Government and the private sector to finance the health care system; with Government providing a stable source of funding for the purchase of comprehensive health insurance coverage for those segments of the population unable to provide for themselves.
4. The Federal Government should establish national standards governing health insurance coverage so that each citizen is assured equal benefits.

5. There should be integrated health care systems to deliver comprehensive health care services which are available, acceptable, and accessible to all people.

6. Integrated systems for delivery of comprehensive health care services for specified population groups should be developed from community health planning mechanisms in which consumers are involved.

7. As a system evolves there should be continuing opportunity for consumers to evaluate its effectiveness in meeting their needs.

8. Comprehensive health care consists of preventive, health maintenance, diagnostic and treatment, restorative, and protective services.

9. The general educational system of the Nation should prepare health manpower of all types in sufficient numbers to provide an acceptable standard of comprehensive health care services.

10. There should be joint planning by all health professions for recruitment, preparation, utilization, and compensation for health manpower.

11. There should be professional, intellectual, social, and financial incentives to bring about deployment of health manpower to those areas where there is scarce supply.

12. There should continue to be a system of State licensure for the practice of nursing which facilitates interstate movement of qualified nurses; and which permits optimum utilization of the professional nursing function in the health care system.

13. There should be provisions within a health care system for the nursing profession to fulfill its function according to established nursing standards; and to collaborate with other disciplines in evaluating health care practices.

I thank this committee for the opportunity to appear here today.

The CHAIRMAN. We thank you very much for bringing your testimony to this committee. Are there any questions?

Mr. Burke.

Mr. BURKE. I wish to commend you for your statement, Dr. Jacobi. It contains a lot of good commonsense, particularly with reference to your cutting costs of health care with the visiting nurses in the homes.

I believe that one of the reasons for the acceleration of health care costs in this country is the long stay in some of the hospitals and then in some of the extended-care facilities. When these people can be passed on to a lower cost facility, I think it should be done. When they can be sent home where a visiting nurse can take care of their needs, I think this should be done, and it would save hundreds of millions of dollars for health care throughout the Nation, and I want to commend you on that.

We have heard about a nursing shortage for years. If we move toward a national health insurance program, do you think we can expect to have the number of nurses such a program will require?

Dr. JACOBI. Enrollments in schools of nursing have increased and they are up this year. In order to provide the number of nurses, however, there are other considerations that must be made. Nurses sometimes leave the field to raise families, and so on. If we had day care centers or child nursery schools provided that would meet the needs for the working mother, this would be very helpful in allowing the mother to leave the home to go to work.

We are attempting to recruit nurses from the inner-city areas, from rural areas, and it is our belief that these nurses will return to those areas.

We are also attempting to increase the number of men in nursing, and we think that it will be helpful.

Miss HOLLERAN. I would agree with what Dr. Jacobi said. We have found a dramatic increase in the number of applications for nursing schools in recent years. I think the talk of a national health plan has stimulated the interest of many students looking for future careers, so if the schools have the resources with which to function, they will be able to recruit the number of nurses we need.

Mr. BURKE. I find in my congressional district that we have hundreds of young ladies who are trying to go into the nursing schools and they are having a great deal of difficulty.

Miss HOLLERAN. Some of the schools have had to cut back due to lack of funding and some have been unable to expand because of cuts in construction funds.

Dr. JACOBI. From the educationally disadvantaged group, there is tremendous need for remedial work throughout the educational program, and this adds to costs and demands on facilities and schools are looking for assistance in this area.

Mr. BURKE. I want to commend you for your work and your fine statement today.

The CHAIRMAN. Mr. Collier.

Mr. COLLIER. You said enrollments were restricted. Is it not a fact that funding for nurses schools and training has increased?

Miss HOLLERAN. It has been increased in the authorizing legislation passed by the Congress. We have not had an increase in appropriations. We are waiting now to see what the request will be.

Mr. COLLIER. You are not suggesting that the funding for these programs has not increased in years. The extent of funding has not been to the full extent of the authorization but the fact remains the funding has been higher.

Miss HOLLERAN. There has been a total increase in funding for nursing education. There has not been an increase in total institutional support for nursing.

Mr. COLLIER. We are talking about a cutback not in actual funding expenditures in recent years.

Miss HOLLERAN. We had a cutback of \$6.4 million this year in the President's budget as compared to last year for nursing and this was in the area of student aid.

Mr. COLLIER. A cutback from the budgetary figure from a year ago?

Miss HOLLERAN. From the appropriations figure a year ago. Also the full amount appropriated in August has not been released yet for student aid.

Mr. COLLIER. I quite agree that there is needed substantial relief in terms of getting more for the health dollar than we are getting.

In your testimony you alluded to refresher courses. Is it your thought these should be financed by the Federal Government, or would you assume the same position that teachers do during the course of the pursuit of their professional work for a master's degree, advancing not only their educational level but in fact advancing their ability to learn?

Dr. JACOBI. I think there are two types of advanced continual education, and one is preparation at the graduate level for specialized nursing, for teachers, supervisors and administrators. Then there is the other aspect of continuing education with the rapid changes in health science and medical science and in technology.

There is a need to keep the nurse up to date, and this is true of all professionals. Some of this requires Federal funding. Much of this is done through the individual's own interest in professional development.

Mr. COLLIER. So it would be a combination of the two.

Dr. JACOBI. That is right.

Mr. COLLIER. You suggest there has been an effort to dilute the standards for nursing services. As a matter of fact, hasn't that come about partly as a result of the necessity or because of the need for nurses, particularly practical nurses, in some instances, is such that you would not have adequate registered nurses available to provide all of these services at least in nursing homes at the present time?

Dr. JACOBI. This is true for certain sections of the country. However, there are areas where the nurse will not work in a nursing home because of the standards of care, the salary and so forth, and I think these are things that we need to change in improving standards of care.

Mr. COLLIER. Changing the salary is not something that this committee can do, as you know.

Dr. JACOBI. No, but the standards of care, I think, are something that need the cooperation not only of the profession but of the public as well.

Mr. COLLIER. I think that is being done, perhaps not as fast as we could like it but in terms of higher standards for nursing homes. Nursing homes have been closed for failing to meet certain standards I agree with you, but in some areas, and it may be down the road apiece because there will be enough licensed nurses to assume the full needs of those services which presently in many instances are being performed by practical nurses rather than registered nurses. Is that a fair statement?

Miss HOLLERAN. We have been unable to get data as to why certain institutions have not met the eligibility requirements. We are in no way able to determine whether it is because they have not been able to employ registered nurses.

Mr. COLLIER. The States in those instances set the standards for the operations of these homes.

Miss HOLLERAN. Yes, but the reasons they have been turned down could be a variety of reasons.

Mr. COLLIER. You are not able to ascertain all of the reasons if there is more than one?

Miss HOLLERAN. No. We have asked for the data from the Public Health Service as well and we have not been able to get it.

Mrs. GRIFFITHS. I think yours is about the best testimony I have heard as you sit here. You have considered every other group besides yours and that is quite unusual. I do commend you and I really feel what you have said about home care and homemaker care should be put in illuminated letters, because this is the best and cheapest care.

I was in North Carolina recently and I talked with a woman there in one school of nursing who had the feeling that funds for nursing

education were being cut back to give the money to paramedics coming out of Vietnam. In your judgment, is she right?

Miss HOLLERAN. The total appropriation request from HEW this year did reflect a cutback, some \$6.3 or \$4 million. The amount that is going to be requested for the new Nurse Training Act is hard to determine. It has not been released. We know the new legislation requests capitation for physicians assistants that would be located in medical schools at the level of \$1,000 per student enrolled. This compares to \$250 for nursing per student enrolled?

Mrs. GRIFFITHS. In general, the medical assistant is a male.

Miss HOLLERAN. Some have recruited registered nurses.

Mrs. GRIFFITHS. They have been given a few weeks training and a year of practical service in Vietnam.

Miss HOLLERAN. Some are baccalaureate graduates and others have had less than baccalaureate.

Mrs. GRIFFITHS. This is compared in many cases with nurses who have master's degrees.

Miss HOLLERAN. That is right.

Mrs. GRIFFITHS. What is the pay differential?

Miss HOLLERAN. In the Federal Civil Service at the moment especially for VA, when it was established a baccalaureate nurse comes in at GS-5. A physician's assistant-----

Mrs. GRIFFITHS. With less than a baccalaureate?

Miss HOLLERAN. Yes; starting at GS-7, and eligible to go to GS-9 on the basis of time and can go to a GS-11 on the basis of time. It is very difficult to get a nurse for clinical ratings to GS-11.

Mrs. GRIFFITHS. Thank you very much. I think this is very interesting testimony to bring before this committee because it describes a totally unfair situation. They are paying an additional sum and we are authorizing it for men who are not as well trained as nurses who have been well trained.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Pettis.

Mr. PETTIS. Thank you, Mr. Chairman.

You mentioned the value of home nursing and homemaker services in lowering health care costs, and in keeping sick people with their families. Just what kind of safeguards should this committee and the Government be thinking about to be sure that services such as this are not abused?

Dr. JACOBI. There should be the creation of utilization review committees and we would see this as a multidiscipline area including the consumer, and we think that building in these needs of review will offer some protection, including looking at the established standards.

Mr. PETTIS. You don't think that we will have some gargantuan bureaucracy involved here if we really do this right?

Dr. JACOBI. I suppose that is always a risk, but I would not anticipate this.

Mr. PETTIS. In other words, you don't think this can be done with existing mechanisms?

Dr. JACOBI. I think it is done in many home health agencies, a review with case conferences on patients' needs and identification of how these needs are met, and what the costs are.

Mr. PETTIS. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Vanik.

Mr. VANIK. I am very happy about the testimony brought out by Mrs. Griffiths. I think it raises a serious problem with the cutback in institutional training. You can't very well have a national health program unless you have training for the people we need.

From the standpoint of home service care, is there some provision whereby, for example, a patient who is comatose and tube fed, could be under the supervision of a nurse at home, or does this have to be done in an institution?

For example, when I could not afford hospital care or extended-care coverage for a patient, could it be possible to obtain the services of a nurse to provide tube feeding and the essential things to a comatose stroke patient in the home?

Dr. JACOBI. I can give a personal example. Recently my elderly neighbor was hospitalized, had been retained in the home. The 80-year-old sister was retained in the hospital to feed that particular patient because the professionals did not have the time, were not tuned into this patient, particularly the idiosyncrasies, and she died some days later. I think with nursing supervision—I happened to be dealing with supervision in the home as a neighbor and not as a nurse—this can be provided. I think the situation has to be evaluated. We need to know who is in a home, who can perform the services, et cetera, but I am sure there are many, many incidents such as I reported.

Mr. VANIK. This is a common problem, and it would reduce the hospital bill from \$75 to \$100 a day to the lesser cost of nursing home care.

Dr. JACOBI. It is amazing what can be accomplished when there is adequate supervision and support of the family members as well as adequate professional supervision.

The CHAIRMAN. We thank you very much for your very fine testimony. All of us agree it is very helpful.

Dr. JACOBI. Thank you, Mr. Chairman.

The CHAIRMAN. The Chair will call as the next witness Mr. Shep Glazer.

We are glad to have you with us, Mr. Glazer. You are recognized.

### **STATEMENT OF SHEP GLAZER, VICE PRESIDENT, NATIONAL ASSOCIATION OF PATIENTS ON HEMODIALYSIS**

Mr. GLAZER. Time will not permit me to read my full statement, so I would like to summarize my thoughts of the problems facing the kidney patient in America today.

(Mr. Glazer's prepared statement follows:)

#### **STATEMENT OF SHEP GLAZER, VICE PRESIDENT, NATIONAL ASSOCIATION OF PATIENTS ON HEMODIALYSIS**

##### **NAPH: ITS ORIGIN AND MEMBERSHIP**

The National Association of Patients on Hemodialysis originated in 1969. The formation of the organization was a natural result of something entirely unique in medical history: individuals facing a terminal disease were restored to life by a dramatic, virtually miraculous product of modern technology, the artificial kidney. The new life given to these individuals by hemodialysis, and the problems the treatment presented, gave them a common bond and the core of N.A.P.H. evolved.

N.A.P.H. membership today, consists not only of patients receiving dialysis, but of recipients of transplanted kidneys, the families of afflicted persons and professionals in the field of health.

Fifteen hundred vitally concerned persons receive the N.A.P.H. News. They are representative of the more than six thousand individuals currently receiving hemodialysis at this time. Hemodialysis and transplant programs have given us the potential to maintain these persons in the mainstream of American life as breadwinners, homemakers, taxpayers and valuable members of their communities. N.A.P.H. membership is national; its range incorporates a wide spectrum of the American people.

#### WHAT N.A.P.H. SEEKS

N.A.P.H. seeks to attain for all Americans, regardless of income, status or other personal limitations, the God-given right to life, now available through advanced medical technology, which is presently denied to a majority of our citizens. What signifies a majority, according to Dr. Benjamin T. Burton of the National Institute of Health, of the 7,500 people last year dying of chronic renal disease, 1,250 persons received dialysis treatment; 917 received transplants but 5,333 persons were permitted to die.

#### N.A.P.H.'S COMMENTS

Why were these 5,333 people allowed to die? They died because existing health programs have been proven inadequate. Our fear is that certain proposed legislation will be as unresponsive as the existing programs.

The alternatives we face are these:

(a) A State program similar to those now available in Maryland, Washington and New Jersey.

(b) A voluntary private program.

(c) A voluntary national program.

In N.A.P.H.'s estimation, none of these alternatives are adequate for the following reasons:

(1) **THE STATE PROGRAM**--If full coverage is available in certain states, kidney patients residing in states where assistance is unavailable, may be forced to relocate to these selected areas thereby placing an unfair financial burden on the taxpayers of these fortunate communities.

(2) **VOLUNTARY PRIVATE INSURANCE PROGRAMS**--In existence for over a quarter of a century, these programs are not only costly, but discriminatory. They have failed to satisfy the health needs of most of our citizens.

(3) **VOLUNTARY NATIONAL HEALTH INSURANCE**--Essentially divisive, a program of this sort naturally separates Americans into two categories; those who can afford to pay for the right to live and those who cannot.

#### IS THIS WHAT YOU ENVISION FOR AMERICA?

#### NAPH'S RECOMMENDATIONS

We are here today before this committee, to implore you to legislate in accordance with every conceivable standard of justice, equity and humanity. We are here to ask you to give the American people a comprehensive health insurance program which will fully protect them in cases of catastrophic illness. This is best illustrated by the National Health Security Plan as proposed by Senator Edward Kennedy and Congresswoman, Martha Griffiths.

A catastrophic illness is catastrophic only for those who cannot afford it. Despite the difficult life required of patients with kidney disease, over 5,000 dialysis patients have proven that if financial means are available, they can remain socially productive citizens. The inescapable fact, however, is that this treatment is beyond the reach of persons of average income.

The cost of hemodialysis treatment ranges from a mean figure of \$5,000 a year for patients on home treatment, to a mean figure of over \$20,000, a year for institutionalized care. Initially, the hemodialysis machine costs between \$2500. and \$3300. But, the consumable products for each treatment costs approximately \$85.00. The patient must have from 2 to 3 treatments a week to survive. (Approximately 15 hours per week.)

## A MATTER OF ECONOMICS

A national health insurance program will systematically lower these costs by inviting more manufacturers to enter the market place in the production of these vital products. This development would lead to expanded medical research, more employment and a new avenue for job training.

Ultimately, the treatment becomes self-supporting. By being able to return to their customary employment, patients can resume their role as taxpayers, circulate their money into the national economy and more than help pay back the cost of their treatment. A federal outlay might even be considered as a short term investment in human life with a guaranteed return.

## SOCIAL IMPLICATIONS OF HEMODIALYSIS

Financial coverage for hemodialysis must be considered a priority. We are addressing ourselves to an issue that involved 50,000 Americans, a figure projected by Dr. Belding H. Scribner of Seattle. Yet, Dr. Scribner tells us just 6,700 Americans, or 14 % of this total are living today on transplanted or artificial kidneys.

A National Health Insurance Program for all would ensure the desired stability of the home life of these 50,000 individuals and their families. It would allow thousands of young persons afflicted by renal failure to realize their potential. While N.A.P.H. is personally aware of dialysis patients ranging from age 6 to 80, the overwhelming majority of those stricken by renal failure are young adults. Dialysis can return these young adults to the tasks of raising their families and continuing in the careers they have prepared for.

Because of presently limited finances, dialysis raises many moral issues. Selection committees are forced to choose who shall be allowed to survive. This moral dilemma can be eliminated. To make dialysis more readily available to a greater number of people, a small number of satellites have been formed. A satellite facility is an out of hospital program which operates at a reduced cost. Often a simple storefront, it alleviates the congestion of a hospital center and provides a method of treatment for those unable to carry out their own care at home. The expansion of satellite facilities, which would be encouraged by a national health insurance program, would allow for more equitable distribution of necessary care. The expansion would be made possible by guaranteeing payment to those interested in providing this service. This has particular meaning in the development of rural medicine and the delivery of medical care in ghetto areas. In addition, if current methods of organ donation and transplantation were improved by uniform federal regulations, the tremendous cost of financing those with this disease would be greatly reduced as fewer people would require dialysis.

## MEDICAL RESEARCH IMPLICATIONS

The development of hemodialysis, in addition to saving the lives of victims of renal disease, has contributed additional dividends to medical science. The most obvious progress has been made in the field of organ transplantation. Because of kidney transplantation, great advances have been made in tissue typing and immunology, paving the way for the successful transplantation of other organs. This treatment has also enabled researchers to gain inroads into the causation of anemia, bone diseases, hypertension, neurology and endocrine disorders, to cite a few.

## SUMMATION

What we are proposing is not revolutionary. At least one state has recognized its responsibility to its citizens. Maryland has taken enormous initiative in this area. We ask that the following extract from the recent Maryland legislation be read into the record.

"It is hereby declared and found that one of the most serious and tragic problems facing the public health and welfare is the death of hundreds of persons in Maryland every year from chronic renal disease, when the present state of the medical art and technology could return these persons to a socially productive life. Advances and discoveries in the treatment of patients suffering from chronic renal disease now allow, not mere survival, but rehabilitation of these patients to their normal occupations and activities. Presently these patients are dying for lack of personal financial resources to pay for the expensive equipment and care which they need.

"The State hereby recognizes its responsibility to its citizens to allow them to keep their health without being pauperized and to use the resources and organization of the State to aid in gathering and disseminating information on the treatment of chronic renal disease. It is believed that these programs will, by making treatment of chronic renal disease easily available, steadily lower the cost of such treatment."

We ask today that you assume this same responsibility on a National scale and report and recommend National Compulsory Health Insurance.

Thank you.

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SENATE OF MARYLAND, BILL NO. 778

AN ACT To add new Sections 781 to 790, inclusive, to Article 43 of the Annotated Code of Maryland (1965 Replacement Volume and 1970 Supplement), title "Health", subtitle "Nursing Home Administrators", to follow immediately after Section 780 thereof and to be under the new subtitle "Kidney Disease Program", creating a Commission on Kidney Disease and providing for the duties and responsibilities thereof; providing for the duties and responsibilities of the Secretary of the Department of Health and Mental Hygiene in connection with the Kidney Disease Program; providing for State financial aid to certain patients under certain conditions and for repayment of the cost of such aid to the State under certain conditions; and generally relating to the Kidney Disease Program

SECTION 1. Be it enacted by the General Assembly of Maryland, that new Sections 781 to 790, inclusive, be and they are hereby added to Article 43 of the Annotated Code of Maryland (1965 Replacement Volume and 1970 Supplement), title "Health," subtitle "Nursing Home Administrators", to follow immediately after Section 78) thereof and to be under the new subtitle "Kidney Disease Program," and all to read as follows:

"KIDNEY DISEASE PROGRAM

"SEC. 781. It is hereby declared and found that one of the most serious and tragic problems facing the public health and welfare is the death of hundreds of persons in Maryland every year from chronic renal disease, when the present state of the medical art and technology could return these persons to a socially productive life. Advances and discoveries in the treatment of patients suffering from chronic renal disease now allow, not mere survival, but rehabilitation of these patients to their normal occupations and activities. Presently, these patients are dying for lack of personal financial resources to pay for the expensive equipment and care which they need.

"The State hereby recognizes its responsibility to its citizens to allow them to keep their health without being pauperized and to use the resources and organization of the State to aid in gathering and disseminating information on the treatment of chronic renal disease. This responsibility is discharged by the provisions of this subtitle, wherein the reimbursement and information programs are established. It is believed that these programs will, by making treatment of chronic renal disease easily available, steadily lower the cost of such treatment.

"SEC. 782 (a) The Commission on Kidney Disease is hereby created.

"(b) The Commission on Kidney Disease, hereinafter referred to as the Commission, shall be composed of twelve members. The members shall be appointed by the Governor, six at his discretion and six from nominations as provided below. Each member shall serve a term of four years and until his successor is appointed and qualified, except that in the initial appointments three members shall serve for one year, three for two years, three for three years, and three for four years and until their successors are appointed and qualified. No member shall be appointed to more than two consecutive four year terms. The members shall serve without compensation but shall be reimbursed for expenses incurred in carrying out their responsibilities as members of the commission.

"(c) Six of the members shall be appointed from nominations as follows:

Each of the following bodies may submit to the Governor, at least three months prior to the date for making appointments, a list of at least three names: The Kidney Foundation of Maryland, the Regional Medical Programs of Maryland, the Comprehensive Health Planning Agency of Maryland, the medical faculty of the University of Maryland, the medical faculty of John Hopkins University, and the Medical and Surgical Faculty of Maryland. If the list is properly submitted the Governor shall appoint a member from the names thereon. If the list is not so submitted, the Governor shall appoint, at his sole discretion, a member.

The six other members of the Commission shall be appointed by the Governor without nominations, provided that four of the members so appointed shall be laymen to the field of medicine and the final two members shall be appointed from the medical insurance industry.

"(d) When a vacancy on the Commission occurs for any reason, the Governor shall promptly appoint a person to serve the remainder of the term of the vacant seat. The Governor may exercise his discretion in the choice of a member to fill a vacancy.

"(e) The full Commission shall meet at least twice a year. If, for any reason, all twelve members are not present at meetings of the Commission, business may be conducted by the members present. A decision of the majority of the members present shall be a decision of the Commission.

"Sec. 783. The Commission shall have the authority to adopt and promulgate rules and regulations to enforce the provisions of this subtitle.

"Sec. 784. The Commission shall have the power to employ an executive director, one assistant, and two secretary-stenographers as the Commission deems necessary to perform its duties and exercise its powers. The compensation of the executive director and of such other help shall be as provided in the State budget.

"Sec. 785. The Commission shall :

"(a) set physical and medical standards for the operation of dialysis and renal transplantation centers. When such centers meet the standards and are approved by the State Comprehensive Health Planning Agency ; they shall be certified by the State Department of Health and Mental Hygiene. Patients treated at any uncertified center shall not be eligible for State aid for their treatments.

"(b) set standards, reasonable in terms of the purpose of this subtitle, for the acceptance of patients into the treatment phase of the program. Patients so accepted will be certified eligible for the medical assistance of the State, provided, however, that nothing in this subsection shall be construed to grant the Commission the power to set standards which would prevent patients from receiving any federal medical or financial aid.

"(c) institute and supervise education programs for the public and for health providers with respect to chronic renal disease and the prevention and treatment thereof. The Commission may utilize existing programs and groups for this purpose, whether or not such programs and groups are governmental.

"(d) annually evaluate the entire Kidney Disease program. An annual report of such evaluation shall be made to the Governor.

"Sec. 786. The Secretary of the Department of Health and Mental Hygiene shall designate such personnel as is necessary to carry out the provisions of this subtitle. The Secretary shall be responsible for :

"(1) the operation of this program within the standards set by the Commission

"(2) the disbursement and collection of funds as provided in this subtitle

"(3) keeping the Commission informed, through its executive director, of the progress of the Program and of any need for changes in rules and regulations. Only the Commission may make rules and regulations.

"Sec. 787. Any person who suffers from chronic renal disease and who resides in the State at the time of his certification may be accepted in the treatment phase of the program, provided that such person also meets the standards set by the Commission under Section 785 (b) of this subtitle.

"Sec. 788. The State may pay the certified cost for all medical treatment, for any cause whatsoever, of certified patients from the date of certification, provided that the treatment be rendered in an approved facility in the State of Maryland or in a dialysis or transplantation center which is approved as such by a contiguous state or the District of Columbia, or in an approved home dialysis program. The Commission may formulate rules relating to payment for such treatment outside the State of Maryland, and may include therein approval or disapproval of any outside center for purposes of State payment under this subtitle.

"Sec. 789(a) Any certified patient for whose treatment the State has paid, or in the person or persons liable for the debts of such patient, shall reimburse the State for the cost of treatment subject to the limitations in subsection (b) of this section.

"(b) No person or persons liable for repayment under subsection (a) shall be liable for more than the sum of:

(1) any proceeds of insurance, group health plan, or prepaid medical care, provided that such proceeds are paid to the insured and are paid by the insurer by reason of liability for the payment of the cost of medical treatment, and

(2) five percent of the adjusted gross income, as defined in the United States Internal Revenue Code for purposes of the federal income tax as amended from time to time, of such person or persons, less yearly premiums such person or persons have paid on insurance which resulted in proceeds under subsection (b) (1) hereof.

Nothing in this section shall be construed to affect any arrangement for payment of costs directly to a medical provider by an insurance company, group health plan, or prepaid medical care plan.

"(c) If a patient loses his certification as a patient under this subtitle, the person or persons liable for repayment to the State of the cost of care shall repay to the date of such loss as provided in subsections (1) and (2) of this section, but the person or persons so liable shall not be liable for any payment based on the portion of the insurance proceeds or adjusted gross income received after the date of the loss of certification.

"Sec. 790. An appropriation of funds shall be made each year as necessary to carry out the provisions of this subtitle."

Sec. 2. And be it further enacted, That this Act shall take effect July 1, 1971.

# naph news

National Association of Patients on Hemodialysis

Vol. II, No. 5, Sept. 1971

A Newsletter by and for Kidney Patients

## NAPH DEMANDS THAT HOW NATIONAL HEALTH INSURANCE BLUE CROSS COVER OUT BILLS AFFECT KIDNEY PATIENTS OF HOSPITAL DIALYSIS

BY WILLIAM HITCHFIELD

NAPH is taking on Blue Cross. In a mismatch that is reminiscent of David vs. Goliath, NAPH is attempting to convince the Associated Hospital Service of Greater New York (AHS), New York's Blue Cross, to change its coverage to include out of hospital dialysis treatments, i.e., at home or in a satellite unit. At present, almost all of the 74 independent regional Blue Cross contracts cover only in hospital dialysis. Each of the local Blue Crosses is a non-profit corporation licensed and regulated by the state in which it is located.

In a letter to Mark A. Freedman, M.D., Executive Staff Officer of AHS, Louis Galsbsky, President of NAPH, stated "Experts estimate that the difference in yearly cost between out and in patient hemodialysis may be as high as \$10,000. I urge you to recommend that Blue Cross change its policy to include out patients in its coverage of hemodialysis treatments."

### NAPH plans demonstrations

In the event that Blue Cross does not change its policy to cover out of hospital dialysis, NAPH plans to take more direct action to accomplish its goals. Representatives of NAPH will demonstrate to bring the financial problems of kidney patients to the immediate attention of Blue Cross. The tentative date is August 24th.

### Ohio Blue Cross acts

Recently, Blue Cross of Southwestern Ohio agreed to grant the same reimbursement for out patients at Kettering Memorial Hospital as they do for hospitalized patients. This plan is viewed as an experiment, and the results will be reviewed in 3 months.

### Galsbsky urges action

In a message to all those interested in fighting kidney disease, Louis Galsbsky stated, "I hope that all of you will take up the cudgel and join the battle for meaningful insurance coverage. Petition your local Blue Cross to change its policy. If enough patients make their voices heard, we can win this battle."

In the next issue, we will include complete details of NAPH's "Fall Offensive" against Blue Cross.

The 92nd Congress seems poised for action on the scores of health proposals now before it. Every major group in the health community has sponsored or endorsed a bill.

Proposed legislation ranges from complete coverage of all citizens for all health services in the Kennedy (S 6) and Javits (S 836) bills to coverage for only catastrophic illnesses as outlined in the Long (S 1476) and Boggs (S 191) bills.

For a chart listing all the bills, their supporters, the coverage, and the importance for kidney patients, write to NAPH Chart, Box 60, Brooklyn, N. Y. 11203.

At the present, no bill specifically excludes treatment for renal disease. All bills specify types of treatment covered (i.e., surgery, x-ray, etc.), location of coverage, amount deductible and amount of co-insurance, but none refers to specific types of disease. Some specify the types of treatment of kidney disease, i.e., out patient dialysis, are not covered because of limitations on expenses or facilities.

### Nixon Bill

Under S. 1623, the Administration bill, all employees would be covered by private insurance policies that meet minimum National Health Insurance Standards. Low income families below \$5000 for a family of four would be covered under the Family Health Insurance Plan, which would be paid for by the government.

Informed Government sources indicate the current interpretation of this bill would cover dialysis costs on an in patient basis only. **OUT PATIENT OR HOME DIALYSIS WOULD NOT BE COVERED BY THIS BILL.** The cost of transplants would be covered in full, in accordance with required deductibles and co-insurance.

### Kennedy Bill

Senator Kennedy's Bill, S. 6, has been endorsed by Walter Reuther's "Committee of 100 for National Health Insurance." Administration of this program would be by a Health Security Board, and all payments would be made by the Government. Financing would be from employer, employee and self employed payroll taxes. It also will stimulate some improvements in the health care delivery system.

The Kennedy Bill would cover the entire cost of dialysis, whether on an in patient, out patient, home or transient basis. It would also cover the entire cost for both the donor and recipient of a kidney transplant.

### Committee action

The House Ways and Means Committee will start hearings on various House Resolutions on National Health Insurance, according to Wilbur Mills (D Ark.), the Chairman. These hearings will last about a month before the Committee goes into executive session. The House is scheduled to recess in October, so it is doubtful if a bill will be reported out of committee before next session. Informed sources tell me that the Committee on Ways and Means will develop its own version of National Health Insurance.

Since this committee must approve all appropriation bills, it is unlikely that any action on National Health Insurance will be forthcoming until 1972. Then look for the big push before elections.

### What you can do

Mr. Roland Forner, the husband of a patient, has started a "Fight to Live Crusade" dedicated to ensuring the complete coverage of dialysis and transplants in National Health Legislation. He has collected thousands of signatures on a letter saying, "I, the undersigned, do not believe any health legislation should exclude treatment for chronic kidney disease patients or those requiring organ transplants." These letters are sent to him, and he forwards them to Washington, to the appropriate Representative, Senator, and the President. This campaign is working!

Everyone interested in helping kidney patients and fighting kidney disease should take action now. Write to Mr. Forner, 50 Arrowhead Drive, Newington, Conn., and he will forward your letter to the proper authority along with others from your district. Perhaps you might collaborate the statement to read, "I believe that any health bill must include coverage for dialysis, whether on an in patient, out patient, or home basis and must cover the full cost for both donor and recipient of a kidney transplant."

## EDITOR'S NOTEBOOK

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### NAPH NEWS

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Assistant Editor and  
Art work  
Legislative Correspondent  
Fund Raising Editor  
Staff

William Blackton  
June Crowley  
William Fitzfield  
Mary Ann Frey  
John Bond  
Richard Luusten  
Michael Sapperstein

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Corresponding Secretary Peter Kellman  
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The NAPH NEWS is the quarterly newsletter of the National Association of Patients on Hemodialysis (NAPH), a non-profit, tax exempt organization which serves the needs of chronic kidney patients. There are no paid employees in NAPH. Everyone is a volunteer. If you would like to become a member and receive the NAPH NEWS, please fill out the form below and mail it to NAPH, Box 60, Brooklyn, N.Y. 11203.

### Membership

- 1) Full member. Open only to kidney patients, dialysis or transplant. Voting privileges. Dues \$2 00/year.
- 2) Supporting member. Open to all others in the U.S. No voting privileges. Dues \$2 00/year.
- 3) Foreign member. Open to anyone (patients and others alike) outside of the U.S. No voting privileges. Dues \$4 00/year.

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Tell us something about yourself!

### NAPH NEWS SEEKS NEW EDITOR

The present Editor of the NAPH NEWS will resign a full college program in the Fall. Unless a new Editor can be found, the NAPH NEWS will have to curtail its operations drastically. Volunteers for such tasks as writing, typing, preparing for printing and mailing are also needed. If you would like to contribute your talents and energy, please call William Blackton at 212 663 6349.

We've been reading a good book called *The American Health Empire: Power, Profits and Politics* prepared by Barbara and John Thurnhach. It's a paperback published by Random House and costs \$1 98. Written in a clear and compelling style, it analyzes the health care system in the United States and explains in detail why patient care is deteriorating, though costs are skyrocketing. Dissolving the huge organism which is the American Health Empire, it isolates the economic and political factors which motivate and control the various parts: the medical supply companies, government agencies, Medicare, Medicaid, Blue Cross, private insurance companies, the A.M.A., and last but not least, the consumer. The viewpoint of the book is definitely left of center, but it's still a good primer for anyone interested in health care. It's especially valuable for kidney patients, who are so intimately involved in the health care system. They, more than any other group, are aware of the system's "short comings" and are committed to finding a better solution.

In the next few years, treatment of chronic renal disease will become simpler and more efficient. The use of adsorbent substances which trap waste products and thus remove them from the bloodstream is being perfected in laboratories all over the world. Some adsorbents, such as oxidized starch, are swallowed and work through the intestines. Others, such as activated carbon (like a cigarette filter) are used in conjunction with kidney machines. New dialyzers that use encapsulated dialysis cylinders are about as large as a suitcase and require only about 2 liters of dialysate. Two patients in California have successfully used such a machine for 9 and 10 months. Look for more developments in the future.

About 8000 patients are on dialysis in the U.S., according to the National Dialysis Registry of the National Institute of Arthritis and Metabolic Diseases. Fourteen hundred of these are on home dialysis. More than 1300 patients are dialyzed at V.A. hospitals or under V.A. auspices. In the last year, 2000 patients received transplants or were put on chronic dialysis. This is far below the number who could have been helped, however. The National Kidney Foundation estimates that 58,000 people died of end stage uremia last year in the U.S.

More good news for coil users! Baxter Labs has just announced that it is reducing the bulk rate cost of a coil to \$13 95 from \$16 95 and the rate on smaller quantities to \$16 95 from \$20. This could save you about \$400 per year.

## OUR ROVING CORRESPONDENT

### DIALYSIS PATIENT VISITS MEXICAN RUINS

By John Bond

I've always been interested in archeology, so when I had a chance to visit the Pre-Columbian Mexican ruins of Chi-Chen Itza, Uxmal (pronounced oosh mahl) and Kabah, I couldn't pass it up. I'm dialyzed every third day, so this posed a problem. But my doctor checked me out and gave me the green light.

I dialyzed early Friday morning, then flew to Tampa and joined the rest of the group. We caught another plane to Mexico and were in the hotel by 8 in the evening.

Early Saturday, we rode some 30 miles to Chi-Chen Itza. It was the end of the dry season, and it was as hot as a Turkish bath.

The ruins here cover some miles with dozens of large stone structures, only a handful of which have been reconstructed. The sheer size of the monuments and the distances between each building indicate this was a huge city in its heyday. Traversing the grounds and climbing the steep stairways challenges even the hardiest tourist. For me, it was a feat!

I sweated profusely, which probably helped my body rid itself of water and salt. After climbing up and down "The Castle" (the largest rebuilt pyramid here), a tourist will gladly pay 50¢ for a Coke. I was no exception.

Our guide, "Pinky", kept up a grueling pace, all the while feeding us a thickly fact-studded lecture on history, folklore and architecture.

Monday was for sightseeing, and on Tuesday, we flew back home. Everyone, myself included, thought I'd be a physical wreck after not being dialyzed for such a long time. But I was in good shape and cheerfully rode home to a 6-hour dialysis (I usually run 5 hours). All the while in Mexico, I ate and drank normally, being careful only to drink distilled water. I suffered no ill effects at all and had a wonderful time.



## TRANSPLANT PATIENTS DESCRIBE THEIR EXPERIENCES

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Many dialysis patients are interested in the possibility of a transplant but hesitate because they don't know what it's like to have one. It's unknown territory to them. The NAPPI NEWS contacted transplant patients successful and unsuccessful all over the country and asked them to give personal accounts of their experience being very honest. Here, then, are some of the reports we received from these travelers in the Land of Transplant.

This is not a random sample, by any means. These reports represent only a few of the many different types of experience which are possible with a transplant. In future issues we will publish more of these accounts. We invite all transplant patients to submit their experiences to the NAPPI NEWS for publication.



Dear Sirs:

I am happy to tell you of my experiences as a transplant patient. It was over 3 years ago that I received this kidney. It was from a cadaver. I had been on dialysis for about 2 years at the time.

When they called me to the hospital, I was at the racetrack. It sure was a lucky day for me!

To the Editor:

When I was first asked to write an account of my experiences as a transplant patient, I hesitated. I didn't want to sound like I was feeling sorry for myself. But then I thought that it's more important that people know what a transplant is really like, so I'll tell the full story.

I got my transplant from a cadaver back in December 1969, and it went pretty well for the first few months. I started to gain weight from the medication, especially in my face and around my waist. But I was very happy. Then, after about 3 months, I started to have rejection. I ran a fever and had a few pains around the kidney. But they stopped the rejection with higher doses of prednisone and Imuran. The only thing was, this started to cause some side effects. I got cataracts in my eyes, ulcers in my stomach and abscesses on my skin. I had to limit my sugar and salt intake, too. My pancreas wasn't producing enough insulin and my blood pressure was high.

For about the next 7 months, I still had to stay on pretty high doses of medication, so the side effects stayed with me. I felt pretty bad. Then, around January 1971, the kidney started to reject again. It got so bad that they just had to take it out. They gradually took me off the medication and I went back on dialysis. The side effects slowly started to go away, and I now feel about the same as I did before the transplant. Now, I'm waiting for another one.

John Redmond  
Trenton, New York

Wilma Bookrick  
Illinois

## V.A. PATIENT SPEAKS OUT

Dear Fellow Patients:

I'm a home patient out of the Boston Veterans Hospital. The V.A. has been wonderful to me and I can't praise it enough, but it is a bureaucracy, and some people love to tug the wheels of progress.

Some of the patients' attitudes seemed a little odd, i.e., after coming into the unit blind and unable to walk and being made whole again, they would snap at the nurses and refuse to help them do little things like opening syringe packets. But after a while, I realized that if I had lain there 9 hours a day, 5 days a week for several years waiting for a kidney, I'd be a little funny, too.

When I came home, it was a tremendous psychological boost, even though I had been in the hospital only a few months. So to me, home is THE WAY TO GO. Thank God I have a wonderful, patient, cool-headed wife who is an R.N. I still have a kid and wouldn't go any other way. I can live with the shirt as opposed to the tystula. But, to each his own, and a cool head beats young. So, I hope to have a 6 hour Max Kil.

**HELPFUL HINTS:** For Kil users: Keep a pan of water in the closet where you store your mem-branes. It'll prevent them from drying out.

I write to everyone, from the President on down. Senators, Congressmen, V.A. people. And I talk to any person or group who will listen. A transplant patient and I have put together a slide lecture. I even man a Listening Post Hot Line on weekends to help people who are up against it and want to talk it out to someone who has been down the path before.

I tell everyone who will listen that some politicians, notably our wonderful President, want to exclude hemodialysis from this proposed National Health Plan. Dialysis costs \$750 a week in Boston Civilian Hospitals. What are the poor to do when the money runs out??? When we build moon-buggies at \$6 million apiece that an old cold from blacksmith up in Maine could put together for a few thousand, our people down on Earth are dying.

After I wrote a letter to the Worcester Telegram and Gazette, a poor old lady, 59, called me and offered me one of her kidneys. When people know the need, they will give of themselves to tick this kidney disease and awaken the drone politicians that don't give a damn. Another lady called and said she, too, knew how it felt to have the government tug pulled out from under her. She wanted to tug together with me. This is great. Instead of living back feeling sorry for ourselves, we have to write and talk and fight.

We need Satellite Dialysis Units, civilian and V.A. We need publicity to encourage people to donate their organs. Maybe we could give tax exemptions for this. Some of the politicians seemed sketchy about this, but they wouldn't if they faced death through renal failure and couldn't get a donated kidney or couldn't get on a dialysis program or had their guts torn out by immunosuppressives.

Rally round, people! With this new crop of 18 year old voters, we can show some of these ding a long politicians where the bear went in the buck wheat. Write and keep on writing.

One thing more: Never underestimate the power of prayer. If a whole big bunch of people from Maine to Connecticut to Massachusetts to New Jersey to Virginia hadn't prayed for me, I'd never have made it. The doctors were guided by Him. I was anxious and oh, so terribly tired. But I was never afraid.

Richard Fuller  
Southbridge, Massachusetts  
(A Down East Yankee that's had the course)

P.S. I am now working on a book that will tell it like it is with kidney disease—good and bad. It's called TIC: A Story of Renal Failure and the Reconstruction of a Man.

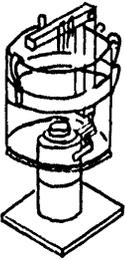
## RESEARCH AND TECHNOLOGY



## DEVICE PERMITS PATIENTS TO REUSE COILS

A device has been developed which permits a patient to use the same coil up to 6 times and the same arterial lines up to 3 times. The system, which is produced by Medigenix, Inc., of Brooklyn, N.Y., is compatible with all existing artificial kidney machines using coils.

After the patient comes off the machine, the coil is infused with a sterilizing solution containing formaldehyde and is hermetically sealed in a plastic chamber. It's stored there until the next dialysis. No refrigeration is needed.



Use of this "regeneration system" lowers the per dialysis cost of disposables to \$9.45, a savings of \$13.45, based on current bulk purchase costs. The estimated purchase price of \$385 would be liquidated by savings in 10 weeks of dialysis.

As of August, 1971, the device has been used by about 15 patients in 5 hospitals in the New York Area: Lenox Hill, Elmhurst, Brookdale, Prospect Heights and Maimonides. The inventor, Dr. Donald Snyder, the Chief of Nephrology at Maimonides, has used it extensively with his patients and reports excellent results. Urea nitrogen dialysance is fairly constant (between 180-200 cc per minute) for up to 6 uses of the same coil.

Patients must have their doctor's OK before they can use it. If you're interested, have your doctor contact Medigenix, Inc., 4324 Twelfth Avenue, Brooklyn, N. Y. 11219.

## PRICE OF A COIL REDUCED TO \$7.25

The Kidney Coil Exchange Foundation (KCEF) can supply individual patients and dialysis units with artificial kidney coils similar to the Travenol 115 for only \$7.25 per treatment. Defective coils are replaced at no cost. Up to \$500,000 of insurance is provided to cover any problem which can be directly attributed to a defect in the coil.

KCEF's price is so low because they salvage disposable coil materials and recycle them. Meeting 3 or 4 times a week, a staff of 40 volunteers rebuilds coils using recovered materials: the plastic core, supporting mesh and the feeder tube guides. Rent free workshop quarters are provided by the First Baptist Church of Westfield, New Jersey.

Sterilization is carried out by a commercial service group which uses a technique developed for and currently in use at the Mayo Clinic. Sterilization certificates are provided by an independent laboratory where, in compliance with USP 18, bacteria count, pyrogen reaction and safety tests are conducted. Certification, in writing, accompanies each lot of coils.

The technique of rebuilding dialyzer coils has been used for the last 6 years by the Dialysis Unit at the Mount Sinai Hospital, Cleveland, Ohio. Raymond McFarlane, the founder of KCEF, simply applied the principles used by Mount Sinai on a large scale. After 18 months of careful study of the problems of kidney patients, he came to the conclusion that the dialyzer coil is the major recurring item whose cost can be significantly reduced.

In June, 1970, KCEF was born. It went into full scale operation in March 1971 after an initial period of training and construction. As of August, 1971, 65 treatments have been performed with KCEF coils on 9 patients at St. Joseph's Hospital Dialysis Unit in Yonkers, New York.

KCEF sends the patient 12 coils to start with. After each dialysis, he unwinds the coil and saves the reusable parts. After 6 coils have been used, he sends them all back to KCEF. When they are received, KCEF forwards the patient 6 more coils with an invoice for the coils that have been used. They keep an emergency supply of 6 coils on hand in their warehouse for each participating patient.

If you want to avail yourself of KCEF's services, first contact your doctor and have him write for their literature, which gives detailed information.

Dialysis patients can help KCEF by sending them the coils that are found to be defective before blood gets into them, i.e., those that burst on start up.

Other volunteer groups can start Kidney Coil Exchanges of their own. KCEF will advise any non-profit group which is interested in rebuilding coils and will provide training for the workers. No special talent is needed to rebuild a coil. About \$3,000 of equipment is necessary, but this figure is flexible. Thirty minutes of labor is required for each coil.

KCEF plans to reduce the price of a treatment to \$6.00 by November '71 and \$5.00 by March '72. And tests being performed now will enable them to reduce their low (5 per cent) rupture rate even further in the future.

Other plans call for the procurement of dialysis machines, the training of personnel to operate them and the providing of other critical supplies at low costs.

For more information, write to KCEF, 626 Mave Street, Westfield, N.J. 07090 or call Raymond McFarlane at 201-232-8798.

## RMP HOLDS RENAL WORKSHOPS

A series of workshops on various aspects of kidney disease is being planned under the auspices of the Regional Medical Program in New York. The first workshop, which will be on home dialysis, will be held on Saturday, November 13th, from 9-12 A.M. at 2 E. 103rd St., Room 21. Future Workshops will be on renal transplant, post-atrial renal failure, and the nephrotic syndrome. A separate series of dialysis workshops for nurses is also being planned.

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## FUND RAISING

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# SUNNY REPORTS FROM SUNNY SOUTHERN CALIFORNIA

Editor's note: Mary Ann Frey is the mother of an artificial kidney patient, Fred Frey. She's very active in kidney projects in Southern California and is the Editor of her own local newsletter for IAK (Transplant and Aid for Kidneys), an organization which raises funds for research. We signed her on as our Fund Raising Editor, and she'll have a regular column. She'll coordinate the fund raising news from all parts of the country. Send in your news items to the Fund Raising Editor, NAPH NEWS, Box 60, Brooklin, N. Y. 11203.

Here's her first report, a summary of news from the Southern California area.

Less than 2 years ago, Mr. & Mrs. Saul Ball, both of Sherman Oaks met with a small group of people interested in aiding victims of kidney disease. They founded and chartered IAK, which has raised close to \$5,000 in spaghetti dinners, boat rides and cabaret evenings.

Under the direction of Leonard Gostlieb, the Southern California Kidney Foundation was chartered in June 1970. It, and also publicity through kidney problems before the public, and chapters were formed. Our son, Fred, will receive a home machine through the Save a Life Program. Happy to report that he lives a fairly normal life with his wife and children and works 45 hours a week at a plantain in Woodland Hills.

Here are some reports from the luncheon meeting at the International Hotel, with the guest appearance of Floyd Bridges. This year's tennis tournament netted \$6,000. The sale of Christmas cards brought in \$15,000. Four hundred persons were processed at the Westside Chapter's Detection Day Clinic. And thus far, 16 machines have been donated to patients by the S. C. Kidney Foundation, aided by gifts of \$17,000 and \$50,000.

News of local SKKI chapters and kidney patients: RIVERSIDE: Chartered only this past March, they have already bought 2 kidney machines and are collecting Betty Crocker Coupons for a third. All this was instigated by Mrs. Lynn Bortwick, a transplant patient who says, "When God gives you a second chance, you have to make the best of it." VALLEY: GLEED staged a carnival and a dinner auction, and they plan to buy a dialysis machine to a teenager and is about ready to give another. DR. RICHARD MACSINCH is responsible for getting more doctors interested in dialysis. Himself a dialysis patient, Dr. Macs is never too tired to give informative pep talks to people who care.

Dear readers: Please send me the particulars of your club's fund raising efforts and I'll write 'em up. I'll next time.

Mary Ann Frey



### HIGH SCHOOL CLUB DONATES MACHINE

The Key Club of Hastings High School, Hastings, on Hudson, New York, a group of 10 dedicated young men, has raised \$3000 to buy a kidney machine for St. Joseph's Hospital's Renal Unit. Last December, we reported that the St. Joseph's Unit was in danger of closing if \$30,000 could not be raised in time. The Key Club learned of the situation and organized a fund raising drive with film shows, rummage sales and collection of old newspapers for recycling.

Dr. Martin Stein, Jr., the Chief of the Dialysis Unit at St. Joseph's said: "At a time when there is so much adverse publicity about the south of this country, I think an outstanding effort like this deserves extra attention and these individuals are to be commended for a wonderful contribution to their fellow man."

### NATIONWIDE

It's Truck or Treat time again! Local Kidney Foundations all around the country are sponsoring the sale of Truck or Treat candy to provide funds for their activities: organ donor programs, research grants, medical information and referral services, drug and blood banks.

The candy costs \$1 per bag and 12 bags are in a case. They'll ship it on consignment, with free delivery for an order of at least one case.

For more details, contact your local Kidney Foundation.

### OHIO

The Kidney Foundation of Central Ohio, with the help of \$500,000 redeemed Betty Crocker coupons, recently purchased 2 dialysis machines for hospital use.

This currently have 8 home units on loan to patients at no cost. When no longer needed, the units will be returned to the Kidney Foundation for servicing and will be loaned out again.

Kidney patients from Central Ohio have recently organized the Buckeye Chapter of the NAPH—the first group of its kind in the area.

### FLORIDA

People in the State of Florida are waging a veritable war against kidney disease. Recently, the State Legislature passed a bill establishing an 11-member board to advise the Department of Health and Rehabilitative Services on its kidney programs. An appropriation of \$100,000 was requested.

In the Jacksonville area, the local Kidney Foundation is trying to convince the city government to allocate \$35,000 for a plant devised by its Health Planning Council that would establish a home training unit at the new University Hospital.

The Kidney Foundation has set up a fund to finance the unit. Their goal is to train 12 patients in the first year, which will require \$100,000.

A 17-year-old patient in Jacksonville, Karen Robinson, recently received a transplant which was paid for by an intensive \$35,000 fund raising drive. Friends, jobmen, civic, social and professional groups, and countless high school students contributed time, effort and money to the campaign. When \$45,000 had been collected, \$10,000 more than they needed, another fund was set up to help other kidney patients.

### BOSTON

The Second Annual Nady Alexander Memorial Symposium on Dialysis and Transplantation was held on June 26, 1971 at Peter Bent Brigham Hospital in Boston. The proceedings began with a speech by Dr. George Baltes, who is associated with the Brigham Kidney Unit and is the Chief Director of the New England Regional Kidney Program. During the 2 hour meeting, doctors, nurses, and other health professionals spoke about advances in kidney research and development, and government and community interest in kidney disease. Topics included techniques of renal reuse, explanation of a new method for freezing blood for transfusion, a review of new dialysis equipment and interpretations of the roles of Federal and State agencies in the treatment of kidney disease.

NAPH was introduced and explained by Mrs. Bennett Kivel, wife of a patient in the Boston Area. According to another patient who was present, everyone showed great interest in NAPH and enjoyed the newsletter.

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To the Editor:

Enclosed is our donation to the Samuel Ockstein Memorial Fund.

We remember meeting Sam in the summer of 1960 when he brought his son Jerry to enroll in Purdue. We were very taken by Sam's friendliness and became close friends of the family. During the last seven years when Sam learned to live with the kidney machine, we came to realize how wonderful a person he was.

We first visited him in Goswinger Hospital in Danville, Pa. He was then already dreaming of bringing kidney machines to the New York Area and making it possible for everyone rich or poor to have the treatment.

When we next came East he was sitting up proudly in the Dialysis Unit of Kings County Hospital that he had helped create. He was giving out advice to doctors and patients alike with humor and insight. Sam, a natural *kibitzer*, gave courage to those around him because he led a vigorous life in between his trips to Kings County. He never slowed down, making each day count.

Because he loved his fellow man, the idea of establishing a fund in his memory to help others in a similar situation. His name will continue to be a blessing to all who enter the Kings County Dialysis Unit.

His children and a wonderful wife may be justly proud that Sam will continue to be a real force in the development of his dream project to help others suffering the same ailment.

My husband be a blessing and a source of life. Most sincerely,

Rabbi and Mrs. Gerald Engel  
The Rabbi is the Director of the  
B'nai B'rith Hillel Foundation at  
Purdue University.

To the Editor:

We enjoy the NAPH NEWS so much I thought your readers would like to hear about this unusual incident.

My husband is dialyzed on a Kid kidney. Just before retransfusing the direction of the dialysate has to be changed. This is done by simply switching the tubes. Then the venous end of the kidney elevated so that any trapped air can get out. One day last summer when we had arrived at this point, Jim hollered, "Hey, what's that in the dialysate line?"

I could not believe my eyes when I looked and saw a cricket! I know it was too big to have gone through the kidney, and I still have no idea how it got into the line. Other than a little psychological trauma, no harm was caused by the incident.

Sincerely,

Mrs. James Sinclair  
Charlotte, North Carolina

## LETTERS



Dear fellow patients:

I started dialyzing in November, 1967 and went on-line as an out-patient in December. I am now using my second kidney machine with grateful thanks to the Kidney Foundation.

After going home I went into the lab prescribed by the hospital doctor, and I began to experiment with alterations of the regular recipe. I ate up only a few good ideas, and I would like to have the best of them with you. I wrote them up in booklet form with the amounts of protein, sodium, and potassium listed for each serving. There are four main dish recipes, one cookie recipe, and one salad dressing recipe.

Unfortunately, I must recover my costs for paper, printing, etc., and I must ask that you include 50¢ and a large No. 10 size envelope with your request.

Phil Holden  
P. O. Box 987  
Foster, Ca. 95321

To all patients: Be sure you alter your diet in any way, consult your own doctor or dietitian. Don't get reckless with your health!

To the Editor:

We enjoy the NAPH NEWS. It is full of joy and sorrow, which is our way of life since George's (my husband's) kidney failure.

He received a transplant on June 16th, 1971, and if he can make it through an unforeseen development of pulmonary embolism, he should be the happiest man alive. Before the transplant, he was on center dialysis (Albany Medical Center) for 1 1/2 year and home dialysis for 2 years. He is a very brave, hard fighting man.

It is a shame that besides battling kidney disease itself, we've got to fight with Blue Cross, Blue Shield and the other insurance companies to pay for the treatments and operations. We are lucky to have this coverage at all. But I hate to think of the people who don't.

Mrs. George Eden  
Catskill, New York

To the Editor:

Thank you for the NAPH NEWS. Especially enjoyed the article "Home Dialysis: Blessing or Struggle" which appeared in the last issue.

Home dialysis is indeed a blessing for us. We're just one big, happy family of 4—the kids and the father. We have been dialyzing my husband in our basement for 3 years now. It has come to be so routine that we rarely realize how "different" we are.

One day recently, our 3-year old daughter (Tara) showed how she has accepted the kidney. She was over in her brother's basement for the first time. With a very worried expression on her face, she asked all over and asked, "Will, where do you guys keep your kidney machine?"

Yes, it certainly is a blessing!  
Mrs. Paul Donovan  
St. Louis, Missouri

To the Editor:

The June '71 issue was very interesting, especially the article on home dialysis. It's very reassuring when you hear about others who are in the same situation. I agree that the entire family should be involved. Our children can set up the machine, do hemostatics, change bathy, and take blood pressures. Every visitor (even a salesman) is introduced to the machine and is told how it works.

Education of the public will help all patients. Families should get informed and involved. I know a 19 year old boy whose mother is dialyzed 4 times a week in the hospital. He thinks that she'll die after a year because he was told that she'll have dialysis for only that time. (She's waiting for a transplant.) When I explained things to him myself, he was relieved and took an active interest in dialysis. He even wanted to explain it to his classmates.

Keep up the good work.

Wife of a patient  
Massachusetts

## NEWS BRIEFS

The decision to withhold \$34.5 million from the Regional Medical Program is being reviewed by the White House.

The Department of Health, Education and Welfare appropriation request includes \$20 million for renal disease. This would pay for the facilities, manpower and services required in setting up demonstration projects in dialysis and transplant.

## NEWS OF NAPH

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## SPEAKERS HIGHLIGHT NAPH MEETING

## SPEAKERS HIGHLIGHT NAPH MEETING

The NAPH held a general meeting on June 13, 1971 at the V. A. Hospital in Manhattan. Patients from all over the New York Area attended, and there was a strong sense of unity expressed at the proceedings.

Leading off the meeting, Louis Gubofsky, the President of NAPH, spoke about the desperate financial plight of dialysis and transplant patients all across the country. He outlined NAPH's plans to attempt to persuade Blue Cross to amend its coverage to include out patients, i.e., home and satellite unit patients. (See story on p. 1)

This was followed by a symposium on end reuse (see Stories under Research, p. 3). The guest speakers were Raymond McFarlane of KUF and Miss Diana Ondrejok of Medgenex, Inc. Both gave demonstrations of their products.

The final speaker was Miss Judith Casey, R.N., Chief Nurse at the Elmhurst Hospital Dialysis Unit in Queens, N.Y. The biggest problem in dialysis patient care, according to Miss Casey, is dietary management. Many of her patients eat and drink more than they should, resulting in weight gain and overhydration. Another patient problem that nurses must deal with is the initial shock and depression a patient experiences when he first goes on the machine. However, this soon disappears, Miss Casey says, as the patient realizes that most dialysis patients can live fairly normal lives.

The next NAPH Meeting will be held on Sunday, September 12th, at 2 P.M. The exact location will be indicated on a postcard mailed to you. For more information, call Louis Gubofsky at 212 475 9832 or Shep Glazer at 212 225 7473.

## A MESSAGE TO ALL LOCAL CHAPTERS FROM THE VICE PRESIDENT

Dear local chapters

NAPH is a federation of local groups. Although we are a national organization, most of our activities are on a local level. Patients can deal most effectively with those problems that concern them directly. This is the strength of NAPH. By uniting local chapters and providing a common bond of information, NAPH achieves integrity and solidarity.

Local chapters should plan their programs to meet the needs of their own patients. We urge you to petition your local Blue Cross for a change in coverage, as the story on page 1 explains.

Other groups who wish to form local chapters should contact me and send a list of members' names. I will send you a copy of the National Constitution and By Laws.

Keep up the good work, all of you!

Shep Glazer  
Vice President

## NAPH GOES ON CBS RADIO

During the last week in June, a panel of people representing NAPH was featured in a 9 minute broadcast on WGBS Radio in New York. The panel was headed by Shep Glazer, the Vice President of NAPH, and his wife Charlotte, Lancelot Nichols and Sidney Warschaw, both kidney patients, and Dr. Eugene Schupak, the Chief of Elmhurst Hospital Dialysis Unit in Queens, N.Y. also spoke. Robert Vaughn moderated the program, which were produced by Mike Tullum.

During the discussions, the panel explored the problems of kidney patients and explained how NAPH is dealing with them. The subjects covered included the high cost of treatments, the emotional problems of kidney patients, the difficulties in employment, and the question of transplant vs dialysis.

After the programs were aired, CBS and NAPH were contacted by people from all over the New England Area. Additional broadcasts were scheduled because of the large response.

In the future, NAPH plans to extend its public relations campaign to other media, including TV and magazines. NBC and David Susskind (Metromedia) have been contacted, and they have shown interest in NAPH. Time Magazine is also interested.

## DIALYSIS PATIENT WITH MACHINE IN TRAILER HAS UNLIMITED HORIZONS

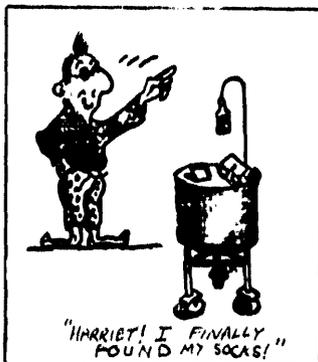
The list of dialysis patients taking to the road in trailers, becomes longer every day. Mr. F. C. Stemmions, 52, of Denver City, Texas recently made his "shakedown cruise" from his home to Galveston for one of his periodic check ups at the University of Texas Medical Branch.

"I got the idea for putting the machine in a travel trailer about 2 years ago," he recalled. "And I have been working on the idea since then. It only took about 15 minutes to take the machine out of the trailer after our trip. The machine (a Kult) is bolted down to the floor on 1-bolt. The men at the Southwestern Public plant and friends helped after the trailer for the machine."

As long as Mr. Stemmions has the chemicals necessary, water tanks, refrigeration and electric hook up, he feels that his horizons are unlimited. "The only real problem we had was insurance. The insurance companies just will not give us trip insurance because the machine is in the trailer."

The fact that Mr. Stemmions and his wife can now travel in a trailer is all the more remarkable because back in 1969 the doctors had lost all hope for him. He had 2 unsuccessful transplants, surgery to remove 1/4 of his stomach for bleeding ulcers, and a heart attack. But his tremendous courage and zest for life pulled him through. He and Mrs. Stemmions now look forward to many more trips in the future.

INGENUITY DEPT - An enterprising teacher makes African jewelry out of the metal discs on top of used saline bottles.



## “WHAT CAN A CHAPLAIN DO FOR ME?”

(Editor's note: David Williams is a hospital chaplain who has worked with dialysis and transplant patients at Massachusetts General Hospital in Boston. At present, he is a divinity student awaiting ordination. He has agreed to try to answer questions of a personal or spiritual nature from dialysis or transplant patients of all faiths. If you would like to correspond with him, write to David Williams, care of NAPH, Box 60, Brooklyn, N. Y. 11203. Here's his introductory statement.)

While on dialysis, have you ever just felt like letting out with a good scream? Or have you ever asked yourself, "Why is this happening to me?" Has it ever seemed unjust that you of all people should have to endure dialysis while so many other people go through life without a care in the world?

People on dialysis have asked me questions like these, and together we have struggled to find some of the answers, though there do not seem to be any, at times.

Problems of a personal or spiritual nature like these need to be talked about and shared. But sometimes patients are reluctant. When a chaplain calls on a patient in the hospital, the first thing he thinks is, "Oh my God, I'm going to die! Otherwise why would he be here?" Nothing could be further from the truth. The chaplain is interested in you as a total human being and is very much involved in the business of life. He wants to see people live their lives with dignity, meaning and a sense of joy.

He can help you come to terms with those problems that doctors, nurses or social workers can't deal with. He can be trusted, and you can share things with him that you can't share with anyone else.

Life, as many of us know, is just difficult enough, just painful enough, that we find our selves calling out, "Is there anyone out there who really knows what I'm going through? Does anyone really care?"

Yes, we are loved and cared for. But the ways of love and care are devious. This is the problem with divine love, we don't always know when we are on the receiving end of it. At times like this, the clergyman can show us a new perspective that we might have overlooked. God's love is funny that way.

The hospital chaplain can be very helpful to you if you will let him. He is familiar with illness and knows what it means to be dependent on other people and machines for one's existence. You can help the chaplain to help you by familiarizing him with the dialysis procedure. Explain how things work and how you feel about the whole dialysis procedure. Tell him of your life, on and off dialysis and how you overcome the problems that arise. Above all, the emphasis should be on sharing. If you are willing to share and struggle with him, he can and will do everything he can to bring out the inner resources within yourself that you never thought were there.

I've had an intense association with several dialysis patients. After several months of talking and sharing, I noticed a change in myself and a change in some of the patients. I'm not taking the credit for myself. I think it was the result of the ineffable chemistry that takes place when "two or three are gathered together in my name."

I feel that I am qualified by experience and interest to undertake the responsibility of helping people to struggle with the meaning of their lives while undergoing hemodialysis. I'm looking forward to hearing from you.

David Williams

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NAPH needs volunteers!! This is a non profit organization, so everyone works for nothing. If you want to help kidney patients, give us a call. Here are the phone numbers. Louis Gibofsky - 212-475-4832; Shep Glazer 212-225-7473; William Blackton 212-663-6439. Call us up. We need you!

MR. GLAZER. Let me introduce myself. I am Shep Glazer, vice president of the National Association of Patients on Hemodialysis, better known as NAPH.

About two and a half years ago this organization was formed as a self-help organization, basically to pool our knowledge and exchange ideas as to how we could help each other.

Kidney disease is the fourth leading cause of death in this country; 100,000 people die from kidney disease each year in the United States. Ten thousand of these people could be saved if they could get artificial kidney treatments.

Kidney disease is unique because unlike other terminal diseases, for all practical purposes the hemodialysis patient can live a relatively normal life. As long as we get our treatments, we can continue to be productive members of society, pay our taxes and circulate our money back into the economy of the country.

But we live in constant terror that if these treatments are taken away from us because our money has run out, death will come in a matter of weeks. It is not easy to live with this thought confronting us each and every day.

However, we are not sitting around feeling sorry for ourselves, as you can see from the active group that I have here with me today.

There are many problems connected with hemodialysis, the most pressing at this time is the inadequate financial coverage for hemodialysis existing in this country today. Unlike the State of Maryland, and I quote from their very progressive bill No. 778, effective July 1, 1971, "The State hereby recognizes its responsibility to its citizens to allow them to keep their health without being pauperized and to use the resources and organizations of the State to aid in gathering and disseminating information on the treatment of chronic renal disease."

The States of Washington and New Jersey have made some provisions for their kidney patients, also.

We feel that funding for hemodialysis should be done on a Federal rather than a State level. If individual States have legislation for hemodialysis, you will find all of your kidney patients flocking to those States which offer them coverage much like people are flocking to New York to receive welfare benefits.

It costs \$12,000 to maintain an artificial kidney machine at home for the first year, and approximately \$5,000 to \$7,000 for each additional year. These treatments are needed for the rest of our lives or until such time we are lucky enough to get a transplant. Even then, there is no guarantee that the kidney will not reject and we will find ourselves back on dialysis.

The major insurance companies in the United States do not include home dialysis in their basic policies. Home dialysis is advantageous to many of us because it enables us to continue working. Needless to say, that if a person is forced to enter a hospital three times a week—assuming there is a bed and kidney machine available to him—he cannot hold down a job.

Some of us are fortunate enough to have major medical policies but the funds are soon consumed by the expensive treatments.

We patients find ourselves confronted with the overwhelming thought of either dying or at best becoming welfare recipients.

Hemodialysis affects not only the patient, but the entire family. Not only can we not provide the basic necessities of life to our families but we cannot provide education for our children so as to insure their futures.

What NAPH is requesting in any future federally sponsored health program is the following:

1. Funds to train dialysis attendants.
2. Funds to make dialysis machines available to all kidney patients who need them.
3. Funds to make available the necessary materials to support the dialysis machine.
4. Funds to promote a donor program for patients who do not have access to a live kidney.

We feel that this country is morally obligated to its citizens to provide this treatment to all who need it.

What was Shep Glazer, vice president of the NAPH. Now let me introduce myself personally. I am 43 years old, married for 20 years, with two children, ages 14 and 10. I was a salesman until a couple of months ago until it became necessary for me to supplement my income to pay for the dialysis supplies. I tried to sell a noncompetitive line, was found out, and was fired.

Gentlemen, what should I do? End it all and die? Sell my house for which I worked so hard, and go on welfare? Should I go into the hospital under my hospitalization policy, then I cannot work? Please tell me.

If your kidneys failed tomorrow, wouldn't you want the opportunity to live? Wouldn't you want to see your children grow up?

Just before our trip down here we received a letter from the president of the New York Blue Cross. I would like to distribute copies to the committee. I would like to read some passages for the record, and may I quote:

\* \* \* we share their concern for the problem they face, the tremendous cost of maintaining a person with total kidney failure on hemodialysis.

Such a patient is in a unique medical position. The machinery to keep him alive exists but the costs are generally prohibitive. Currently, there is no adequate program for covering the necessary health expense of appropriate hemodialysis.

AHS believes the efforts of the National Association of Patients on Hemodialysis must be supported.

We recognize that we can not do the whole job. The resolution of a health problem of the magnitude of that presented by persons requiring hemodialysis can be solved only by the joint efforts of all responsible for financing health care.

The letter is signed "J. Douglas Colman," who is president of AHS. (The letter referred to follows:)

BLUE CROSS,  
ASSOCIATED HOSPITAL SERVICE OF NEW YORK,  
New York, N.Y., November 2, 1971.

HON. WILBUR MILLS,  
*Chairman, House Ways and Means Committee, House of Representatives, House Office Building, Washington, D.C.*

DEAR MR. MILLS: Associated Hospital Service (Blue Cross of Greater New York) has been informed that the National Association of Patients on Hemodialysis is invited to testify before your Committee. We have met several times with representatives of this Association, and share their concern for the prob-

lem they face: the tremendous cost of maintaining a person with total kidney failure on hemodialysis. Such a patient is in a unique medical position. The machinery to keep him alive exists, but the costs are generally prohibitive. Currently, there is no adequate program for covering the necessary health expense of appropriate hemodialysis treatment, even though Blue Cross routinely provides these services when rendered by hospitals to both inpatients and outpatients at a very substantial cost each year.

AHS believes the efforts of the National Association of Patients on Hemodialysis must be supported. Over the years, we have participated in many and varied meetings on this vital issue, but no totally effective resolution for prepaying appropriate services by all segments of society has been forthcoming. The technical progress of the past decade has been substantial, and while not necessarily at the optimal stage, nevertheless it is sufficiently advanced that we are obligated, in the absence of other leadership, to foster an innovative approach to the provision of hemodialysis.

We recognize however that we cannot do the whole job. The resolution of a health problem of the magnitude of that presented by persons requiring hemodialysis can be solved only by the joint efforts of all responsible for financing health care—Federal, State and Local governments, employers, employees, prepayment agencies and philanthropy. We are prepared to work with all others concerned to make appropriate hemodialysis treatment readily available at reasonable cost to all those who require it.

We welcome this opportunity to share with you our concern over, and involvement with this problem.

Sincerely,

J. DOUGLAS COLMAN.

Mr. GLAZER. I would like now to introduce first from the State of Texas, Mr. William Litchfield.

**STATEMENT OF WILLIAM LITCHFIELD, LEGISLATIVE CORRESPONDENT, NATIONAL ASSOCIATION OF PATIENTS ON HEMODIALYSIS**

Mr. LITCHFIELD. Mr. Chairman, I am a hemodialysis patient from Houston, Tex. One of the fortunate few in Texas on a program partly funded by the health service as a demonstration project.

I think you can see by the very presence of us today that this process of hemodialysis has demonstrated that the process does rehabilitate persons so that they can lead a relatively normal life.

Thank you.

Mr. GLAZER. Next, from the State of Connecticut, Mr. Roland Fortier.

**STATEMENT OF ROLAND FORTIER, MEMBER, NATIONAL ASSOCIATION OF PATIENTS ON HEMODIALYSIS**

Mr. FORTIER. Mr. Chairman, we in Connecticut have started to organize our own local chapter of National Association of Patients on Hemodialysis. We have also started what we call the fight to live crusade.

I am sure some of you Congressmen received correspondence from us already. We are circulating a letter nationwide in support of complete health insurance.

Again, to summarize what Shep has already said, patients can be rehabilitated. In our unit we have a 36-year-old male school teacher

who works full-time teaching school, head of a family of four. We have two accountants, we have a college student who has been on the machine for 5 years. He will graduate this year.

We have a pole lineman for the utility company.

Therefore, it is very simple, all we are looking for is some sort of medical insurance coverage. We want to be recognized as a continuing care disease regardless of income—a man in the middle as you see here today; the middle class are the ones being affected.

One man is on welfare and the other man working \$100,000 a year—what happens to the man making \$15,000 to \$20,000 a year? You all know the costs of these treatments are \$20,000 to \$25,000 a year and up, in a hospital. Again, our cause is to try to educate everyone as to what the disease actually is. This machine has been helpful today.

As part of our letter writing campaign, we have contacted quite a few Senators and Congressmen, and have had very favorable results from every one with whom we have talked. It is very simple. All we want is recognition.

We have here Mr. Peter Lundin, who is from California, a medical student on dialysis.

**STATEMENT OF PETER LUNDIN, MEDICAL STUDENT, AND MEMBER, NATIONAL ASSOCIATION OF PATIENTS ON HEMODIALYSIS**

Mr. LUNDIN. Mr. Chairman, I would like to say that I am probably, to my knowledge the first and only person to go through medical school on dialysis. I think my presence here is an indication of the efficacy of dialysis as a rehabilitative therapy to put those who are unfortunately stricken by kidney disease back on their feet again to become contributing members of society.

Mr. FORTIER. We thank Dr. James Carey of Georgetown University for getting this dialysis machine here today.

Mr. GLAZER. I would also like to introduce Mrs. June Crowley.

**STATEMENT OF MRS. JUNE CROWLEY**

Mrs. CROWLEY. I would like to mention just a few words about myself.

I have been a patient for 3½ years on dialysis. I became ill in the fall of 1967. At that time, had it not been for Dr. Freedman at Down State Medical Center and the grants that were given to him by the Department of Health, Education, and Welfare, I would not be here alive today. I was able to return to my family of four children, one of whom will become a teacher, one of whom will become a doctor, one of whom is going to study marine biology, and there is a question about the fourth.

Thank you very much.

Mr. GLAZER. With Mrs. Crowley is Mr. Ed Crowley.

Mr. CROWLEY. I have nothing to add.

Mr. GLAZER. Next is Mr. Abraham Holtz.

**STATEMENT OF ABRAHAM HOLTZ, ACCOUNTANT AND MEMBER,  
NATIONAL ASSOCIATION OF PATIENTS ON HEMODIALYSIS**

Mr. HOLTZ. My name is Abraham Holtz. I am an accountant and I am working full time, taking only time off once in a while to have a checkup at the doctor's office. I have a family and I am glad to be here because I know had we not had that grant from the Department of HEW, I would not be here today. I am on the machine since February of 1970.

Mr. GLAZER. Last, I would like to introduce my wife and administrator of my dialysis.

**STATEMENT OF MRS. SHEP GLAZER**

Mrs. GLAZER. The idea of bringing the dialysis machine was not for shock value or for publicity, it was to prove and inform, because there has been so much misconception about dialysis in the country today.

As you can see, it is not necessarily a hospital procedure. It can be done anywhere if it could be done here in the hearing room. We feel it should not be restricted to hospitals but be in the home or in satellite centers so a person can hold down a job and support his family.

I will not repeat the rest of the things my husband has said.

The CHAIRMAN. Does that complete the statements of the group, Mr. Glazer?

Mrs. GLAZER. We have some additional information we would like to pass around.

The CHAIRMAN. Do you want to put it in the record?

Mrs. GLAZER. Yes, sir.

The Chairman. Without objection, we will put it into the record at this point.

(The material follows:)

[From the Newsday (Long Island, N.Y.), Nov. 1, 1971]

**FOR LI'S KIDNEY PATIENTS—SURVIVAL IS AN ORDEAL**

With no treatment facilities in Suffolk and few in Nassau, many Long Islanders suffering from kidney failure must regularly travel to New York City for the blood-cleansing treatment necessary to keep them alive. They find the trip arduous and wonder who cares about their plight.

(By David Zinman)

The Long Island Railroad platform at Jamaica is Joseph Carastro's Mount Everest.

"There's a terrible lot of stairs to make," the 60-year-old former barber from Holbrook says. "It seems like I can't always reach the top." On those nights, he sits down on the steps to muster enough strength to go on. When he gets home, he usually skips dinner and goes right to bed.

Carastro—and an estimated 60,000 Americans stricken each year—suffers from irreversible chronic kidney failure. An artificial kidney (hemodialysis or dialysis machine) is available to let them live a near-normal life. But because of the enormous costs involved, the nation has never fully responded to their dramatic need. Great gaps in coverage exist throughout the country.

On Long Island, for example, no Suffolk hospital has a facility for chronic patients like Carastro. So to stay alive, he has to make a four-hour round trip to a dialysis center in Queens. There, six hours a day, three times a week, an artificial kidney—a unit about the size of a washing machine—filters the poisons

from his bloodstream that his own diseased kidneys cannot remove. And then, in his weakened, debilitated condition, he starts the long journey home. He takes a subway, a bus, a train and his car.

"He gets out of breath," his daughter, Mrs. Teresa LeSpisa, says. "He walks with a cane. He hesitates every few steps. In the summer, he nearly passes out."

The irony of Carastro's odyssey is that at least five Suffolk hospitals—Good Samaritan, Central Suffolk, Brunswick General, Smithtown General, and Huntington have artificial kidney machines. But hospital officials say they are used only for acute (emergency) short-term cases. And so Carastro has joined a small but growing number of terminal kidney patients from Suffolk who must look to New York City for help.

In West Babylon, 16-year-old Aileen Fuchito gets up at 4 AM to be ready for her father to drive her at 5 AM to Einstein Hospital's dialysis unit in the Bronx. In Mastic Beach, Bruce Houck, 19, makes the 5:45 AM train to go to an artificial kidney unit at Downstate Hospital in Brooklyn. His thrice weekly round trip covers nearly 300 miles.

"I think it's horrendous for a county with over 1,000,000 people not to have a single dialysis facility," says Louis Gibofsky, president of the National Association of Patients on Hemodialysis. "Why should Suffolk depend on New York City to relieve it of its burden?"

Part of the reason is that Nassau can't do it. It lacks adequate facilities for its own residents, let alone Suffolk's. Units for chronic (long term) dialysis exist in only three Nassau facilities—Nassau County Medical Center, North Shore Hospital and Nassau Hospital. Even counting Long Island Jewish Medical Center, situated just across the county line in Queens, Nassau has facilities to handle only 63 patients.

About half the patients are from Suffolk. But all four programs have waiting lists. Doctors conservatively estimate that in one year alone more than 100 kidney patients in Nassau and Suffolk become suitable candidates for long-term dialysis.

"For some reason, the Island has turned its back on this problem," says Mrs. Paula White of West Islip, a registered nurse whose husband is a dialysis patient. "It has shrugged it off and let people fend for themselves. That's how they end up in Brooklyn, Queens and the Bronx. And these are sick people, people with terminal disease."

And yet, they consider themselves fortunate. With a population of 8,000,000, New York City has dialysis facilities for only about 600 patients. Nobody knows the numbers left to die because they are unable to get on the city's 20 crowded dialysis programs.

"You have the vague feeling there are people out there in Suffolk not being treated," says Dr. William F. McCully Jr., an internist and nephrologist (kidney specialist) from West Babylon. "My God! I simply, honestly, don't know what's happening to them."

Many doctors feel the long-range answer to kidney failure lies in transplantation. One day, surgeons think, a kidney transplant will last indefinitely. But now their success depends on hard-to-come-by tissue matches. And even then, in many cases, the body eventually rejects the organ. Or the patient, his resistance weakened by immuno-suppressive drugs succumbs to other illnesses.

And so physicians fall back on chronic dialysis, a technique Dr. Belding Scribner of Seattle worked out in 1960. However, in the 11 ensuing years, there have never been enough centers to support even half the patient load. Last year, of the estimated 7,500 new patients with chronic uremia who were medically suitable, treatment by transplant was available for 917 and by chronic dialysis for 1,200.

"So we have taken care of about 2,000 out of 7,500 suitable patients," says Benjamin T. Burton, chief of the artificial kidney program at the National Institutes of Health. "The picture is not as gloomy as it sounds. I'm optimistic."

Others in the medical field find little to be optimistic about in statistics that show 5,500 people dying needless deaths every year. "This national crisis is unparalleled in our history," says Dr. Samuel L. Kountz of the University of California's medical school. "Never before has a proven life-saving treatment been denied to so many people because of lack of money."

Doctors say the staggering cost of dialysis is the chief factor discouraging hospitals from starting dialysis programs. Hospital charges run between \$10,000 and \$20,000 per patient per year. These astronomical bills have reduced many

families to poverty level. Equally frustrating, when patients go on home dialysis where costs are cut to \$5,000, they find Blue Cross and other medical insurers drop their coverage.

Beyond the problem of soaring finances, hospitals have difficulty finding trained personnel, space and a medical specialist to run the program. Moreover, unlike treatments for many other serious illnesses, chronic dialysis is unique in that it demands an open-ended commitment. The dialysis patient cannot be cured. His disease can only be controlled. So he becomes a patient for life.

Ultimately, with the ever-increasing patient load, there is constant pressure on the hospital to expand its unit as the years go by. "Quite frankly," said a spokesman for Good Samaritan Hospital in West Islip, "we don't have the financial wherewithal to support such an ambitious program."

However, some doctors feel that the most important reason for the gap between the patients' need and the medical community's response can be traced to a lack of initiative in Washington. The federal government has yet to demonstrate that it views the plight of the dialysis patient as a national emergency.

Here's what its record looks like:

In the mid 1960s, the government began funding research and demonstration projects. These projects showed that dialysis could be done not only in hospitals but in storefront dialysis centers where expenses are minimal and even in the home where costs are lowest of all. In addition, home dialysis allows the patient to work by day and be treated at night.

In 1967, Dr. Carl W. Gottschalk headed a distinguished medical committee that addressed itself to the question of what the government's commitment ought to be. After due deliberation, the panel urged a federally financed, \$1-billion national treatment program to provide dialysis or transplantation for everyone who needs it. Four years later, virtually none of the committee's recommendations have been implemented.

Why has the government failed to marshal the nation's medical resources? Gottschalk says he is not sure. He supposes budget cuts are the main reason. Perhaps, he says, his committee did not make its point forcefully enough.

What is certain is that the government's apathy has found its way down to lower levels. A few years ago, Dr. Norman Schupak, a Suffolk kidney specialist who runs the Elmhurst Hospital's dialysis program in Queens, tried to get federal and state funds for a satellite center. Although he failed, he did finally get private backing. But Schupak has not forgotten one state official's reaction. Schupak said the official bluntly told him: "Society has not yet made the determination these people [dialysis patients] should be saved."

The reality of the situation is that kidney disease is competing for the federal health dollar with heart disease, cancer and stroke—which cripple or kill 10 times as many people. Last year, the U.S. Regional Medical Program allocated 26 per cent of its funds to research in heart disease, 13 per cent for cancer, and 12 per cent for stroke. Kidney disease got four per cent.

"When you are dealing with bureaucrats, it's hard to make out a case for funds if the numbers aren't there," one doctor said. Moreover, the public knows comparatively little about kidney disease. Nearly everyone can recall a member of his family stricken or dying from heart disease, cancer or stroke. But far fewer people have had personal experiences with kidney ailments.

The low numbers have had their effect on professionals, too. The average community hospital may not see more than three or four kidney deaths a year. It doesn't emerge as a crisis unless a doctor can see beyond his own hospital.

Even then, this slow, incipient disease often escapes attention. Recently, a reporter asked Suffolk's No. 2 public health officer how many dialysis patients his county had. Dr. Michael D. Buscemi, the county's deputy health commissioner, said he did not know. "I'm not familiar with the depth of the problem," Buscemi said. "I'm sure we have people who require dialysis. But I don't know how many. Or where they're treated."

Given this low visibility, the federal agency responsible for coordinating health efforts on Long Island has yet to work out a master plan to expand dialysis facilities. "I wouldn't argue there is a need," said Dr. Glen Hastings, executive director of the Nassau-Suffolk Regional Medical Program. "The question is whether there is a need for these facilities in terms of costs and expenses? And should they be a first priority basis?"

What could be a higher priority item than a life-saving treatment? "Why don't you ask how come migrant workers can be denied primary health care?" Hastings said. "Let's ask how come there still can be malnutrition problems in

this affluent area of the country? Let's ask why there aren't any comprehensive mental health services beyond the three western towns in Suffolk?" He paused, then added: "If you want to get morally indignant, I'll get morally indignant. But it goes far beyond renal [kidney] disease."

And so planners, hard-pressed by budget squeezes, are reluctant to spend their resources on a therapy with limited return while the whole system of medical care needs support badly. Over-shadowed by other major diseases, kidney ailments have taken a back seat among America's health concerns. And because their numbers are small and dispersed, the dialysis patients' influence is insignificant in Washington.

"Politically, it's not possible to believe there will be any massive infusion of government funds for dialysis in the next few years," said Edward Mitchell, executive director of the National Kidney Foundation. "Before that happens we would have to see a whole reevaluation of priorities . . . The next logical step can only be a national health insurance program to include catastrophic aspects of kidney disease."

Congress opened hearings on a national-health-insurance bill Oct. 19. But there is no assurance that the measure, if it passes, will come out with a category covering catastrophic illness. Even if it does, the fact that patients will be covered for this treatment will not of itself build dialysis facilities and train the nurses and the technicians to run them. That commitment has to come from the medical community and the public.

In the meantime, John Carastro, Alleen Fuchito, and Bruce Houck will continue their life-dependent pilgrimages. Houck's parents will soon start home-dialysis training. And Miss Fuchito hopes to get a transplant one day.

However, these alternatives are not open to Carastro. And so his lonely journey will go on for as long as he lives.

But in a sense, they are the lucky ones. Last November, John A. Gleason, a Mastic Beach kidney patient, died at 58. The autopsy report said uremic poisoning was the cause of death. His daughter said she had been told the nearest dialysis unit was at Long Island Jewish Medical Center. She said she was told there were no openings.

#### THREE WAYS TO HELP

How can Long Island meet the needs of its terminal kidney patients?

The problem, according to Dr. Joseph Letteri of Nassau County Medical Center (formerly Meadowbrook Hospital) will not be solved by the small community hospitals. "Each can make a contribution by setting up a small dialysis unit," Letteri said. "But as soon as it is saturated, each hospital is back where it started. And the situation still hasn't been solved."

Instead, Letteri, chief of the center's renal (kidney) diseases division, sees the answer in a three-pronged program—home dialysis, transplantation and a satellite dialysis center.

First, Nassau Medical's facilities should continue to be used for home-dialysis training. This would allow the patient to put his own artificial kidney in his home and allow the hospital's machines to be constantly turned over to new patients.

Second, Letteri proposes that the hospital begin a kidney transplantation unit. This program, which he expects to start within a year, will allow medically suitable patients to free themselves from dependence on the machines. But its opening depends on the budget situation.

Third, and most important, would be the establishment of a satellite dialysis center. Since hospital space is at a premium and costs are excessive, he would locate it outside the center—perhaps along the Nassau-Suffolk line. The store-front-type facility, which would be supervised and backed up by the hospital, would run from 8 AM to midnight, six days a week, and be capable of taking 40 patients. Letteri estimates start-up costs at \$150,000. Operational costs, he says, would be difficult to figure until the patient load was established.

"The total solution to the problem of dialysis must be an integrated approach," Letteri says. So far, Long Island has only taken the first step.

Mr. ULLMAN. Mr. Chairman.

The CHAIRMAN. Mr. Ullman.

Mr. ULLMAN. Mr. Chairman, I want to say that this has been a very impressive demonstration before this committee on something that there has been a lot of misconception about. I am sure it will be

extremely helpful in our deliberations. Thank you very much for coming.

The CHAIRMAN. Mr. Brotzman.

Mr. BROTZMAN. I just want to add to what the gentleman from Oregon has said. I don't know of any testimony that I have heard in such a short period of time that has made a more dramatic impact on me. I want to thank all of you for your courage and for taking the time to very forcefully bring this particular message to the committee. You are to be congratulated.

The CHAIRMAN. Mr. Gibbons.

Mr. GIBBONS. I would like to commend the witness panel for coming here today, and compliment Mr. Glazer for his very fine statement.

I had a member of my family afflicted with a kidney problem, and I am surprised you get by as cheaply as you do.

Mrs. GLAZER. It is \$25,000 and upward at the hospital, compared to about \$7,000 at home.

Mr. VANIK. What problems are there with insurance policies covering this?

Mrs. GLAZER. They cover out-patient or in-patient dialysis but only in hospital treatments. We feel that this is completely wrong because a patient is much more comfortable in the surroundings of his own home, number one.

Second, you run into inclement weather, the extreme cold or heat, and just to reiterate, he is better off at home. There is no question about it. It does not have to be performed at hospitals. Studies have been made and they show the home patient fares much better than the patient in the hospital.

Actually, there are not enough beds for all of the people who need dialysis in the hospitals. There is a waiting list and this has necessitated opening up satellite units which are basically empty stores stocked with dialysis machines and lounge chairs and they service ten or twenty patients, depending on the size of the store, because of the shortage of hospital beds.

The CHAIRMAN. Again, we do thank you, Mr. and Mrs. Glazer, and members of your committee, for bringing to us this very excellent testimony. We appreciate your doing it and we commend you.

Mrs. GLAZER. I have an excellent article that was published in Newsday, a local newspaper.

The CHAIRMAN. Leave that with us and we will put it in the record. We think it will be helpful.

Mrs. GLAZER. Thank you.

The CHAIRMAN. Without objection, the committee will recess until 2 o'clock.

(Whereupon, at 12:25 p.m. the committee was recessed, to reconvene at 2 p.m. the same day.)

#### AFTERNOON SESSION

(The committee reconvened at 2 p.m., Hon. Charles A. Vanik presiding.)

Mr. VANIK. The committee will be in order.

The first witness this afternoon is Maxime Taylor, president of the Professional Nurses Bureau.

I might say this is Ohio day because Mr. Jackson Betts is here, so we have Ohio day.

**STATEMENT OF MAXIME TAYLOR, PRESIDENT, PROFESSIONAL NURSES BUREAU**

Miss TAYLOR. It is a very, very fine State.

Mr. BETTS. We will agree.

Mr. VANIK. Please proceed with your statement.

Miss TAYLOR. Mr. Chairman and members of the Committee on Ways and Means: Thank you for the privilege of appearing before you to present our concerns and recommendations.

My name is Maxime Taylor. The organization for which I speak and whose members I represent is the Nurses' Registry Owners Association of C.E.A. They number the majority of the licensed nurses registries in California of which there are presently over 105. Also, I have had contact with some of the licensed nurses registries in Arizona, Texas, and Illinois.

The registries in California represent many thousands of nurses in all categories who are working as self-employed, private contractors.

Furthermore, I have been and currently am director of the A-1 Nurses Registry of San Francisco and Los Angeles. Also, I am president of the Professional Nurses Bureau with offices in San Francisco, Hollywood, Oakland, Van Nuys, and Westwood in the State of California and in Chicago, Ill. After due consultation, the following does state our thinking.

**PROBLEM**

Any health care planning within the legislative scope must be patient oriented. It must be forward looking in order to plan for and meet the actual needs of the sick with humaneness and empathy. It should encompass plans that are workable, that give patient care based upon the skill required, at a realistic cost for that level of skill and in an environment most conducive to diagnosis, treatment, recovery and convalescence.

Under the Social Security Amendments of 1965, the total emphasis throughout the act was directed toward the hospitalization of the consumer-patient.

It made available hospital benefits to great numbers of persons who previously could not avail themselves of these resources. However, the prerequisite for being eligible for benefits, required admission to the hospital for at least 3 days. This was a mandatory procedure for any reimbursement for care and services that were to be given.

Under the present system, patients enter a hospital for diagnostic tests and stay until the results of the tests are made available to the physician for diagnosis. This takes from 3 days to a week or more. The patient, if not acutely ill, could go to a diagnostic clinic attached to an acute hospital for all the necessary tests to determine a proper diagnosis of the problem.

If the physician judged that nursing care was required during this period but hospitalization was not necessary, qualified nursing care could be ordered at the level of skill required and could be given under his supervision in the home environment.

There are many patients who are acutely ill and require constant skilled nursing care in hospitals. The hospital may not have special units such as intensive care units, cardiac care units or recovery rooms.

Those that do have them find at times they are completely full and no beds are available in the special units. Private-duty nursing is the only alternative for proper medical care under these circumstances.

There are many patients who do not require the expensive equipment at the high costs of intensive and special care units but their type of illness does require constant observation or treatment beyond that offered by hospital floor care. This need could be filled by private-duty nursing.

Most of the health insurance programs that are offered by private insurance carriers as well as the prepaid health programs like the Kaiser permanent health program, include private-duty nursing, when ordered by the physician. They have found that the health coverage cannot be complete unless private-duty nursing is included.

It is a recognized medical fact that sick people of all ages, but especially the senior citizens do convalesce and recover in an environment with which they are familiar and among things to which they are accustomed. This means to convalesce at home, surrounded by their family and friends, in their own bed, eating foods they enjoy, being loved, cared for, encouraged and wanted by the family. These ties are important to the patient in order not to feel deserted or neglected or abandoned or discarded. A home atmosphere is always superior to an institutional one. In fact, an institutional atmosphere is dehumanizing and the physician's direct supervision becomes less and less a part of the picture.

Many patients within the hospital area could be discharged to home care if a nurse based on the skill required would be utilized to go to the home and stay with the patient. At the present time this important service is not being made available to medicare and medical patients. Therefore, the patients are kept in the hospital until they are able to be self-sufficient, or they are transferred to a convalescent hospital for prolonged stays. Hospital confinement is expensive, as the average hospital bed per day nationally is costing about \$62, not including the cost of any diagnostic procedures.

Incidentally, in California it is averaging over \$80 a day now.

How much could be saved if the hospital stay could be reduced by an average of 1 day? Or how much could be saved by outpatient diagnosis and home care?

In many cases, a physician could treat patients within the home environment for illnesses that were not acute, if home nursing care for the days needed were available and permitted without hospitalization. This would cut costs substantially.

This demand for resident hospitalization has caused a total upheaval within the family unit of our society and is aiding in the destruction of the family.

#### PROPOSED SOLUTION

Any proposed solution to the foregoing problems must provide for adequate medical and nursing care at a reasonable cost. Also, it should be able to be properly controlled. There is answer which is relatively simple in operation, in controls and also reasonable in costs. It is private-duty nursing in both the hospital and the home.

This type of nursing would meet the urgent needs in an acute hospital where the special care units are not available for the patient or are unnecessary because of the diagnosed needs of the patient.

This type of nursing care would meet the needs of the patient within the home environment, especially for the senior citizen. Home care for the patient should be based on the time required to properly care for the needs of the patient, be it a few hours or on a daily basis. This is particularly pertinent where the patient lives within the family unit and especially where the members of the family unit are employed. This would keep the wage-earner working and contributing to our society, to our economy and remain self-supporting. It would keep the family unit intact. This would bolster the morale of the patient, especially the senior citizen and would stimulate earlier recovery.

Private duty in homes and hospitals should be given only on the orders of the physician and under his supervision and control.

Only persons who are eligible to perform nursing duties at various levels of skills would participate in private-duty nursing. This would be distinguished between nurses and sitters, companions, domestics, relatives, and so forth. Each State would approve various levels of nursing skill and designate who is eligible to perform these functions by licensing and certification. These would be R.N.'s, L.V.N.'s/L.P.N.'s, or certified nursing assistants which meet a third level of nursing care.

The required nursing service prescribed by the physician would be provided through designated sources. These services would be given through the State licensed nurses registries both proprietary and those owned by State nursing associations. These are usually carefully regulated by the State Department of Consumer Affairs or by the Department of Labor law depending upon the State. There are definitely defined responsibilities and obligations to both the nurses they represent and to the patients they service. Many of these registries have been in the position of representing private duty, self-employed nurses for well over 25 years. There are at least 800 nurses registries throughout the country that are presently giving service. These registries represent thousands of nurses as private duty, self-employed persons in all levels of skills, for both home care duty and hospital care duty, and have always been available to meet these needs.

These registries accept the responsibility that their nurses are prepared and do their work under the direction and supervision of the physician, who remains in charge of the patient. To prevent exploitation by unauthorized and unscrupulous groups, these licensed registries and authorized organizations could be certified as vendors with proper regulations that will meet both Federal and State rules under the 1965 Social Security Act, as to be amended currently.

In California, because of the growing concern for the primary rights of the consumer, who is the patient, the licensing of the nurses registries was transferred to the Department of Consumer Services, a division of the Department of Consumer Affairs.

The law was rewritten, tightening up responsibilities of recordkeeping, past and present nurse performance evaluations, and management.

In Illinois, the Governor appointed a commission whose responsibility it is to study these problems as put forth above and to come up with recommendations for solutions in these matters.

It is our firm belief this would give a greater service to the growing numbers of aged patient consumers of health care, at a greatly reduced per unit care cost and in a more kindly, humane, and acceptable manner.

This could be a part of either a prepayment insurance plan or any other logical device or method of payment coverage approved by this committee. Nurses registries and other organizations which meet the criteria set down by the State could be authorized to accept and fill orders for private-duty nursing and these would be the sources that would supply private-duty nursing service ordered by the physician for both hospitals and homes.

Attached is a copy of the present law governing registries in the State of California. This could assist the committee in formulating basic principles to certify nurses registries as vendors.

If we can be of further assistance, please contact us.

(The material referred to follows:)

## Senate Bill No. 645

## CHAPTER 1399

*An act to add Chapter 20.5 (commencing with Section 9890) to Division 3 of the Business and Professions Code, and to repeal Chapter 5 (commencing with Section 1710) of Part 6 of Division 2 of the Labor Code, relating to nurses' registries, and making an appropriation therefor.*

[Approved by Governor September 18, 1970. Filed with Secretary of State September 18, 1970.]

*The people of the State of California do enact as follows:*

SECTION 1. Chapter 20.5 (commencing with Section 9890) is added to Division 3 of the Business and Professions Code, to read:

## CHAPTER 20.5. NURSES' REGISTRIES

## Article 1. General Provisions

9890. This chapter may be cited as the Nurses' Registry Act.

9890.1. "Person" means an individual, company, partnership, corporation, society, association, manager, or their agents or employees.

9890.2. "Nursing service" means the assignment of a nurse, male or female, as a private duty, self-employed, licensed registered nurse, licensed vocational nurse, or practical nurse to render service to a patient under the direction or supervision of a physician or surgeon registered to practice in this state.

9890.3. "Fee" means any moneys or valuable consideration paid or promised to be paid for services rendered or to be rendered by any person or persons functioning as or conducting the business of a nurses' registry.

9890.4. "License" means a license issued by the division to carry on the function or business of a nurses' registry.

9890.5. "Licensee" means a nurses' registry which holds a valid, unrevoked, and unforfeited license under this chapter.

9890.6. "Nurses' registry" means a person who engages in the business of obtaining and filling commitments for nursing service and who may incidentally make referrals, not to exceed one-tenth of the total annual nursing assignments, for nursing employment other than private duty nursing.

9890.7. "Private duty nurse" means a self-employed nurse rendering service in the care of the patient either physically

or mentally ill, under the direction of a physician or surgeon, but who is paid by either the patient or the designated agent of the patient and who accepts the responsibilities of a self-employed private contractor.

9890.8. "Department" means the Department of Professional and Vocational Standards.

9890.9. "Division" means the Division of Consumer Affairs.

9890.10. "Director" means the Director of Professional and Vocational Standards.

9890.11. "Chief" means the Chief of the Division of Consumer Affairs.

## Article 2. Application of Chapter

9890.20. (1) Nothing in this chapter shall apply to a non-profit organization or corporation, organized for the purpose of economic adjustment, civic betterment, and the giving of vocational guidance and placement of its members when all of the following conditions exist:

(a) None of the directors, officers, or employees thereof receive any profit other than a nominal salary for services performed for the organization or corporation.

(b) No fee is charged for the registry services other than a membership fee or dues entitling the person paying the same, to full participation and benefits of the organization or corporation.

(c) Membership fees or dues charged are used solely for maintenance of the organization or corporation.

(2) Nothing in this chapter shall apply to persons exempted by Sections 2731, 2789 and 2800 from the Nursing Practice Act (Chapter 6 (commencing with Section 2700) of Division 2).

9890.21. Nothing in this chapter shall apply to a nonprofit organization or corporation which has been formed in good faith for the promotion and advancement of the general professional interests of its members and which maintains a placement service principally engaged in securing employment for such members with the state or any county, city, district or other public agency under contracts providing employment for one year or longer, or any organization or corporation exempted by Section 9890.20.

9890.22. Any organization or corporation charging membership fees or dues and engaged in furnishing employment to its members shall, in order to be exempt under this section or under Section 9890.20 or 9890.21, file on or before the first day of April of each year with the division, a copy of its

bylaws and constitution, together with a sworn statement setting forth:

- (a) The place of business.
- (b) The names and addresses of officers, directors, and employees and the salaries they receive.
- (c) The various benefits furnished to members.
- (d) The membership and placement fees and dues charged or collected by such organization or corporation from its members and that it does not charge additional fees to its self-employed private contractual members or to nonmembers using the service.

### Article 3. Administration

9890.30. (a) There is in the Department of Professional and Vocational Standards a Division of Consumer Affairs under the supervision and control of a chief. The chief shall be appointed by the Governor and shall serve at his pleasure. His compensation shall be fixed by the director in accordance with law. The duty of enforcing and administering this chapter is vested in the chief and he is responsible to the director therefor.

(b) The director shall be the appointing power for all personnel employed in the division to carry out the functions of the division.

(c) All inspection and investigative services shall be performed by personnel in the Division of Investigation.

9890.31. With the approval of the director, the chief may adopt rules and regulations necessary for the orderly administration of this chapter. All rules and regulations shall become effective not earlier than 30 days after approval by the director, and only upon compliance with the procedure provided in Chapter 4.5 (commencing with Section 11371) of Part 1 of Division 3 of Title 2 of the Government Code.

9890.32. The title to all equipment, supplies, and other property used in administration of this chapter shall be vested in the department.

### Article 4. Licensees

9890.50. No person shall engage in the function or business of a nurses' registry without first obtaining a license from the division. Such license shall be posted in a conspicuous place in the office of the nurses' registry. Licenses issued for nurses' registries prior to the effective date of this chapter shall not be invalidated thereby, but renewals of such licenses shall be obtained in the manner prescribed by this chapter.

9890.51. A written application for a nurses' registry license shall be made to the division in the form prescribed thereby and shall include:

(a) The name and address of the applicant, or the names and addresses of each partner from applicant partnerships, or each officer, from applicant corporations.

(b) The full address of the building where the business of the nurses' registry is to be conducted.

(c) The business or occupation engaged in by the applicant for the past five years preceding the date of application.

(d) The proposed name of the nurses' registry. The division shall reject any proposed name which is the same or similar to that of a licensed nurses' registry. When such name is used on any sign, advertising or promotional material, the entire name as shown on the license shall be used.

(e) The application shall be accompanied by affidavits of at least three reputable residents of the state that the person is of good moral character. One of the affidavits shall be from a physician and surgeon licensed by the State of California.

(f) Such questions and information as will assure the division of the applicant's eligibility to hold a license.

9890.52. Upon receipt of an application for a license, the division shall cause an investigation to be made as to the character and responsibility of the applicant, and of the premises designated in such application as the place in which it is proposed to conduct the business or functions of a nurses' registry.

9890.53. To be eligible for application for a license, the applicant shall show financial responsibility, and the applicant, or one partner of a partnership, or one officer of a corporation shall have all the following:

(a) Be of good moral character.

(b) Be at least 21 years of age.

(c) Be a person whose license in any field of endeavor has not been revoked within five years from the date of application.

(d) Be a person with a minimum of two years' experience in personnel work or equivalent experience as determined by the division.

(e) Be a person who has completed the 12th grade, except that the division may establish proof satisfactory to them that the applicant is possessed of a 12th grade education in point of intellectual competency and achievement.

9890.54. Upon completion of the investigation by the division and upon the favorable recommendation of the division, the license to conduct a nurses' registry shall be issued. A decision shall be given within 90 days from the date of receipt of the application by the division.

9890.55. The division shall not grant a license to conduct a nurses' registry:

- (a) In rooms used for living purposes.
- (b) Where boarders or lodgers are kept.
- (c) Where meals are served for profit.
- (d) Where persons sleep.

9890.56. The division, on proper notice or hearing, may refuse to grant a license. Such proceedings shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code and the division shall have all the powers granted therein.

9890.57. Each license issued shall run to and including the 31st day of March next following the date of issuance, unless sooner revoked by the division, and may be renewed each year upon the filing of an application of renewal.

9890.58. The license shall protect only the person or persons to whom it is issued and only those places for which it is issued. No license shall be issued, transferred or assigned to any person unless written consent is obtained from the division.

9890.59. A license when issued shall designate:

- (a) The name of the licensee.
- (b) The number and date of issuance of the license.
- (c) The city, street, and number of the premises in which the nurses' registry is authorized to carry on its business.

9890.60. The division may grant permission to establish branch offices to any licensed nurses' registry. No branch office shall be established without written permission of the division.

9890.61. All applications for renewal of a nurses' registry license shall state all the following:

(a) The names and addresses of all persons financially interested as required in the primary application.

(b) All the names and addresses of all persons who are authorized by the nurses' registry to accept orders to assign, to discontinue or to consummate contracts with the nurses, doctors, hospitals, and the patients, either in writing or by phone.

9890.62. All valid, unforfeited and unrevoked nurses' registry licenses in effect, on the effective date of this chapter, may be renewed from year to year.

9890.63. The division may issue to a person eligible therefor a certificate of convenience to conduct the business of a nurses' registry where the person licensed to conduct such nurses' registry has expired, or has been declared incompetent by the judgment of a court of competent jurisdiction, or has had a conservator appointed for his estate by a court of com-

petent jurisdiction. Such a certificate of convenience may be denominated as an estate certificate of convenience.

9890.64. To be eligible for an estate certificate of convenience, a person shall be one of the following:

(a) The executor or administrator of the estate of a deceased person who is licensed to conduct the business of a nurses' registry.

(b) If no executor or administrator has been appointed, the widow or heir otherwise entitled to conduct the business of such deceased licensee.

(c) The guardian of the estate of the incompetent person licensed as a nurses' registry, or the conservator appointed for the conservation of the estate of a person licensed to conduct the business of a nurses' registry.

9890.65. The estate certificate of convenience shall continue in force for a period of not to exceed 90 days, renewable by the division for only one additional period of 90 days pending the disposal of the nurses' registry license or the procurement of a new license under the provisions of this chapter.

#### Article 5. Bonds

9890.80. A nurses' registry shall deposit with the division, prior to the issuance or renewal of a license, a surety bond in the penal sum of one thousand dollars (\$1,000).

9890.81. The surety bond shall be payable to the people of the State of California and shall be conditioned that the person applying for the license will comply with this chapter. The aggregate liability of the surety for any and all claims which arise under the bond shall not exceed the amount of the bond.

9890.82. If any licensee fails to file a new bond with the division within 30 days after notice of cancellation by the surety of the bond required under Section 9890.80, the license issued to the principal under the bond shall be automatically suspended until such time as a new surety bond is filed. A person whose license is suspended pursuant to this section, shall not carry on the business of nurses' registry during the period of such suspension.

#### Article 6. Operation and Management

9890.90. Nurses' registries may enter into a continuing contract with private duty nurses covering the assignment of such nurses by such nurses' registries. The continuing contract shall state:

(a) The name, address and telephone number of the nurses' registry.

(b) The name, address and telephone number of the nurse.  
(c) The fee schedule of the nurses' registry currently on file with the division.

(d) The date of its execution by the nurses' registry and the nurse.

(e) The contract shall specify that the provisions thereof are to govern only the assignment of private duty nurses and shall:

(1) Designate the nurses' registry as the continuous agent of the nurse for purposes of assignment.

(2) Provide that the contract in effect may be terminated at any time by written notice given one to the other for any future assignment.

(3) Provide for delivery to the nurse at the time of the execution of the contract a written schedule of the rates of nurses charges currently agreed to between the nurses' registry and the nurse for the nurse's services to the patient.

(4) State that the nurses' registry will immediately notify the nurse in writing of all subsequent changes in the rates to be charged the patient for services, and that the nurse shall agree to abide by these rates.

(5) Contain express undertakings by the nurses' registry that it shall continuously maintain true and correct records of orders and assignments as provided in this chapter.

(6) Provide that the nurses' registry shall periodically and at least once each month render to the nurse a written statement of all fees claimed to be due the nurses' registry, and further that such statement shall adequately identify each assignment as to the inception date and period of service covered by the claim, including the name of the patient and the amount of service fee claimed.

(7) Contain appropriate wording advising the nurse of his right to dispute the correctness of any service fee claimed by the nurses' registry in such written statement above referred to, and that in the absence of objections within a reasonable time, any such service fee may be presumed to be correctly charged.

(8) Include any other term, condition, or understanding agreed upon between the nurses' registry and the nurse.

9890.91. Each such contract shall be numbered consecutively in original and duplicate, both to be signed by the nurse and the nurses' registry. The original shall be given to the nurse and the duplicate shall be kept on file at the nurses' registry within the nurses' records.

9890.92. Each nurses' registry shall submit to the division all forms of contract to be utilized by such nurses' registry in entering into written contracts with private duty nurses for the use of the services of such nurses' registry and secure ap-

proval as to form from the division. Such approval shall not be withheld as to any proposed form of contract, when at least the basics of all of the eight foregoing points are included in the contract. There shall be printed on the face of the contract in prominent type, "This nurses' registry is licensed by the Division of Consumer Affairs."

9890.93. (a) Each person engaged in the business or function of a nurses' registry shall file with the division a schedule of the fees to be charged the nurse, for the services rendered by the nurses' registry. No change in fee schedule becomes effective until 10 days after the filing date with the division, and until each nurse under active contract for the use of the services rendered by the nurses' registry has been notified by mail of the change and its effective date.

(b) No fee shall be charged except for actual assignment.

9890.94. Each nurses' registry shall cause each applicant for the use of the services of the registry to fill out an application form, giving the following information:

(a) The name and address of applicant.

(b) Whether or not such applicant is a licensed registered nurse or licensed vocational nurse in the State of California.

(c) The number and date of each license and date of expiration.

(d) If not a holder of a current registration or license, his or her qualifications as a nurse.

(e) The names and addresses of such person or persons who can verify the experience or training claimed.

(f) Such other information as may be appropriate.

9890.95. No nurses' registry shall send out any person to render nursing service unless such person has been interviewed by the licensee or its agent. The application shall have endorsed thereon the date of the interview and the signature of the person who interviewed the applicant.

9890.96. It shall be the duty of the nurses' registry to verify in writing the claims as to the experience or training listed on the application and to keep a file of such records in the nurse's folder within the nurses' registry. It shall also be the duty of the person interviewing the applicant to require the applicant to exhibit his license, with a notation to be made on the application by the interviewer that such license has been inspected and the date of expiration of such license.

9890.97. If any nurses' registry which assigns private duty nurses to perform nursing services also engages in any other business or function, then the records of the licensee pertaining to the "nursing services" shall be kept separate and apart from the records of any other business or function.

9890.98. Each such nurses' registry shall continuously maintain in its offices true and correct permanent log sheets

and other records which shall disclose, in addition to the other information required, the date and hour of the receipt by the nurses' registry of each order for a private duty nurse, and the date and hour of the making or giving of each assignment to the nurse by the nurses' registry, together with the name of the nurse assigned. No nurses' registry, his agent or employees, shall make any false entry in such records.

9890.99. All books, records and other papers kept pursuant to this chapter by any nurses' registry shall be open at all reasonable hours to the inspection of the director or his agents. Every nurses' registry shall furnish to the director upon request, a true copy of such books, records, and papers or any portion thereof, and shall make such reports as the director prescribes.

9890.100. Each such nurses' registry shall post in a conspicuous place in the office of the nurses' registry a printed copy of this chapter. Such copies shall also contain the name and address of the division charged with the enforcement of this chapter. The division shall furnish to nurses' registries printed copies of any statute required to be posted under the provisions of this section.

9890.101. No nurses' registry shall publish or cause to be published any false, fraudulent, or misleading information representation, notice or advertisement. All advertisements of a nurses' registry by means of cards, circulars, or signs and in newspapers and other publications, and all letterheads, receipts and blanks shall be printed and contain the licensed name and address of the nurses' registry and the words, "nurses' registry" if not in the name.

9890.102. No nurses' registry shall knowingly assign any nurse to any patient in any place where a strike, lockout, or other labor trouble exists, without notifying the nurse of such conditions.

9890.103. No nurses' registry shall divide fees with any physician and surgeon, nurse, hospital, patient or any agent or employee of any of these.

9890.104. No person shall accept a fee from a private duty nurse because of an assignment for nursing service unless such person is licensed by the division as a nurses' registry.

9890.105. All actions brought in any court against the licensee shall be brought in the name of the State of California.

9890.106. In the event that a nurses' registry shall collect from a nurse a fee or expenses for an assignment, and the nurse shall fail to obtain such assignment, or the nurse shall fail to be paid for the assignment, the nurses' registry shall upon demand therefor, repay to the nurse the fee and expenses so collected.

Unless such repayment is made within 48 hours after demand, the nurses' registry shall pay to the nurse an additional sum equal to the amount of the fee.

#### Article 7. Disciplinary Proceedings and Offenses Against the Chapter

9890.110. The division may suspend or revoke licenses after proper notice and hearing to the licensee, if the licensee has been found guilty by the division of any of the acts or omissions constituting grounds for disciplinary action. The proceedings under this article shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the division shall have all the powers granted therein.

9890.111. All accusations against licensees shall be filed with the division within one year after the performance of the act or omission alleged as the ground for disciplinary action.

9890.112. Upon receipt of a complaint, or upon its own motion, the division shall ascertain whether or not the accused licensee has been guilty of an act or omission constituting a ground for disciplinary action and make or cause to be made such investigation it deems necessary in order to ascertain this fact. All inspections and investigations are to be performed by personnel assigned by the director.

9890.113. Acts or omissions constituting grounds for disciplinary action by the division shall include, but shall not be limited to:

- (a) Engaging in unprofessional conduct.
- (b) Obtaining a license by fraud, misrepresentation or mistake.
- (c) Violations or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiracy to violate, any provision or term of this chapter.
- (d) Making or giving any false statement or information in connection with the application for issuance of a license.
- (e) Conviction of a felony or any crime involving moral turpitude.
- (f) Engaging in any other conduct, whether of the same, or different nature than specified in this section which constitutes fraud or dishonest dealing.

9890.114. Any person or agent or office thereof who violates any provision of this chapter is guilty of a misdemeanor punishable by a fine of not less than fifty dollars (\$50) nor more than five hundred dollars (\$500) or imprisonment for a period of not more than 60 days, or both such fine and imprisonment.

**Article 8. Revenue**

9890.120. The division shall receive and account for all fees and revenues derived from the operation of this chapter and at the end of each month, shall report such fees and revenues to the State Controller. These fees shall be deposited in the Nurses' Registry Fund, which fund is hereby created. The fees and revenues contained in this fund are continuously appropriated to the division to carrying out the provisions of this chapter. All fees deposited in the Nurses' Registry Fund during the 1970-1971 fiscal year, in excess of fees over expenditures from the fund during such fiscal year, but not to exceed two thousand dollars (\$2,000), shall be transferred to the General Fund.

9890.121. The division shall charge the following fees:

(a) A filing fee of fifty dollars (\$50) for each new application for a nurses' registry license.

(b) A filing fee of one hundred dollars (\$100) for each new application for a branch license.

(c) A filing fee of fifty dollars (\$50) for application to transfer or assign a license.

(d) A renewal fee of not more than one hundred fifty dollars (\$150) for a nurses' registry license.

(e) A renewal fee of not more than seventy-five dollars (\$75) for each license of each nurses' registry branch license.

(f) A reinstatement fee of two hundred dollars (\$200) in addition to other fees to reinstate a nurses' registry license revoked or suspended.

9890.122. No fee shall be prorated for the unexpired portion of the license year.

SEC. 2. Chapter 5 (commencing with Section 1710) of Part 6 of Division 2 of the Labor Code is repealed.

SEC. 3. All rules and regulations adopted by the Labor Commissioner in respect to Chapter 5 (commencing with Section 1710) of Part 6 of Division 2 of the Labor Code which are in effect when this act takes effect shall remain in effect for the purposes of Chapter 20.5 (commencing with Section 9890) of Division 3 of the Business and Professions Code until the Division of Consumer Affairs adopts rules and regulations for the administration of the latter.

SEC. 4. Licensees licensed under the provisions of Chapter 5 (commencing with Section 1710) of Part 6 of Division 2 of the Labor Code shall renew their licenses with the Division of Consumer Affairs pursuant to Chapter 20.5 (commencing with Section 9890) of Division 3 of the Business and Professions Code, when their present licenses expire.

SEC. 5. The unencumbered balance of all money available for expenditure by the Labor Commissioner in carrying out

the functions vested in him by Chapter 5 (commencing with Section 1710) of Part 6 of Division 2 of the Labor Code shall, for the purposes of Chapter 20.5 (commencing with Section 9890) of Division 3 of the Business and Professions Code, be made available for the support and maintenance of the Division of Consumer Affairs; and all books, documents, records, and property of the Labor Commissioner relating to a function vested in him by Chapter 5 (commencing with Section 1710) of Part 6 of Division 2 of the Labor Code shall, for the purposes of Chapter 20.5 (commencing with Section 9890) of Division 3 of the Business and Professions Code, be transferred to the Division of Consumer Affairs for the purposes of the division's administration of Chapter 20.5.

Sec. 6. Section 9890.8 is added to the Business and Professions Code, to read:

9890.8. "Department" means the Department of Consumer Affairs.

Sec. 7. Section 9890.9 is added to the Business and Professions Code, to read:

9890.9. "Division" means the Division of Consumer Services.

Sec. 8. Section 9890.10 is added to the Business and Professions Code, to read:

9890.10. "Director" means the Director of Consumer Affairs.

Sec. 9. Section 9890.11 is added to the Business and Professions Code, to read:

9890.11. "Chief" means the Chief of the Division of Consumer Services.

Sec. 10. Section 9890.30 is added to the Business and Professions Code, to read:

9890.30. (a) There is in the Department of Consumer Affairs a Division of Consumer Services under the supervision and control of a chief. The chief shall be appointed by the Governor and shall serve at his pleasure. His compensation shall be fixed by the director in accordance with law. The duty of enforcing and administering this chapter is vested in the chief and he is responsible to the director therefor.

(b) The director shall be the appointing power for all personnel employed by the division to carry out the functions of the division.

(c) All inspection and investigative services shall be performed by personnel in the Division of Investigation.

Sec. 10.5. Section 9890.92 is added to the Business and Professions Code, to read:

9890.92. Each nurses' registry shall submit to the division all forms of contract to be utilized by such nurses' registry in entering into written contracts with private duty nurses

for the use of the services of such nurses' registry and secure approval as to form from the division. Such approval shall not be withheld as to any proposed form of contract, when at least the basics of all of the eight foregoing points are included in the contract. There shall be printed on the face of the contract in prominent type, "This nurses' registry is licensed by the Division of Consumer Services."

SEC. 11. All rules and regulations adopted by the Labor Commissioner in respect to Chapter 5 (commencing with Section 1710) of Part 6 of Division 2 of the Labor Code which are in effect when this act takes effect shall remain in effect for the purposes of Chapter 20.5 (commencing with Section 9890) of Division 3 of the Business and Professions Code until the Division of Consumer Services adopts rules and regulations for the administration of the latter.

SEC. 12. Licensees licensed under the provisions of Chapter 5 (commencing with Section 1710) of Part 6 of Division 2 of the Labor Code shall renew their licenses with the Division of Consumer Services pursuant to Chapter 20.5 (commencing with Section 9890) of Division 3 of the Business and Professions Code, when their present licenses expire.

SEC. 13. The unencumbered balance of all money available for expenditure by the Labor Commissioner in carrying out the functions vested in him by Chapter 5 (commencing with Section 1710) of Part 6 of Division 2 of the Labor Code shall, for the purposes of Chapter 20.5 (commencing with Section 9890) of Division 3 of the Business and Professions Code, be made available for the support and maintenance of the Division of Consumer Services; and all books, documents, records, and property of the Labor Commissioner relating to a function vested in him by Chapter 5 (commencing with Section 1710) of Part 6 of Division 2 of the Labor Code shall, for the purposes of Chapter 20.5 (commencing with Section 9890) of Division 3 of the Business and Professions Code, be transferred to the Division of Consumer Services for the purposes of the division's administration of Chapter 20.5.

SEC. 14. If this bill is enacted and the Governor's Reorganization Plan No. 2 of the 1970 Regular Session becomes effective Sections 6, 7, 8, 9, 10, 10.5, 11, 12, and 13 of this act shall become operative and supersede the Governor's Reorganization Plan No. 2 of the 1970 Regular Session, and Sections 9890.8, 9890.9, 9890.10, 9890.11, 9890.30, and 9890.92 of the Business and Professions Code as added by Section 1 of this act, and Sections 3, 4, and 5 of this act, are repealed.

SEC. 15. If this bill is enacted, and the Governor's Reorganization Plan No. 2 of the 1970 Regular Session becomes effective, Section 9890.59 of the Business and Professions Code, as added by Section 1 of this act, is repealed.

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Mr. VANIK. Mr. Betts?

Mr. BETTS. I have no questions.

Mr. VANIK. We very much appreciate your testimony.

I would like to ask you one or two questions.

Of the various national health plans which have been proposed, which start from the doctors' medicaid plan and go on to President's Nixon's plan and the Kennedy-Griffiths bill, which of these proposals does your organization favor?

Miss TAYLOR. At the present time we have not taken a position. We are studying all three proposals. In all three proposals there is very little mention of home care in the form we are recommending.

Mr. VANIK. Because of this wide spectrum of choices, it is going to be awfully difficult for us to arrive at a program that is going to be suited toward the Nation's needs. If you do develop a policy, as one member of this committee, I would appreciate having your views.

Miss TAYLOR. We would be delighted to forward our views.

Mr. VANIK. In connection with your licensing, are there many States in which licensing or renewal of license of a professional is simply a matter of forwarding a renewal fee each year? Do you lose your license if you just fail to forward your fee?

Miss TAYLOR. Presently in California there is a bill sitting on the Governor's desk to be signed that will require evidence every 2 years, not only of the fact that you were previously licensed, but that you have had continuing education within the 2 years or your license will be denied you.

Mr. VANIK. Up to the present, will simply forwarding the fee will renew the license?

Miss TAYLOR. That is correct.

Mr. VANIK. Isn't that the practice in most of the States?

Miss TAYLOR. As far as I know, in Illinois and California that is the practice.

Mr. VANIK. In most of the other States the payment of the fee simply renews the license without evidence of continuing training or qualification?

Miss TAYLOR. That is right.

Mr. VANIK. One other question, if I may: In the loss of a comatose patient, could that sort of patient be handled by a visiting professional nurse in the home? Could such a patient be tube-fed and served and prepared and observed by a nurse during a home visit?

Miss TAYLOR. If the patient is comatose and there is no one available within the household who is trained to care for the patient under those circumstances, that would be a very difficult situation.

Mr. VANIK. Would that require at least extended care?

Miss TAYLOR. Where the patient is comatose, extended care is primarily for the person who is convalescing, this type of patient would be in a nursing home probably.

Mr. VANIK. Are nursing homes equipped to provide that type of service?

Miss TAYLOR. Some are good, some are average, and some really should not be functioning.

Mr. VANIK. But this would not be the type of thing within the scope of home care?

Miss TAYLOR. That is right.

Mr. VANIK. Thank you very much. We certainly appreciate your testimony.

(The following letter was received by the committee:)

PROFESSIONAL NURSES BUREAU, INC.,  
November 9, 1971.

Mr. JOHN MARTIN,  
Committee on Ways and Means,  
Washington, D.C.

DEAR MR. MARTIN: There was one very important point that was not covered by either the testimony or the questions asked. This was the matter of costs. The nurse is a private contractor and the cost of her services is set by Nursing Associations within each state. There is no additional cost for administration, as she bills either through the Vendor or directly herself for her services. Working through a Vendor which is a Nurses Registry, as per the law attached to my presentation, means that there is an agreement between the nurse and the Registry as to the cost to the nurse for the services of the Registry. This service must be a twenty-four hour service as nurses work different shifts, either day, night or weekends.

This cost is a cost of doing business to the nurse which is deductible on her income tax as she is in business for herself. There are other deductions that she acquires because of the situation of being in business for herself.

The basic objective of utilization of Private Duty Nursing personnel must be to provide more adequate patient care at a total cost that is no more, and preferably less, than otherwise provided modes. To achieve this objective, the following protocol would be required:

1. The Private Duty Nursing care would be provided only upon express written order of the attending physician.

3. The provision of the care would be an approved expense of the Medicare, Medicaid, or National Health Insurance program only if furnished upon prior authorization of an appropriate person or persons acting for and on behalf of the program administration. Such individual could be in the nature of the MediCal consultant employed by the State of California for such purpose under the existing California Medicaid program. If no such official person is provided by the program then such function would be performed by the Peer Review body authorized to review and pass upon the utilization of physicians and institutional services. In case of emergency such certification could be retroactive.

3. Such certification would be for a specific limit in terms of shifts or days and the level of qualification required (R.N., L.V.N., Nurses Aide, etc) and extension could only be obtained upon recertification.

4. As a standard for certification it would be required that the beneficiary or his attending physician establish that such service was required to substitute for necessary service not otherwise available at the hospital, such as Intensive Care, Cardiac Care, etc., or that care in the home with Special Duty service would provide more effective care than would institutional care, such as hospital or E.C.F. or Home Health Care through a Home Health Agency, and would be at a lesser cost.

5. For purposes of supervision and appropriate screening such Private Duty service could be obtained only through a licensed or otherwise appropriately approved Nurse Registry.

6. The compensation for the Private Duty service would be on usual customary and reasonable basis and the charge of the Registry would be borne by the Private Duty practitioner so no other costs or overhead would be borne by the program.

Appropriate regulations would be adopted to implement the objectives and protocol above specified in the best interests of control of both cost and utilization.

Furthermore, the question was presented as to which, if any, of the proposals introduced in the 92nd Congress would be the one that we would favor most. After much discussion and evaluation we find that each bill has something in it that is of value. Some bills have more acceptable values than others. However, it is our thinking that wherever possible that responsibility should be

put upon the private sector. This would curtail the establishment of a tremendous bureaucracy and tend to make the individual citizen who, after all, does pay the bill directly or indirectly, more cognizant and conscious of the cost factors.

Again, I thank you.

Sincerely,

MAXIME TAYLOR, *President.*

Mr. VANIK. The next witness is Dr. Ernest M. Weiner, president of the American Podiatry Association, accompanied by Dr. Seward P. Nyman, executive director, and Werner Strupp, general counsel.

You may proceed.

**STATEMENT OF DR. ERNEST M. WEINER, PRESIDENT, AMERICAN  
PODIATRY ASSOCIATION; ACCOMPANIED BY DR. SEWARD P.  
NYMAN, EXECUTIVE DIRECTOR; AND WERNER STRUPP, GEN-  
ERAL COUNSEL**

Dr. WEINER. Mr. Chairman and members of the committee, I am Dr. Ernest M. Weiner, president of the American Podiatry Association and a practicing podiatrist in New York City. Accompanying me today are Dr. Seward P. Nyman, APA executive director, and Mr. Werner Strupp, general counsel for the association.

The American Podiatry Association is indeed pleased to present its position on a subject of vital concern to all Americans. Complete copies of my written statement have been earlier furnished members of the committee. I will now briefly summarize the principal points advanced in that statement.

(The statement referred to follows:)

**STATEMENT OF ERNEST M. WEINER, DPM, PRESIDENT, AMERICAN PODIATRY  
ASSOCIATION**

**SUMMARY OF MAJOR POINTS**

*General Recommendations*

In its support of national health insurance, the American Podiatry Association recommends the following objectives be included in any NHI plan:

That NHI be preceded or accompanied by remedying the deficiencies in existing programs, namely, Medicare and Medicaid.

That NHI be more than just a financing mechanism to cover more health costs for more people. It must recognize the need to improve the organization and delivery of health care services.

That payroll taxes not be expected to bear the burden for any NHI plan; that additional means be evaluated by the Congress to supplement payroll taxes in this regard.

That NHI encourage, indeed require a partnership effort. As a minimum, the government should finance a system which draws heavily on the private sector in managing and providing health care services.

That "freedom of choice" among both systems of health care and health care practitioners characterize any NHI plan.

That an expanded commitment be made by the Congress to "peer review" in NHI.

*Specific Recommendations*

That a clear definition of physicians' services, including podiatrists' services, be contained in the Committee's plan.

That the Congress and the Administration—in cooperation with the concerned health professions—develop and implement meaningful guidelines to improve the effectiveness of peer review.

That multiple approaches for delivering health care services be respected and authorized by NHI.

## INTRODUCTION

Mr. Chairman and Members of the Committee, I am Dr. Ernest M. Weiner, President of the American Podiatry Association and a practicing podiatrist in New York City. The American Podiatry Association, whose membership I represent here today, is a voluntary, non-profit organization, established in 1912 and composed of fifty-three (53) component societies—one in each state, the District of Columbia, Puerto Rico, and a society for podiatrists in Federal Service.

The American Podiatry Association is indeed pleased to present its position on a subject of vital concern to all Americans. The critical issues we face in delivering comprehensive health care to all citizens has produced a national debate. And our present health care systems, known to be seriously lacking, require remedial action before the "right to health care" can be assured for all persons.

The severity of this problem cannot be denied. Neither can we afford to delay any longer in finding and applying meaningful solutions. And since the President of the United States, the Congress, the health community and the American people have already recognized this fact, the time for responsible action has clearly arrived.

It is not my purpose today to restate the many symptoms of our present dilemma. The evidence has been abundantly documented for and presented to the Congress on previous occasions. Rather it is my intent to complement this evidence by, first, presenting our position with respect to national health insurance; secondly, outlining the principal objectives which we believe any national health insurance program should strive to achieve; and lastly, emphasizing those goals which, as a minimum, must be realized to assure comprehensive foot care services in any national health insurance effort.

#### *Association Posture on National Health Insurance*

The American Podiatry Association has made its position quite clear on the subject of national health insurance. At its 58th annual meeting in San Francisco during August, 1970, the Association's House of Delegates unanimously approved a resolution endorsing the establishment of prepaid, comprehensive health insurance for all Americans. Included in this same resolve was a charge to the profession to provide leadership and cooperation in the fulfillment of this essential national goal. And in cooperation with the Congress, the Administration and the American people, the American Podiatry Association will constructively pursue this goal.

I must make it quite clear, however, that we do not view a national health insurance plan, by itself, to be a panacea for all the problems which now engulf the health community. With this in mind, it is very important that the Congress and the American people not be persuaded to enact a system which does little more than subsidize and perpetuate the status quo. In this regard, it is difficult to conceive any plan being enacted which does not advocate responsible action to counter: rising medical and health care costs; health manpower shortages; and the maldistribution of critically needed health personnel. Without a responsible plan, we are compounding our present dilemma as well as abdicating a public responsibility.

#### *Association Guidelines for Evaluation NHI Plans*

In its support of national health insurance, the American Podiatry Association has developed basic guidelines for its evaluation of specific legislative proposals. The following objectives, we feel, are vital to the success in any such program:

The enactment of comprehensive national health insurance should be preceded or accompanied by remedies for the deficiencies in existing public health insurance and assistance programs, namely, Medicare and Medicaid.

National health insurance must be more than just a financing mechanism to cover more health costs for more people. It must recognize the need to improve the organization and delivery of health care services by promoting the comprehensiveness, continuity, and accessibility of services.

The Association believes that, unlike Medicare, payroll taxes cannot be expected to bear the burden of any national health insurance plan. We recommend, therefore, that additional means be evaluated by the Congress to supplement payroll taxes in the financing of any such plan.

Any such plan enacted by the Congress must encourage, indeed require, a partnership effort, if our program experiences are to be successful. Neither the

public nor the private sectors can—individually or separately—fulfill the task. As a minimum, the government should finance a system which draws heavily on the private sector in managing and providing health care services.

With respect to the private sector's participation in the program, individuals must be assured the "freedom of choice" among both systems of health care and health care practitioners.

An expanded commitment must also be made by the Congress to "peer review." This important and well-established means of assuring quality health care is the responsibility of each participating health profession. Experience has proven that services provided by those in one health profession can most effectively be reviewed by members of that same profession.

These principles have generally served to guide our thinking on this most important subject, including our evaluation of the various NHI proposals presently pending in the Congress. For it is our objective, as it most certainly is the committee's to assure a qualitative level of health care—including foot care, under any enacted NHI plan. With this clearly in mind, I would like now to comment on three specific areas which, resulting from our accumulated Medicare-Medicaid experiences, must be borne in mind if our mutual objective is to be achieved.

#### *Specific Recommendations for NHI*

1. *Defining Physicians' Services.*—The lack of coordination between Medicare and Medicaid has been noticeable on many fronts. This disparity has been particularly distressing when one considers the varying program definitions for "physicians' services."

Recognizing that the doctor of podiatric medicine is licensed to independently diagnose and treat conditions of the foot by medical and surgical means, the *Social Security Act* properly includes the podiatrist, alongside doctors of medicine, osteopathy, and dentistry, within the meaning of physicians' services for Title XVIII, Part B. This action by the Congress was both necessary and appropriate, since there are only four classes of doctors in every state licensed to treat medically and surgically. At the same time, Title XIX fails to define the term "physician," leaving this responsibility to administrative interpretation. The result has been to exclude the services of podiatrists from the meaning of "physician services" for purposes of Title XIX. This particular lack of consistency has produced serious consequences for carriers, administrators, and—most importantly—the program's beneficiaries.

A specific example of this problem is the Medicare "buy-in" arrangement, in which more than forty states participate. These states, by paying the Medicare Part B charges, qualify the elderly poor for Medicare benefits, including podiatrists' services which are defined as physicians' services under Title XVIII. Yet in many of these same states, Medicaid beneficiaries under 65 are denied a podiatrist's services.

I reference this incongruous situation in hopes that, when the Committee composes its NHI plan, the same confusion with respect to "physicians' services" will be avoided. This can be accomplished by clearly defining the nature and scope of physicians' services, including podiatrists' services, in any subsequent NHI plan.

2. *Improving Peer Review.*—We heartily endorse the Committee's long-standing desire to make peer review a more effective instrument for evaluation of the quality and efficiency of health care. Since 1960, the American Podiatry Association has formally engaged in peer review activities in cooperation with carriers representing public and private insurance programs. Our objective has been and always will be to assure the highest quality podiatric care at the most reasonable cost for all citizens.

In pursuit of this objective, our experiences during the past ten years have clearly revealed that, *where peer review committees and carriers work hand in hand, quality and efficiency result, the interests of the public are fully protected, problems are more readily detected, and remedial measures, when required, are more effectively applied. Additionally, where carriers have availed themselves of podiatrists as consultants to regularly evaluate professional activities, improved efficiency again results.*

Conversely, however, where such a spirit of cooperation does not prevail, where peer review and carrier consultants function inadequately or are viewed only as "courts of last resort" and not as bona fide preventive mechanisms, the potential for abuse, indeed abuse itself, sharply increases. Though quality care

is the primary concern and responsibility of the various health professions, cooperation among all concerned parties—patients, carriers, and providers of health care—is the most essential prerequisite for any successful peer review program. In this regard, the absence of any federal guidelines with respect to peer review activities under public supported health programs has retarded the effectiveness of peer review. This problem must be overcome. *And we urge the Congress and the Administration—in cooperation with the concerned health professions—to develop and implement meaningful guidelines to improve the effectiveness of peer review.*

We are aware that there have been abuses of both the Medicare and Medicaid programs. And where the evidence was justified, our component societies have taken prompt and effective action in response to these circumstances. We fully support, therefore, H.R. 1's recommendations to prevent and control program abuses. And we want to cooperate in every way to assure now and for the future the effective application of these recommendations.

I should like to emphasize once again, however, that where close working relationships have existed between peer review committees and carriers, both public and private, problems have been minimal and often times non-existent. Thus whatever can be meaningfully done to strengthen peer review by promoting closer cooperation between the public and private sectors has our unequivocal support.

3. *Group Practice Developments.*—Clearly a shift has occurred in the way we Americans regard and rank our health problems. Until recently center stage was occupied by our efforts to remove the economic impediments to health care. These efforts led to voluntary health insurance, to Medicare, and to the overhaul of medical assistance. Now, and partly because of these actions, our primary attention has shifted to improving the organization of care. By common consent, this has now become our highest ranking problem.

Improvements in organization are needed on several fronts, including: the further extension and refinement of financing; the application of new technology; the identification, training, and use of auxiliary personnel; and the development of new links between medical research and the application of new medical knowledge. Central, however, to the improvement of the organization of health care is the need for greater interprofessional understanding and cooperation among physicians. The present upsurge of interest and activity with respect to group practice responds in part to this need. H.R. 1, too, proposes to significantly aid the cause by permitting pre-paid group plans to be reimbursed on a prospective basis.

The American Podiatry Association supports the pre-paid group practice movement as one important means of delivering and financing health services. But at the same time we are pluralists, in that we do not believe any one system or approach to be completely adequate. It is therefore important that we continue to be open-minded and receptive to new concepts while not forsaking existing delivery patterns. Solo practice, fee for service, private insurance, and public assistance have been and are important considerations deserving improvement, yes, but abandonment, no! We would therefore hope the Committee might include in its plan such a multiple approach to delivering and financing health care services.

#### CONCLUSION

In accordance with the action of the 1970 House of Delegates, the American Podiatry Association seeks to cooperate in every way, with the Committee and the Congress, in bringing quality health care to all Americans. One significant way of accomplishing this objective is through the enactment of a meaningful and truly comprehensive national health insurance plan, one which I hope will be achieved in the not-too-distant future. But to develop such a plan at the expense of all that has preceded it would be a mistake.

Thank you, Mr. Chairman, for this opportunity to make our views known on this important subject.

Dr. WEINER. The American Podiatry Association has made its position quite clear on the subject of national health insurance. At its 58th annual meeting in San Francisco during August 1970, the association's house of delegates unanimously approved a resolution endorsing the establishment of pre-paid, comprehensive health insurance for all

Americans. Included was a charge to the profession to provide leadership in the fulfillment of this essential national goal in cooperation with the Congress, the administration and the American people.

In its support of national health insurance, the American Podiatry Association has developed six basic guidelines for evaluating specific legislative proposals. The following objectives are vital to the success of any such program :

The enactment of comprehensive national health insurance should be preceded by remedies for the deficiencies in existing public health insurance and assistance programs; namely, medicare and medicaid.

National health insurance must be more than just a financing mechanism to cover more health costs for more people. It must recognize the need to improve the organization and delivery of health care services by promoting the comprehensiveness, continuity, and accessibility of services.

Unlike medicare, payroll taxes should not bear the full burden of any national health insurance plan. We recommend, therefore, that additional means be evaluated by the Congress to supplement payroll taxes.

Any such plan enacted by the Congress must encourage a partnership effort. Neither the public nor the private sectors can—individually or separately—meet the need. As a minimum, the Government should finance a system which draws heavily on the private sector in managing and providing health care services.

With respect to the private sector's participation in the program, individuals must be assured the freedom of choice both among systems of health care and health care practitioners.

An expanded commitment must also be made by the Congress to peer review. This important and well-established means of assuring quality health care is the responsibility of each participating health profession. Experience has proven that services provided by those in one health profession can most effectively be reviewed by members of that same profession.

These principles have generally served to guide our evaluation of the various NHI proposals presently pending in the Congress. It is our objective, as it most certainly is the committee's, to assure a qualitative level of health care—including foot care, under any enacted NHI plan. I will now comment on three specific areas which must be dealt with if our mutual objective is to be achieved.

#### SPECIFIC RECOMMENDATIONS FOR NHI

##### DEFINING PHYSICIANS' SERVICES

The lack of coordination between medicare and medicaid has been noticeable on many fronts, particularly when one considers the varying program definitions for "physicians' services."

The Social Security Act recognizes that the doctor of podiatric medicine is licensed to independently diagnose and treat conditions of the foot by medical and surgical means and properly includes him, alongside doctors of medicine, osteopathy, and dentistry, within the meaning of physicians' services for title XVIII, part B. This action by the Congress was both necessary and appropriate, since there are

only four classes of doctors in every State licensed to treat medically and surgically.

However, title XIX fails to define the term "physician," leaving this responsibility to administrative interpretation. The result has been to exclude the services of podiatrists from the meaning physician services for purposes of title XIX. This lack of consistency has produced serious consequences for carriers, administrators, and—most importantly—the program's beneficiaries.

I reference this incongruous situation with the hope that, as the committee develops its NHI plan, the same confusion with respect to physicians' services will be avoided. This can be accomplished by clearly defining the nature and scope of physicians' services, including podiatrists' services, in any subsequent NHI plan.

#### IMPROVING PEER REVIEW

We heartily endorse the committee's longstanding desire to make peer review a more effective instrument for evaluating the quality and efficiency of health care. Since 1960, the American Podiatry Association has formally engaged in peer review activities in cooperation with carriers representing public and private insurance programs.

Our experiences during the past 10 years have clearly revealed that, where peer review committees and carriers work hand in hand, quality and efficiency result, the interests of the public are fully protected, problems are more readily detected, and remedial measures, when required, are more effectively applied. Additionally, where carriers have availed themselves of podiatrists as consultants to regularly evaluate professional activities, improved efficiency and lower costs again result.

Where such a spirit of cooperation does not prevail, where peer review and carrier consultants function inadequately or are viewed only as courts of last resort, and not as bona fide preventive mechanisms, the potential for abuse, indeed abuse itself, sharply increases. The absence of any Federal guidelines with respect to peer review activities under public supported health programs has retarded the effectiveness of peer review. This problem must be overcome. We urge the Congress and the administration—in cooperation with the concerned health professions—to develop and implement meaningful guidelines to improve the effectiveness of peer review.

#### GROUP PRACTICE DEVELOPMENTS

The American Podiatry Association supports prepaid group practice as one important means of delivering and financing health services. At the same time, we are pluralists, in that we do not believe any one system or approach to be completely adequate. We must continue to be openminded and receptive to new concepts while not forsaking existing delivery patterns. Solo practice, fee for service, private insurance, and public assistance have been and are important considerations deserving improvement not abandonment. We would therefore hope the committee would include in its plan such a multiple approach to delivering and financing health care services.

In conclusion: In accordance with the action of the 1970 house of delegates, the American Podiatry Association seeks to cooperate in

every way, with the committee and the Congress, in bringing quality health care to all Americans. One significant way of accomplishing this objective is through the enactment of a meaningful and truly comprehensive national health insurance plan. But to develop such a plan at the expense of all that has preceded it would be a mistake.

Thank you, Mr. Chairman, for this opportunity to make our views known on this important subject.

Mr. ULLMAN. We very much appreciate your testimony.

Are there questions?

If not, thank you again.

Our next witness is Dr. J. Vincent Murphy, president-elect, American Osteopathic Association.

Doctor, we are glad to have you before the committee.

If you would further identify yourself and your colleagues, we would be happy to recognize you.

**STATEMENT OF DR. J. VINCENT MURPHY, PRESIDENT-ELECT, AMERICAN OSTEOPATHIC ASSOCIATION; ACCOMPANIED BY DR. MORRIS THOMPSON, ON BEHALF OF AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE; AND JOHN ROWLAND, PRESIDENT, AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION**

Dr. MURPHY. Thank you, Mr. Chairman.

Mr. Chairman, distinguished committee members, I am Dr. J. Vincent Murphy, president-elect of the American Osteopathic Association. With me are Dr. Morris Thompson, president of Kirksville College of Osteopathic Medicine in Kirksville, Mo., representing the American Association of Colleges of Osteopathic Medicine, and Mr. John Rowland, president of the American Osteopathic Hospital Association.

Mr. ULLMAN. We are very pleased to have you three gentlemen present today.

Dr. MURPHY. We appear today on behalf of the entire osteopathic profession. We can make that statement with some assurance because all elements of our profession are represented before you at this time. We are pleased to have this opportunity to appear together before this distinguished committee to express the views of our profession on the very important question of national health insurance.

In July 1970, and again in July 1971, the House of Delegates of the American Osteopathic Association, during its annual meeting, adopted resolutions endorsing the concept of national health insurance. In October of this year the American Osteopathic Hospital Association similarly supported the basic principle that health care is an inherent right of all individuals.

While our profession favors a program of national health insurance, we have consciously refrained from specifically endorsing any of the myriad health insurance proposals now before Congress and from presuming the competence or responsibility for proposing a program of our own. Our profession's expertise lies in the delivery of quality health care not in the field of legislative drafting and advocacy.

We would, however, briefly note for the record a few general recommendations which we believe are reconcilable with any program of national health insurance which may be enacted and which we believe

will help insure that any such system instituted will be an effective and viable one.

1. To insure continuity in the delivery of quality health care, the institution of any national health insurance plan should be accomplished, insofar as is practicable, through the modification of the existing delivery system rather than through the inauguration of a system which would be wholly foreign to both physician and patient.

2. In order to avoid the vice of depersonalizing the delivery of health care, any program of national health insurance should insure the maintenance of the free choice of physician.

3. To further promote continuity in the delivery of health care and consistent with the concept of maintaining the free choice of physician, any national health insurance program should be designed to encourage the fullest participation of all of our country's physician manpower.

4. Any program of national health insurance should be drawn so as to operate in consonance with our Nation's system of free enterprise, leaving with the physician options as to his practice location, method of delivery and manner of payment for his services. We believe that by insuring such options unto the physician the concept of pluralism in the delivery of health care is absolutely essential to meet the varying health service requirements of our Nation.

5. To promote economy in national health insurance the services offered under any such program should be specific to actual health needs.

6. In the interest of maintaining the general good health of our population and to reduce the cost of the program, by reducing the number of inpatient hospital claims, we believe that any national health insurance legislation enacted should include a sophisticated mechanism for the comprehensive delivery of preventive medical care.

7. To the end that the American people may enjoy the highest caliber health care, any national health insurance program should provide that responsibility for the establishment and enforcement of standards for continuing education of health personnel, the certification of medical personnel to specialty bodies and professional standards review be vested in the various health professions, who are best equipped to make enlightened decisions in those areas.

8. Because of our Nation's existing health manpower crises, it is imperative that any program of national health insurance concomitantly provide the necessary support to health education to insure that the promise of comprehensive health care for all Americans can be fulfilled.

It is our hope that the foregoing recommendations will be considered by this committee in its evaluation of the various health proposals before it, and in forwarding a program of national health insurance to Congress.

We would conclude by assuring the committee that our profession, as represented before you this afternoon, stands ready to cooperate in the execution of any national health insurance program which realistically responds to the needs of the people to make high quality health care accessible to all who require it.

Mr. VANIK. You have given quite a broad endorsement to national health proposals. Thank you very much. The committee appreciates your testimony.

The next witness is Dr. Stanley J. Brody, member, social policy and action committee, accompanied by Dr. Elizabeth Watkins.

Dr. Brody, I want you to know we are voting on the higher education bill. We have members running to the floor to vote on these important issues.

We are happy that you have with you Dr. Elizabeth Watkins from my city. I am especially pleased you are here to testify today.

**STATEMENT OF DR. STANLEY J. BRODY, MEMBER, SOCIAL POLICY AND ACTION COMMITTEE, NATIONAL ASSOCIATION OF SOCIAL WORKERS; ACCOMPANIED BY DR. ELIZABETH WATKINS**

Dr. BRODY. Thank you very much.

My name is Stanley J. Brody, and I am appearing today representing the National Association of Social Workers. I am an associate professor with the departments of community medicine and psychiatry and associate chief of the regional medical program at the University of Pennsylvania Medical School.

Accompanying me is Dr. Elizabeth Watkins, associate professor and chairman of the health concentration, at the School of Applied Social Services, Case Western Reserve University.

On behalf of NASW, a national organization with a membership of 55,000 professional social workers, I wish to thank the members of this committee for the opportunity to present our position regarding pending legislation on national health care.

We join with those who have expressed and documented the urgent necessity for legislation which will meet the needs of the people of this country. We do not propose to take the committee's time in restating our written testimony. Rather we would like to highlight those points we consider most important from our position of experience and competence; 23,000 professional social workers are presently serving in a variety of health settings. We feel particularly competent to present our position today, as a result of our accumulated knowledge from daily experience with people who have been most vulnerable to the shortcomings of the present system.

Any health care bill, to be supported by NASW, should present a functional as well as a disease-oriented approach. The key to such an approach would be provision for a health-social service system which maximizes the potential functioning and health maintenance of the individual. Implicit in such an approach is the view that social as well as physical and mental factors have equal weight in the prevention and treatment of illness and the continuing care.

For example, while the aged have need for acute medical care, their major requirement is in the continuum of services for the chronically ill that will enable them to function optimally. A recent Senate committee report points up the environmental problems of concentrations of the elderly poor isolated in neighborhoods which have experienced radical changes, locked in by what has been euphemistically described as substandard, low-cost housing; subject to malnutrition; lacking appropriate transportation to the sources of medical care and other

services; and often imprisoned in their own homes by an intense fear, based on fact, of being subject to robbery and attack. Social disability and consequent impairment of function arise in part out of environmental hazards. Just as mental and physical impairments develop and mesh, so do environmental limitations.

The two main groups in our population who are particularly vulnerable to the onslaughts of illness are the children and the elderly.

There are 70 million children under 18 years of age in the United States today, comprising 34 percent of the population. Currently the amount spent by the Federal Government on health care for children is less than \$10 per year per child, yet children are our major consumers of health service; they are dependent on others to seek their health care; those they are dependent upon are in the lowest earning period of their lives and subject to other calls on their incomes from aging parents.

The aged consume health services well beyond their numbers spending, despite medicare, more on health care than those in any other group in the population. Four out of five over 65 are chronically ill. More than half of those over 75 suffer a significant impairment of function. We are in the middle of a population explosion of the over-75. From 1960 to 1970 the number has grown from 5.6 to 7.6 millions.

I might say that is three times the growth rate of the 65 to 70 age group.

Given the present mortality expectations, there will be almost 11 millions of elderly over 75 in 1990.

The disease-oriented system has not and will not meet the needs of these vulnerable groups. Medicare specifically has failed to respond to the need for health-social services which are key to a continuum of health care support.

Less than 3 percent of medicaid subscribers were reimbursed for home-health care. The elderly disabled person, like "Catch-22's" Yosarian, is put in a bind by medicare that unless he is sick enough to require institutional care, he cannot receive identical services in his own home. Home health agencies have restricted their services in response to the disease-oriented aspects of the Medicare Act and its administration.

There are other successful programs which support the functional concept in addition to the disease limited orientation. Material and infant care projects, children and youth projects, community mental health and mental retardation centers, and the Veterans' Administration programs are testimony to congressional wisdom as we have all groped for solutions to the health delivery problem. They have provided for a multidisciplinary approach which has recognized the equal importance of contributions from physicians and health-social service professionals including social workers in assuring the continuum of health care.

The proposal which NASW can endorse out of our collective experience should include as clearly stated benefits to recipients and specific reimbursements to the providers, the following list of health-social services. These include five groupings of services, and we would see these as specific benefits:

1. Supportive or extended medical services in the home which are the function of the nurse, physical, occupational, or recreational thera-

pist who carry out physicians' orders and observe and provide feedback to the monitoring physician.

2. Personal services which are keyed to personal hygiene, including grooming, dressing, and bathing. Home-health aides perform these services.

3. Maintenance services which include housekeeping, environmental hygiene, and food preparation, usually the work of the homemaker.

4. Personal planning through which the social worker assures that the patient will be able to mobilize or use the resources of the health care system and other related support systems.

5. Increasingly, linkages are being recognized as a vital set of services without which available health care is not utilized. Outreach, information, referral, and health education are bound by communication and transportation in assuring utilization and effectiveness of health services.

We believe that communities, consumers, and providers should have a major voice in determining programmatic priorities most relevant to their health needs.

While H.R. 22, the Griffiths bill, comes closest to recognizing the importance of public accountability and consumer-provider participation, we feel that it is not specific enough in creating a structure which will incorporate these concepts.

We are particularly concerned that the bill calls for a Presidentially appointed five-member Health Security Board with broad powers, while it relegates consumer-provider participation to solely an advisory role.

We recognize and applaud some of the concepts espoused in the Griffiths-Kennedy bill. However, we must conclude that all of the present health legislation falls far short of incorporating the components and supportive framework for a functional and disease-oriented health system. We feel that such a system must be implemented with the inclusion of health social services if we are to effectively deal with the present health crisis.

(The statement referred to follows:)

**STATEMENT OF DR. STANLEY J. BRODY, NATIONAL ASSOCIATION OF SOCIAL WORKERS**

My name is Stanley J. Brody and I am appearing here today representing the National Association of Social Workers. I am an Associate Professor with the Department of Community Medicine and Associate Chief of the Regional Medical Program at the University of Pennsylvania.

On behalf of NASW, a national organization with a membership of 52,000 professional social workers, I wish to thank the members of this Committee for the opportunity to present our position regarding pending legislation on National Health Care.

We join with those who have expressed and documented the dire need for legislation which will result in a health delivery system truly relevant to the needs of the people of this country. We do not propose to take the Committee's time in re-stating present failures and gaps in the delivery of vital health services so eloquently and clearly stated by Mr. Leonard Woodcock in his appearance before this and other legislative bodies. The volume of proposed health legislation is testimony enough to present failures. There is no doubt, that in spite of widely divergent viewpoints, we are joined together by a common and sincere concern of meeting the challenge before us: that of maximizing the potential well-being of every American.

Twenty three thousand, seven hundred professional social workers are presently serving in a variety of health settings. We feel particularly competent to

present our position today, as a result of our accumulated knowledge from daily experiences with people who have been most vulnerable to the shortcomings of the present system.

The relevancy and adequacy of a health care system ultimately must be measured by what it will mean to the aged and infirm in the single-room occupancy, the undernourished and ill-housed family, preoccupied in negotiating the health hazards of their community, the desperate parents who deny the illness of a disturbed child out of fear of losing him to a back ward of an institution.

Any health care bill, to be supported by NASW, should present a functional as well as a disease-oriented approach. The key to such an approach would be provision for a social service system that maximizes the potential functioning and health maintenance of the individual. Implicit in such an approach is the view that social as well as physical factors have equal weight in the prevention and treatment of illness. A conceptual framework constructed on the basis of understanding of the definition of health is a basic requirement for evaluating any program which asserts that it is a comprehensive health plan. The goal of an integrated health-social services delivery system would be most in keeping with the World Health Organization's widely accepted definition of health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity".

The major criticism of the pending health proposals is that they continue a disease orientation and in so doing, provide different formulas for more of the same. If the new understandings of health are to be implemented, the traditional emphasis of medicine on disease and the institutions developed for its treatment must be augmented by new institutional forms and emphasis. The hospital, with its dramatic emphasis on acute episodic care, has consumed the major share of fiscal, manpower, and facility resources. Like the automobile gasoline engine, it has been refined to the point where it no longer is responsive to the ecological needs of the community. A major problem in health care is providing the health-related supports where medicine can no longer alter or change the disability.

The individual's index of health and his ability to rally from insults depend not only on his own capacities but also on the supports necessary and available to achieve optimum functioning.

Nowhere is the need for a more creative and responsive health system more dramatically illustrated than in the plight of our aged population. Any health system which continues to be disease oriented will not meet the increasing needs of the aging community. While the aged have need for acute medical care, their major requirement is in the continuum of services for the chronically ill that will enable them to function optimally. A recent Senate Committee report points up the environmental problems of concentrations of the elderly poor isolated in neighborhoods which have experienced radical changes, locked in by what has been euphemistically described as sub-standard, low-cost housing; subject to malnutrition; lacking appropriate transportation to the sources of medical care and other services; and often imprisoned in their own homes by an intense fear, based on fact, of being subject to robbery and attack. Social disability and consequent impairment of function arise in part out of environmental hazards. Just as medical and physical impairments develop and mesh, so do environmental limitations.

Lack of information can also be characterized as an environmental hazard. Everywhere services are available, they are either complexly organized, physically dispersed, inadequately advertised, or encrusted with eligibility requirements all of which deter and discourage their utilization by the elderly and the families for whom they were hopefully designed. Thus, a system of comprehensive health care delivery should not only provide medical and health resources, but should include those support services that would enable the elderly who are physically disabled and/or mentally impaired to utilize those resources.

We can compare the need for a similar system-orientation when viewing the needs of others who are most vulnerable to the inequities of the present system: children, the economically disadvantaged, the ill and disabled regardless of class. In a paper presented at the Social Workers Symposium of the Massachusetts Heart Association, Chauncey Alexander, Executive Director of NASW, noted that "the entire spectrum of the diagnosis, treatment and rehabilitation of coronary patients is replete with examples of neglect of the social aspects. For example, the experience of the Los Angeles County Heart Association's Work

Evaluation Unit, with more than 1,000 patients, was that 82 percent could return to the same or equal work, 20 percent of those at higher work levels than before. These figures were the reverse of the prevailing medical and community attitudes on work capability of coronary patients. Underestimation of cardiac capabilities and lack of knowledge of vocational energy requirements—the social application of medical knowledge—were the primary causes". Other illustrations are cited pin-pointing the social aspects of cardio-vascular disorders and concluding that supportive programs, comprehensive in scope, aimed at the integration of services as well as dealing with community, familial and individual attitudes, *must* be initiated and give relevancy to the medical advances in cardio-vascular disease. In essence, the patient remains a patient until those social components are dealt with, which allow his restoration to optimum functioning. The same kinds of problems may be encountered in the field of child health, where the physician may identify the health problem such as anemia or malnutrition but underlying cause may be social and thus must be incorporated into plans for treatment. In the field of mental health, there is increasing emphasis on a community-oriented team approach to the problems of emotional and mental disability. There is increasing concern in dealing with those social factors, or pressures which may be ego damaging and related to the onset of illness, unemployment, poor housing, a demeaning welfare system, to name but a few. There is increasing recognition on the part of mental health facilities for the development of linkages between agencies which would result in the delivery of maximum services with a minimum of stress.

A study conducted by the Special Services Division of the Department of Social Services in 1970, revealed that virtually none of the patients discharged from State Hospital facilities and referred for public assistance, could be found or traced to a community facility one year after the date of discharge. In most cases the hospital and Department of Social Services had failed to institute appropriate follow-up and thus the patient had been "lost" in a network of agencies "passing the buck". While obviously, a health system cannot account for all the indignities suffered by individuals and their families, it must, nevertheless, provide linkages to other systems which are already in a position to advocate creation or implementation of such supports.

We consider the following concepts crucial to a functionally and disease-oriented health system :

1. *A non-categorical universal government health insurance program, with equal access to all Americans.*—The Health Security Act, sponsored by Senator Kennedy and Representative Martha Griffiths, offers the best benefit structure of the major proposals. We are opposed, however, to the limitations which it places on dental and psychiatric care. We fully support the concept of no deductibles, no co-insurance and no means test.

Our experience has indicated that the complexity of waiting periods, deductibles and co-insurance discourages early utilization of health services, especially those of a preventive nature.

2. *Health-Social Services Integrated System.*—Medical Services must take their place as part—and only part—of the continuum of health care. All current health proposals concentrate mainly on physicians' services and on institutional providers. The Javits, Kennedy, Health Insurance Association, and American Hospital Association proposed plans include the need for Allied Health Manpower training and development. However, they implicitly relegate health professionals to secondary status within the health delivery system, thereby perpetuating the idea of a medically-focused health delivery system. This can be clearly seen in the Kennedy bill provision for private vendor payments to physicians. Social Workers have and are serving as private individual vendors of services in a variety of health settings; as counselors, therapists, consultants and as such are entitled to the same reimbursement for services as physicians.

The Health-Social Services system provides for continuum of care. It is based firmly on the team approach. At one point, the physician plays the principal role and at the other times, depending on the situation and need, the social worker or other allied health professional (with the physician in a consultative role).

Health-Social Services in the community closely conforms to parallel functions in the in-patient acute hospital. The five components of health-social services—personal services, supportive medical services, personal care, maintenance, counselling and linkages—are common to both in-patient and community care. Increasingly, linkages are being recognized as a vital set of services without which available health care is not utilized.

The social work profession has a major role in the development of a linkage system in which we not only insure that patients receive health social-service supports for optimum functioning but also through research we indicate needs for changes in social policy.

3. *Consumer and Provider Control of Health System.*—If one is not to be bogged down in another bureaucratic medicare experience, there must be allowance for strong consumer participation at policy-formulating and decisionmaking levels.

We endorse the Kennedy bill's advocacy of "Public control of basic policies governing the program and full public accountability for its financial and operational activities".

However, its recommended administrative and policymaking structure would not appear to support the above. Decisionmaking authority is heavily centralized in the five-member, president-appointed Health Security Board, with few provisions for autonomy at a local or regional level.

While the Kennedy bill is the only major health proposal to strongly incorporate the concept of consumer input, we are critical of the fact that it relegates the consumer to a purely advisory role. It is ambiguous and vague regarding the extent of consumer input into basic policies governing the program. The bill would establish an Advisory Council to the Health Security Board, of which consumer representatives will constitute a majority membership. Although the Health Security Board will be required to consult regularly with the Council, the Board will control expenditures from the Trust Fund, establish national benefit patterns, *set standards of participation* and develop policy guidelines! We doubt that public accountability would be developed under such an administrative structure.

A truly preventive and relevant health system is one which seeks the involvement of people; a delivery system in which a community has a stake. We believe that communities and consumers should have a major voice in determining programmatic priorities most relevant to their health needs.

Present proposed legislation is vague and fails to cite effective mechanisms or to define the limits and extent of citizen or consumer participation in the proposed systems. We specifically recommend that National Health Care legislation include the concept of consumer-provider controlled health systems. We consider this a major provision for a humanly viable system.

Medicaid and Medicare, by its failure, and the Children and Youth Comprehensive Care Programs, by their success, have demonstrated the significance of prevention and the need for health social-services.

It is significant that Congress has developed and supported the Veterans Administration Program and the Children and Youth Comprehensive Care Program, both of which have given us some experience in establishing continuum of care. We are glad to note that the Social Work Professional is not alone in seeing the need for a continuum of medical Health-Social Services.

We recognize and applaud some of the concepts espoused in the Kennedy-Griffiths Bill, most notable of which is the concept of consumer participation and public accountability. However, we must conclude that present health legislation falls far short of incorporating the components and supportive framework for a functionally and disease-oriented health system. We feel that such a system must be implemented if we are to effectively deal with the present health crisis.

Dr. BRODY. Thank you very much for allowing us to testify before you this afternoon.

Mr. VANIK. Thank you very much, Dr. Brody.

Does Dr. Watkins want to add to your statement?

Dr. WATKINS. No, unless there are questions.

Mr. VANIK. I appreciate your testimony, and I applaud your taking a firm position on the legislation.

We are anxious to get a reading from as many witnesses as possible concerning the variety of proposals that have been submitted, and we certainly appreciate your far-reaching and courageous statement this afternoon.

Our next witness will be Jane Keeler on behalf of the Visiting Nurse Association of New Haven, Conn.

**STATEMENT OF JANE D. KEELER, PRESIDENT, COUNCIL OF HOME HEALTH AGENCIES AND COMMUNITY HEALTH SERVICES, NATIONAL LEAGUE FOR NURSING; ACCOMPANIED BY MRS. LEAH HOENIG, EXECUTIVE DIRECTOR OF THE COUNCIL**

Miss KEELER. Mr. Chairman and members of the committee, my name is Jane D. Keeler, and I am the director of the Visiting Nurse Association of New Haven, Conn., an accredited community health service. I am also the president of the Council of Home Health Agencies and Community Health Services of the National League for Nursing, and it is in that capacity that I appear before you today. I am accompanied by Mrs. Leah Hoenig, the executive director of the council.

The council is the national spokesman for over 1,400 home health and community health agencies throughout the country and includes in its membership the majority of the large community health agencies. These agencies provide services to people outside of hospitals; in other words, in patients' homes, in schools, ambulatory centers and other community settings such as senior centers and neighborhood health centers.

The scope of health care provided through such agencies includes services directed toward preservation and restoration of health, prevention of disease and disability, as well as therapeutic care and rehabilitation in the presence of illness. The delivery of services is accomplished through working with individuals, with families, and with groups. All age groups are served.

Our work with families extends to the health status and health needs of all family members. Health teaching and counseling ranges from fostering basic sound health practices to concern with critical health problems such as drug abuse, the increasing incidence of venereal disease, mental and emotional disturbances, and infant and maternal mortality and morbidity. In addition, we consult with patients, their families and other components of the health care team to determine the most appropriate patient care plan with particular reference to the utilization of hospitals, nursing homes, and community health services.

Community health agencies utilize the services of nurses, physical therapists, occupational therapists, physicians, social workers, nutritionists, home health aides, and speech and hearing therapists. Therefore:

Recommendation No. 1: The Council of Home Health Agencies and Community Health Services fully supports the enactment of legislation that would authorize a program of national health insurance for all our citizens.

At this time we are not prepared to wholly endorse or reject the provisions of any of the several legislative proposals in behalf of national health insurance that fall within the jurisdiction of this committee. We are confident the measure approved by the committee will be the product of the careful consideration of the many complex factors that are involved. On the basis of our experience in the health care field, however, we urge that favorable consideration be given to several principles in the adoption of the final bill.

It is axiomatic that the finance of health care services is a determining factor that affects the organization and delivery of health care services. When voluntary health insurance programs expanded sharply following World War II the emphasis with respect to covered services was focused on hospital care, the most expensive health care service.

The irony of the situation is that the availability of this most expensive health care service sharply expanded the utilization of hospitals while care at home in many instances would have been more appropriate and much less costly. But care at home was not covered by insurance. Between 1940 and 1965 the number of admissions to general hospitals increased from 74.3 per 1,000 population to 145.5 per 1,000.

The enactment of medicare further contributed to the demand for hospital care and its costs by making it possible for senior citizens to pay for hospitalization. Hospital costs have doubled over the past 5 years. Under existing law a part A medicare beneficiary must be hospitalized before he is eligible for home health services. The financial incentive, therefore, is for hospitalization. In addition, the emphasis of medicare is on the payment of curative as opposed to preventive health services.

There are many elderly people who have slim prospects for total recovery, but who have the need for part-time intermittent skilled nursing observation, preventive and restorative services. Changes in the patient's physical or emotional condition may alternate between an acute or stable state, requiring observation, change in regimen and medication. Denial of reimbursement for intermittent skilled nursing or therapeutic services to these individuals in their homes under the present regulation has, in many instances, resulted in the patient being served in a hospital or extended care facility at much higher cost to the taxpayer. Therefore:

Recommendation No. 2: The Council of Home Health Agencies and Community Health Services urges the Congress to adopt national health insurance provisions that will give priority to preventive health services and provide incentives to care for people on an out-of-hospital basis.

The cost of health care cannot be considered in the absence of standards of care and the quality of health care services. Consequently, we believe that any national health insurance legislation should provide for quality performance standards on the part of providers.

In the interests of improving the quality of community health services, the National League for Nursing and the American Public Health Association cosponsor a national accreditation program for community health agencies. The criteria are more comprehensive than those required for certification under medicare for home health agencies and should be required for community health agencies participating under the national health insurance program that is approved.

In addition there is no provision under existing law for the utilization review process for home health agencies that is now required for hospitals. This process is a safeguard against overutilization and should be extended to home health services.

Therefore, recommendation No. 3: The Council of Home Health Agencies and Community Health Services recommends that the Con-

gress require high standards for all national health insurance providers, including home health agencies, and that the utilization review process be extended to and required of home health and community health care agencies.

The need is great for redirection of the health care system from the narrow concept of "medical care in institutions during periods of acute illness" to one of "health care which include improvement and maintenance of health, prevention of diseases, curative and rehabilitative services." In the restructure necessitated by this change in focus it would be wasteful to encourage the development of agencies or services which parallel or compete in communities with existing agencies who provide quality services. We have seen the results of funding which encouraged the establishment of agencies whose services duplicated those provided by existing community agencies. Failure of the new agencies to coordinate with the existing community agencies by contract or similar mechanisms has led to overlapping, increase in administrative costs, confusion for communities, with insufficient evidence that the new independent services lead to improved care for people.

Therefore, recommendation No. 4: The Council of Home Health Agencies and Community Health Services urges the Congress to provide for the most effective use of existing health care resources and the elimination of duplication of health care resources in the enactment of national health insurance. To avoid the existing duplicating and fragmentation that now exists at the Federal level in the case of health care programs, we recommend a single organizational unit for the administration of national health insurance. Such a unit might be a Department of Health—at the Federal level—and it should make provision for consultation from community health agencies and other providers.

To reduce inpatient care, further reduce hospital costs, and provide for coordinated care through early referrals to community health agencies, we recommend that community health agencies be permitted to employ home health service coordinators whose salaries would be fully reimbursable. Such coordinators would work with the physician, patient and family to develop appropriate posthospital plans for the care of the patient.

Therefore, recommendation No. 5: The Council of Home Health Agencies and Community Health Services urges the Congress to require inpatient providers under national health insurance to affiliate with community health agencies and to encourage full utilization of such agencies.

I am attaching three resolutions that are pertinent to the consideration of national health insurance. These resolutions were approved by the National League for Nursing membership on May 12, 1971.

Thank you for the opportunity to present these recommendations. We will be glad to answer any questions you might have.

(Attachment to Miss Keeler's statement follows.)

## NATIONAL LEAGUE FOR NURSING

(Resolutions approved by the NLN Membership May 12, 1971)

## RESOLUTION I

Whereas, National legislation has yet to make available to all people of this country a fiscally sound, coordinated, and adequate system of health care to the people, despite the fact that more public and private funds than ever before have been expended for health, and

Whereas, The present distribution of funds inhibits the full utilization of health care knowledge and techniques, particularly in relation to the control of preventable diseases, and

Whereas, An adequate health care system should provide for the following :

1. Care on the basis of need rather than on the basis of geographical location or ability to pay,
2. Preservation and restoration of health, prevention of disease and disability, as well as therapeutic treatment of the sick,
3. Insurance coverage for health care in homes and in ambulatory settings as well as in institutions,
4. Planning by consumers and providers of care to establish priorities for health care, taking into account the cost and variations in health problems of certain groups of people and in certain geographical locations, and
5. Education programs related to smoking, drug abuse, environment and other factors that affect health.

Whereas, The crisis in health care in this country transcends differences in political views and calls for concerted efforts of all health agencies to work together; therefore be it

*Resolved*, That members of the National League for Nursing urge the speedy passage of federal legislation which will make high quality health care readily accessible to all segments of our society; include all aspects of health care services with greater emphasis on the preventive as well as therapeutic aspects of care; and include financing mechanisms which make health care services more readily available to all citizens and, at the same time, provide appropriate controls of health care costs.

## RESOLUTION II

The present outcry for a dramatic change in the delivery of health care can be satisfied only with a coordinated approach in which the consumer, the provider, the payor, and the giver of health care all participate. An adequate delivery system requires preventive as well as therapeutic and restorative services delivered to people where they are and in response to what they need and want, and given in such a way that all health personnel function to the level of their potential.

Whereas, The effective redesigning of the health care system requires responsible collaboration among all human service disciplines and health care clients, and

Whereas, The wise utilization of all health personnel, and their distribution to meet consumer needs depends upon understandings by all of the roles of each participant, including the consumer, and

Whereas, There is a continuum of health care needed at various stages of wellness and illness, and various levels and kinds of care are appropriate at different stages, and

Whereas, Incentives are needed which are directed to keeping patients ambulatory and functional insofar as is compatible with the health status of the person, using all health facilities as economically as possible; therefore be it

*Resolved*, That the National League for Nursing request the President of the United States to call a White House Conference on Health Care to establish national priorities to create an effective, efficient, and economical health care delivery system which guarantees each individual access to a full range of preventive, therapeutic, and restorative services; and be it further

*Resolved*, That representatives of the consumers, providers, payors, and givers of health care be invited to attend this White House Conference on Health Care and address themselves to all aspects of the health care system including manpower needs, facilities, financing, and distribution of services; and be it further

*Resolved*, That the National League for Nursing urge national health, health related, and consumer organizations to support this request to the President.

RESOLUTION III

Whereas, The costs of health care continue to escalate, and

Whereas, Care delivered at the home level of the health care system in general has been demonstrated to be less costly than in hospitals as well as highly acceptable to those receiving such care, and

Whereas, Home health agencies have demonstrated their capacity to deliver high quality of patient care in the patient's home; therefore be it

*Resolved*, That the National League for Nursing affirm the need for continued emphasis on the utilization of home health services; that efforts be initiated and continued to avoid duplication of such services at the community level and that existing home health care agencies presently providing patient care services be utilized in any community level development, restructuring, or reorganization of health care services; and be it further

*Resolved*, That positions taken by the National League for Nursing relating to national health care coverage and the restructuring of the health care delivery system reflect the significance of home health care in the total delivery system.

Mr. DUNCAN. May I commend you upon your excellent presentation. I realize you have given it great thought and study. In fact, I think it is one of the finest statements we have received at these hearings during the past 2 weeks. We thank you very much for your contribution.

You say between 1961 and 1965 hospital admissions increased from 74.3 percent per 1,000 of population to 145.5 per 1,000 population. Has it been on the increase since then?

Miss KEELER. I frankly would not be able to answer that question with any degree of accuracy. I would presume the escalation has continued and particularly in view of the fact that the medicare program, which expanded the availability to more individuals in their older years, came into being in 1966. I think we can presume that that rate has continued to increase.

Mr. DUNCAN. Do you think it would be less if we had better and more health care at home?

Miss KEELER. We certainly support that premise, particularly as it relates to the present law under part A, and unless the individual is admitted to the hospital, he is not entitled to home benefits. We feel there would be many situations in which individuals could be quite adequately cared for at home.

Mr. DUNCAN. I think the Veterans' Administration has been very successful in moving veterans out of the hospital and into home care programs.

Miss KEELER. They have recently assisted some of their members with aid and assistance.

Mr. VANIK. Thank you very much, Miss Keeler. We appreciate your being here.

Miss KEELER. Thank you.

Mr. VANIK. Our next witness is O. L. Frost, Jr., member of the Federal Affairs Committee of the Los Angeles Area Chamber of Commerce.

You may proceed.

**STATEMENT OF O. L. FROST, JR., ON BEHALF OF LOS ANGELES  
AREA CHAMBER OF COMMERCE**

Mr. Frost. Mr. Chairman, my name is O. L. Frost, Jr., and I am vice president of Occidental Life Insurance Co. of California, here today representing the Los Angeles Area Chamber of Commerce, a nonprofit organization with over 2,500 member business organizations from five southern California counties: Ventura, Los Angeles, Riverside, San Bernardino, and Orange.

We are grateful for an opportunity to be heard on this important matter of health care.

To conserve your time, I will briefly summarize our statement at this time, and request permission to file our full statement for the record.

Mr. VANIK. Without objection, your full statement will appear in the record at this point.

(Mr. Frost's prepared statement follows:)

STATEMENT OF O. L. FROST, JR., LOS ANGELES AREA CHAMBER OF COMMERCE

Mr. Chairman: My name is Otis L. Frost, Jr. I am a vice president of Occidental Life Insurance Company of California here today representing the Los Angeles Area Chamber of Commerce, a nonprofit organization, with over 2500 member business organizations spread through five Southern California Counties.\* The Chamber represents a broad spectrum of the business community from the very smallest to very largest.

On June 3, 1971, the Los Angeles Area Chamber of Commerce Board of Directors adopted the following resolution:

That the Board of Directors of the Los Angeles Area Chamber of Commerce support the principle of the institution of an efficient national health-care system which will maximize access to such a system for all citizens, with minimum government participation, and prominent private enterprise participation, and which will seek to balance the supply of and demand for healthcare services; and

That the Board of Directors endorse the basic principles contained in the Administration program and the health insurance industry proposal, or a combination thereof, which would preserve and encourage the private enterprise approach to health care; and

That the Board of Directors vigorously oppose the so-called Kennedy plan, or similar proposals, which would create a federalized health care system.

This resolution was based upon the recommendation of the Chamber's Federal Affairs Committee which studied the current healthcare situation in depth through a special subcommittee under the chairmanship of this witness. Much of the following material was the basis for that committee's and the directors' actions.

**BACKGROUND**

In recent months it has become politically fashionable to decry the terrible healthcare crisis in the United States. Often the implied scenario depicts a system on the verge of collapse, unwilling or unable to respond to the just needs of any of its citizens. And yet, a dispassionate look at some of the relevant facts discloses no crisis of capability, but rather a crisis of recognition that, in an era when our nation's health has never been better, there are many who are ill-cared for—that is a time of plenty, there is want. Thus, the crisis of recognition comes from the realization that our system is basically capable but, for a variety of reasons, is not doing the full job we would like.

But let us depart from essay and move into the world of perspective achieved through analysis of carefully juxtaposed facts.

\*Los Angeles, Orange, Riverside, San Bernardino, Ventura.

Statistics since 1950 show that life expectancy has increased 3.4 percent, infant mortality has dropped 2.3 percent, and maternal mortality has gone down 66 percent. Between 1960 and 1968, the days lost from work per person have decreased by 3.5 percent, and the days lost from school per person have decreased 7.5 percent.

And yet, to gain insight into these figures one must look to the experience of similarly situated countries. Such comparisons are imperfect and must be used with considerable caution, but with this in mind, note that Sweden, which devotes about as much of its national product to health as the United States does, has an infant death rate that is about half that of the United States; 12 countries have lower maternal death rates; 17 countries have longer life expectancies for their men; and 10 have longer life expectancies for their women. However imperfect the comparison, these facts show a disparity between what has been accomplished in the United States and what may be possible.

Another set of figures indicates that the national effort to purchase better health has been expanding at a rapid rate. For example, in 1960, total health-care expenditures were 26 billion dollars or 5.3 percent of GNP. In 1970, total health-care expenditures were 67 billion dollars or 7 percent of GNP.

In greater detail, the 1970 figures amount to \$324 per person. In fact, the 1970 figure is \$33 per person higher than the 1969 figure—an increase of 12 percent. The public sector has increased its pace of health-care expenditures from 25 percent in 1966 to more than 37 percent in 1970, and Federal contributions have risen even more rapidly from 3.5 billion dollars in 1960 to 21 billion dollars in 1970. The annual rate of growth in health-care expenditures since 1929 has been 7.4 percent. However, the rate of growth in the latter half of the 60's was 12 percent.

However, a further look at the statistics relating to health-care expenditures uncovers the startling fact that 60 percent of the growth in expenditures has been solely for inflation! In the last four years, hospital costs have risen at an average rate of 13 percent a year, and in 1970 rose 15 percent over 1969. The costs of hospitalization rose to an average of \$70 a day in 1969 with \$100 a day not uncommon in many big city hospitals. Physicians' fees have been increasing at more than twice the rate of the consumer price index. In 1970, the average expenditure per person for physicians' fees was \$62. In 1969, Americans spent half as much on medical care as they did on food, and the bill for health services is rising faster than the bill for food. The amount spent for the average family of four in 1969 was more than \$1,000; just three years earlier it had been under \$750. And for persons of retirement age, the bill in 1969 was almost \$700 each, up from \$423 in 1966.

Other indices show that health-care resources have been growing faster than the population. Hospital beds per 1,000 people have risen from 12.4 in 1963 to 13.5 in 1969. Between 1950 and 1966, when the population grew by 29 percent, the number of people in health occupations grew by more than 90 percent. From 1960 to 1966, the percentage of the labor force representing health workers rose from 2.9 percent to 3.7 percent. In the same period, the number of physicians rose by 34 percent.

But as before, a further examination of the statistics reveals that the 34 percent increase in the number of physicians since 1960 still leaves this country seriously short of the needed physicians. We find that 130 counties in the United States have no private doctors at all and that number is growing. The national average is one doctor per 630 persons, but over one-third of the United States' counties have a per capita rate that is less than one-third that high. There are 1,000 Midwest towns that have no physicians at all. In New York City, some areas have one doctor for every 200 people, and yet in other areas we find only one doctor for every 12,000. In Chicago, inner-city neighborhoods have 1,700 fewer physicians than ten years ago.

Perhaps the most controversial issue is the best method of financing health-care and therefore an appraisal of the record of the private sector is of special importance. We find a substantial increase in health insurance coverage over the last two or three decades. In 1950, only 50 percent of the population had any health insurance. By 1970, over 90 percent of the civilian, noninstitutionalized population under 65 had private hospital insurance. In greater detail, in 1940 only 12.3 million persons had hospital coverage; in 1950, 76.6 million were so covered; and by 1970, 175.2 million had this coverage. In 1940, only 5.4 million had surgical benefits and none had major medical. By 1950, 54.2 million had surgical benefits but there was still no major medical. However, in 1970, we found 162.1 million had surgical and 76.2 million had major medical.

In recent years the type of insurance coverage has been shifting to more all-inclusive comprehensive coverage—the major medical expense type of policies which pay virtually all kinds of hospital and medical care in or out of a hospital, prescribed by a physician, including drugs, nurses, and prosthetic appliances. Maximum benefits usually range between \$10,000 and \$50,000 and higher. The number of persons under age 65 covered by this type of insurance grew from 70.4 million at the end of 1969 to 76.2 million at the end of 1970. Dental insurance is a new coverage but it is showing good growth—benefits paid grew \$60 million in 1970 to \$138 million and persons covered reached 6.6 million. Disability income insurance to replace lost wages while ill has grown rapidly and benefits paid in 1970 reached \$1.7 billion. Rehabilitation coverage and other experimental plans are available, providing new concepts in financing medical care. Of course, there has been a great increase in protection for the aged and the poor through the Medi-Care and Medicaid programs.

But, though exact comparative figures are difficult to establish because quasi-health expenditures (toothpaste, band-aids, aspirin, veterinarian fees, etc.) are included in the private benefit payments of \$15 billion leave a substantial gap. Thus, despite the fast advance of health insurance, the remaining financing problem is large.

Finally, the evidence shows a general profusion of impressive new techniques, powerful new drugs, and splendid facilities. Penicillin and sulfa drugs are commonplace. Polio vaccine has virtually wiped out the once dreaded disease. Tuberculosis is relatively a minor problem today. Open heart surgery and organ transplants are not regarded as unusual. Computers and electronic devices have aided tremendously in diagnosis and treatment of health problems. Medical research in recent years has given some hope that the two major killers, heart disease and cancer, can be overcome.

But of what value are these to the poor who in many instances do not benefit at all from far less sophisticated treatments. Fifty percent of children living in families whose incomes are below the designated poverty line are never immunized against childhood illnesses. The disability rate for families below the poverty line is 50 percent higher than for families with \$10,000 or more income per year. It hardly needs to be said that poverty breeds illness and illness, more poverty.

The positive impression created by the fact that Medicaid has now spread to 48 of the 50 states is moderated by the realization that only one-third of the estimated poverty population received services under this program in 1970. Only 133,000 of an estimated 750,000 women and infants in low-income circumstances received comprehensive maternity and infant care. Note also that 16 of the participating states got 80 percent of the money and two, New York and California, got 30 percent of the money, although they only have 20 percent of the population.

Thus, what we find in the above litany of statistics is a maldistribution of what we have, a maldistribution of the financing with which to have it, and an inflationary spiral in the cost of having it. Admittedly, these are interrelated problems that must be simultaneously attacked, but whose causes must be individually identified before the coordinated attack can begin.

What then are some of the causes of this dislocation and inflation?

#### CAUSES

Take as a beginning point the doctor problem. While there has been a heavy population migration to the cities, physicians and other healthcare personnel have sought the amenities of the suburb. Also, fewer services are available from primary-care physicians (general practitioners, pediatricians, and internists) because their numbers are declining. This decline is brought about by an increased emphasis on specialization in medical schools, which to some extent has been encouraged by the greater prestige and income that attends such specialization. In fact, some medical schools almost seem to regard the family physician with contempt.

More importantly as a cause, however, is the orientation of the medical care system. The system is directed to acute rather than diagnostic-preventive medicine. There are few incentives to prevent illness or to diagnose illness and treat before the problem becomes acute.

Another known impact on costs whose quantitative effect is hard to measure is malpractice litigation. Recoveries have grown so that malpractice insurance

costs have risen 10 percent per year for the past five years. Many doctors cannot purchase protection at any price. Consequently, many feel doctors have become overly cautious, thereby leading to ordering excessive tests or lengthening hospital stays to avoid any ground for suit. Such a situation also discourages the use of physicians' assistants and causes further deterioration in the doctor-patient trust relationship.

In relation to cost, the role of Medi-Care and Medicaid has been a substantial factor. Such programs have been willing to reimburse hospital expenses at cost, which means that there have been few incentives to hold down costs, to seek means of increasing the productivity of health manpower or to substitute capital for labor. Also, Medi-Care provides that physicians will be paid their customary fees. In many cases, physicians had been giving care free of charge or at prices below what they consider to be their value. As a result of Medi-Care, there was a rapid jump in the cost of physicians' "customary" fees for services. In general, Medi-Care and Medicaid increased effective demand for services without increasing their supply.

Note also that in the healthcare insurance area only half of those covered have coverage for out-patient and laboratory services or for treatment in the physician's office or in the insured's home. As a result, there is an overutilization of expensive hospital facilities. The average hospital stay is one day longer today than it was eight years ago. In some areas, one-fourth of the available hospital beds are occupied by patients who could get better care on the outside. In fact, one estimate says that if the average length of hospital stay could be reduced by one day, 1.7 billion dollars could be saved per year.

Much more detail in the form of statistics, illustrative stories, etc., about the nature and cause of the current healthcare situation is available in lengthier studies. However, we hope that the foregoing adequately substantiates our conclusions as to the basic nature and cause of the problem and we believe that the general thrust of the remarks would be concurred in by most every responsible spokesman in the field, despite his particular emphasis on the facts. The disagreement among the many spokesmen in this field comes as to the manner in which these fundamentals should be attacked. After carefully analyzing what is possible in relation to what is desirable, and after carefully considering those motivations and approaches that have best served Americans in the past when confronted with a substantial problem in their way of life that arouses their usually humanitarian spirit, we believe that a program incorporating the following principles will best accomplish the task before us.

#### *1. Heavy participation by the private sector*

One of the basic problems as described earlier is that of financing the cost of healthcare. It is generally agreed that an insurance mechanism will be utilized (as contrasted by a socialized medicine system as found in Great Britain). Thus, the question becomes—who will fund and operate it? (There are also interrelated questions of inflation control, ability to pay, etc., that will be discussed elsewhere.)

The Chamber believes that the record shows a good effort to date by the private sector in this area; a record that justifies continued confidence in this sector given a proper mandate.

The statistics noted earlier relating to the growth in insurance coverages clearly demonstrate that this mechanism has played an important role and is constantly seeking new ways in which to play a greater and more effective role. A great body of expertise has developed within this industry that enables it to do as effective a job as it does. However, there are also some serious shortcomings which were pointed out but which can be taken care of by a combination of Government direction and incentive with a great effort on the part of the involved companies. We believe that the past performance of this industry justifies the conclusion that it can effectively respond in the future. We are of the opinion that the best course in the circumstance where a system has performed well, but needs improvement, is not to discard the system, but rather to build upon its strengths and to correct its weaknesses. There is no justification for discarding the accumulated experience of thousands of persons in preference to the creation of a new, untried, untested, monolithic Federal Bureau. Destruction of a tested system which has shown capabilities of change and adaptation is wasteful, especially when contrasted with the inevitable costly and duplicative mistakes that will be made by a new untried system. Retention

of the private system preserves an element of cost consciousness which would be completely lacking in a monolithic system. Retention of the private system preserves an element of healthy competition which will strive to produce better service at lower cost; such motivation would be lacking in a monolithic system.

The government should set certain minimum standards for insurance protection and then through a mandate or incentive program ensure that all Americans are covered (whether employed or self-employed). The success of such a privately administered program is augured by that of group insurance currently being marketed. At the same time, the government should be sure that such protection applies to any delivery system selected, be it HMO or private physician.

Such a program, because of the many different carriers involved, would have the necessary flexibility to account for the extreme vulnerability of the small businessman to the cost of health programs. Whereas a monolithic system like some of those currently under consideration would no doubt lead to a situation like the current unfortunate impasse of Social Security. These taxes have become so burdensome (particularly for small businessmen) as to be of great concern. This is the classic example of the lack of cost-consciousness and consequent spiralling inflation attendant upon government bureaucracies.

But if there is to be this partnership between government and business, some consideration must be given to the regulation of the industry that will operate the partnership.

### *2. State regulation of the insurance industry*

The Chamber believes that the track record of state regulatory bodies of the health insurance industry has been quite good. As in any regulatory enterprise, there are exceptions. However, most of the state insurance departments have, like the industry that they regulate, developed considerable expertise in their business. As noted in the discussion above, it would be wasteful and unjustifiable to discard such expertise in an area as vital as this. Consequently, the Chamber believes that regulation of the health industry should be preserved at the state level.

However, the Industry also recognizes that the problem of healthcare is a national one and that certain national standards must be met. The Chamber further recognizes that if the national government is to mandate or provide incentives for certain minimum coverages, that it must be able to guarantee that such coverages will be provided for sums expended. The Chamber further realizes that certain other national controls may be desirable. Consequently, the Chamber believes that it is desirable that national standards be set and periodically reviewed by a national commission of one description or another. But, the Chamber emphasizes the importance of leaving enforcement to state regulatory bodies who are much more effectively equipped to perform that enforcement that would be any newly created government bureaucracy. To the extent that individual states are unwilling or unable to perform this task, then and only then should the Federal Government participate in this aspect of the enterprise.

### *3. Provisions for inflation*

The Chamber has identified several aspects of the basic inflationary problem. A primary one, of course, is supply and demand. Consequently, a further expansion of financing demand without any increase in the services supply will exacerbate this problem. Thus, any legislative program that attempts to confront the problems of national healthcare must, of necessity, provide for increased support to medical education and research; must provide for increased use of medical assistants so that existing services can serve a larger number of people than is currently possible; must encourage greater use of ambulatory care facilities, prepaid group practices, and so on. Community healthcare planning must be improved to better distribute current and future health resources.

The Chamber recognizes that there will be a lag in time between the increased support of medical education and subsequent increase of physician output. There will be similar lags in other programs to increase supply in an effort to reduce cost. Therefore, the Chamber suggests that whatever changes are made in the financing system, they be phased in on a schedule which is coordinated with that during which the supply of services is growing. This will minimize inflationary pressures. At the same time, the Chamber believes that wherever possible persons must have some involvement in the cost of their medical care. Such involvement, through the use of coinsurance and deductibles, can go a long way toward dis-

couraging overutilization. At the same time, the Chamber realizes that such cost consciousness factors must not impede the progress of the poor toward improved health. Other cost reducing incentives are available and should be concomitantly implemented, such as peer review, prospective service payments, equality of payment for equal service rendered, etc.

#### 4. Provisions for the poor

Since the Chamber believes that every American should have equal access to quality medical care, special provision must be made for those who, through no fault of their own, are unable to fully participate in the financing of their own protection. Such persons, regardless of how they are designated, or by what criteria, should have a dignified opportunity to achieve good health. The Chamber believes that such provision can be made using the private sector as a primary carrier or as an administrator (analogous to the current Medicare).

As a primary carrier, private insurers who are participating in the minimum standards program could form state insurance pools for all those not covered in the employer-employee program. Risk of loss and gain could be apportioned between government and carriers. On the other hand, Medicaid could be extended to the poor as well as the aged and disabled and administered through the private sector much as Medicare is administered currently. Either approach would utilize the administrative expertise of the private sector with its attendant advantages of cost consciousness, competition, etc., and thus, would be able to supply better coverage at lower cost than a Federal bureaucracy.

#### SUMMARY

Thus, we have explored the quality of healthcare in America and find many difficult problems, such as shortages of health manpower, maldistribution of health personnel, rapidly rising costs, and lack of development of preventive care. We have also seen that the private sector has responded well in the past, and with proper redirection and invigoration, will respond quite emphatically and effectively now to the recognized healthcare needs of the nation.

To accomplish this task we propose a partnership of government and private enterprise which would combine the flexibility, innovativeness and efficiency of the private sector with the unique fiscal and legislative capacities of the Government and oppose programs which scrap the present system and seek to erect a new monolithic Federal Bureau.

Mr. Frost. Other witnesses have well stated the problems which our studies also revealed—there is no purpose in restating them now for we all recognize the shortages of health manpower, its maldistribution, the lack of sufficient attention to preventive care, medical education, the rapidly rising costs of the present delivery system and their causes.

We must seek solutions and the problem is not one of the goal to be reached but how.

We see no sound reason to scrap the accumulated experience of thousands of persons in preference to the creation of a new, untried, untested monolithic Federal bureau. Destruction of a tested system which has shown capabilities of change and adaptation is wasteful, especially when contrasted with the inevitable costly and duplicative mistakes that will be made by a new, untried system. Rather, we believe the best approach is to modify and improve the present system. Therefore, we support a partnership of Government and private enterprise which will combine the best traits of private enterprise; namely, flexibility, innovativeness, and efficiency with the unique qualities of Government; namely, its fiscal and legislative capacities.

Both the administration program and the health insurance industry programs express these basic principles. We urge the committee to give careful consideration to the plight of both business and employees under the increasing burden of social security taxes. An untested, new monolithic Federal program coupled with an increased social

security tax is a concept which the chamber vigorously opposes. It could quickly have the most serious economic consequences and particularly for our smaller member business firms. The drain on employees' purchasing power, coupled with income tax withholding, has become substantial.

Therefore, the chamber supports and urges the principle of the institution of an efficient national healthcare system which will maximize access to such a system for all citizens, with minimum government participation, and prominent private enterprise participation, and which will seek to balance the supply of and demand for healthcare services.

Thank you, Mr. Chairman.

Mr. VANIK. Thank you very much. We are very pleased to have your testimony.

Mr. DUNCAN. Mr. Frost, does your company have a hospitalization program? Do you sell hospitalization insurance?

Mr. FROST. Yes, Mr. Duncan. Occidental, I believe, is the eighth largest group insurance writer in the world and roughly half of our writing is group health insurance, and we write, I believe, every kind of health insurance written today.

Mr. DUNCAN. Do you have any idea of the size of the indigent hospital care budget for the city of Los Angeles?

Mr. FROST. I should have that number at my fingertips because I am a member of the chamber's State and local committee which studied that budget, but there are too many numbers in it.

Mr. DUNCAN. It is very, very large.

Mr. FROST. Yes, sir.

Mr. VANIK. Thank you very much.

Mr. FROST. Thank you, Mr. Chairman.

Mr. VANIK. Our next witness is Anthony P. Mynders, chairman, public health committee, National Hearing Aid Society.

**STATEMENT OF ANTHONY P. MYNDERS, CHAIRMAN, PUBLIC HEALTH COMMITTEE, NATIONAL HEARING AID SOCIETY; ACCOMPANIED BY ANTHONY DIROCCO, EXECUTIVE SECRETARY**

Mr. MYNDERS. Mr. Chairman, I am Anthony Mynders, chairman of the public health committee of the National Hearing Aid Society. I am accompanied by Mr. Anthony DiRocco, our executive secretary.

On behalf of the society, I wish to thank you for the opportunity to appear and testify along with other members of the hearing health team. We all have the same purpose—to emphasize the importance of every American's need to hear.

Before I begin my remarks, I would like to give you a brief description of the society and what it does. The society which marked its 20th anniversary 2 weeks ago, is an association of more than 3,000 hearing aid dealers. There are some 5,500 hearing aid outlets employing 20,000 people.

The society's main objective is to build an ever-improving force of competent and reliable dealers to provide help for the hearing handicapped through electronic amplification, after medical or surgical correction has been ruled out. To assure that the best possible assistance

is rendered to the hearing handicapped, the society administers a stringent code of ethics, which closely parallels the FTC trade practice rules for the hearing aid industry.

The society provides study courses, workshops, and seminars resulting in the certification of competence. Under our certification program, the applicant must have at least 2 years of practical experience, complete the study course and pass a rigorous examination, and provide character and proficiency recommendations, including at least one by an otologist.

The society has supported strong legislation for the licensing of hearing aid dealers. Twenty-seven States now have dealer licensing laws that legally define the dealer's role and responsibility in the public interest as qualified members of the hearing health team.

Incidentally, our certification examination has been used in most of these States as a model for the State Licensing examination.

Mr. Chairman, our organization is vitally interested in the problems of hearing loss among people of all ages. It is our life work—the career to which we have dedicated ourselves and in most cases our life's investment. In other words, we are committed.

#### THE PROBLEM—AND WHAT CAN BE DONE

In a recent Public Health Service monograph, it is estimated that some 8,500,000 Americans have auditory problems which impair communication. Of these, we estimate 2 million now wear hearing aids. Most of the remaining could probably benefit from the use of electronic amplification.

The socioeconomic impact of communication problems inherent in hearing losses leads to psychological maladjustment, learning disability, loss of income, and withdrawal from society.

Hearing loss is the hidden disability, because it cannot be easily pictorialized, and because the very psychology of progressive deafness seemingly demands concealment on the part of those so handicapped. The ability to hear is essential to the full development of individual capabilities and to the enjoyment of life on the part of young and old alike.

These people can be helped, and the hearing aid dealer has historically been the provider of such help. He measures hearing, fits, selects, and adapts hearing aids to individual requirements. Of the approximately 500,000 persons who buy hearing aids each year, at least 98 percent of them benefit from the services of a dealer.

The hearing aid dealer has long been a source of identification for rehabilitation. In 1968, this fact was recognized by the Government in an agreement between the National Hearing Aid Society and the Social and Rehabilitation Services of HEW, then under the late Miss Mary Switzer. HEW said then that members of the National Hearing Aid Society "are frequently the first point of inquiry from hard of hearing people and thus are strategically situated to increase the flow of referrals to the State divisions of vocational rehabilitation." John Twiname, now director of the Social and Rehabilitation Services, reaffirmed the agreement recently.

## THE DEALER IN SERVICE TO THE HARD OF HEARING

The hearing aid dealer is doing his job well. U.S. Public Health Service figures say that 93 percent of those who use their hearing aids constantly are satisfied. A recent study conducted by a highly respected market research organization, commissioned by NHAS and the Hearing Aid Industry Conference (the manufacturers' association) revealed a 90 percent satisfaction rate among users. Not many fields of endeavor can boast of a better record.

The dealers enjoy this successful, satisfying rapport with their clients, first because they must sell service, not just an electronic gadget. Their job just begins with the delivery of the hearing aid. From then on, they will see their clients on an average of about once a month for the life of the aid. And they will supply the psychological and social reinforcement and a myriad of maintenance services. The hearing aid user must not only learn to use his instrument, but also must learn to hear again by reestablishing sound memory, tolerance levels of noise, and instantaneous selective recognition of speech sounds.

The dealer's afterfitting services represent a greater part of the retail price than the hearing aid itself. In terms of the cost of time, his investment, and the constant availability of services, the hearing aid user is really getting maximum benefits.

Second, the dealers' geographic distribution closely parallels general population distribution and makes these services that are so essential to user satisfaction available at local levels. Most towns of any size at all offer the community a choice of several different dealers. Many dealers serve rural communities too small to support a full-time dealership on a regular basis. Dealers are the only providers of hearing aid services to the homebound and those in homes for the aged and similar institutions where it is impossible for the hearing handicapped individual to travel. The dealer is there with his products and services, wherever you are, and he is the only one there.

## THE DEALER IN GOVERNMENT SERVICE

As your committee considers various proposals to provide national health insurance for all Americans—and I certainly presume that hearing health will be a part of any national health insurance program—I beg you to keep in mind the complex and diverse needs of those you seek to serve.

The National Hearing Aid Society—and I believe I can speak for the Hearing Aid Industry Conference as well—believes that the hard of hearing can best be served by utilizing to the fullest extent the existing dealer delivery system. Not to utilize fully this great national resource would be fiscal extravagance and a disaster of inconvenience for those whom a Government program is designed to help.

The hearing aid dealer stands ever ready to help his customers, on virtually a moment's notice. Rarely does a client have to wait more than half a day to get an appointment to see his dealer for help. In an emergency, help is immediately available. Using centers and clinics often results in a wait of 6 weeks or more for an appointment. They simply do not have the manpower available to handle the caseload. The answer, gentlemen, is not simply to spend vast sums of public money

to build more hearing clinics and staff them—the answer is to make full use of an already existing resource that is ready—right now, today—to provide help for the hard of hearing. The answer is to make full use of a system that pays taxes instead of consuming tax dollars.

Once a doctor has determined that hearing loss can be helped only by a hearing aid, it is simply not necessary, in the overwhelming majority of cases, for the physician to send a patient anywhere but directly to a local hearing aid dealer—and that is the way it is in actual practice today.

Why subject the person to a long wait for a clinical evaluation, after which he eventually winds up in a hearing aid dealer's office, if he is to get a hearing aid? Most doctors send him to the dealer in the first place. He can usually get an appointment with a dealer the very day he calls. The dealer measures the remaining hearing, if the doctor has not already done so, and selects the instrument best suited to the client's needs. Within a few days, the person is on his way back to the world of communication.

For most of his patients, the otolaryngologist knows that all that is needed is a simple measurement of the extent of the loss, followed by the selecting and fitting of an instrument which best compensates for that loss. There is no need to complicate this procedure with either bureaucracy or the delay and academic overkill of an elaborate sequence of clinical evaluations.

The dealer stands ready to provide his prompt, competent, reliable help to Government-aided clients. In fact, he is already doing so under vocational rehabilitation, medicaid, and other State and Federal programs.

One Government program where the dealer is not in the picture is in the VA distribution system. And we contend that the veteran is therefore inconvenienced and slighted in too many instances. VA is well intentioned, of course, but it is depriving the veteran of local, on-the-spot service and the local availability of someone who understands his problems, and who can help him get through the sometimes difficult adjustment period of learning to use a hearing aid and who can provide continuing service.

Not only is the veteran short changed, but so is the taxpayer. VA must pay, in addition to the cost of the aid itself, all the costs that a dealer must bear in terms of space, equipment, staff, inventory maintenance, et cetera. The resulting total outlay by the taxpayer far exceeds the cost for perfectly satisfactory, superbly convenient service—with absolute fiscal controls—available only in the local commercial hearing aid market place.

In addition, because there are only 40-some VA locations in the country, the taxpayer must pay considerable transportation costs for the veterans. Close to half of the States have no VA hearing aid facilities at all. Would it not be better, gentlemen, to send the veteran to a dependable source of help right in or near his home town?

#### SUMMARY AND RECOMMENDATIONS

The National Hearing Aid Society believes that in any Government aided procurement of hearing aids, the dealer network should be utilized and fully effective.

Use us because :

The dealer has proven competence and reliability, as is demonstrated by the following :

1. The Public Health Service survey which determined that 93 percent of the constant users of hearing aids expressed satisfaction with their aids.

2. The independent market survey which reinforced these statistics by reporting a solid 90 percent satisfaction rate with services rendered by the hearing aid dealer.

3. The fact that licensing laws in 27 States have legally defined the role and responsibility of the hearing aid dealers, providing sanctions against incompetence or betrayal of public trust.

4. The FTC rules and regulations for the hearing aid industry which provide interstate controls when intrastate legislation does not suffice.

Use us because :

The dealer delivery system provides a reservoir of well-distributed manpower available nowhere else—in place and operating right now.

This reservoir of manpower has available office space, test equipment, inventory of new and loaner instruments, service facilities, and counseling services essential to user satisfaction in every State at convenient locations that can be put to use today, without 1 cent of cost to the American taxpayer. In addition, home service as required is available at all these locations.

Use us because :

The fitting of a hearing aid is an art—not a science. The 90-percent rate of user satisfaction with a hearing aid is related to the character and capacity of the man behind the hearing aid—the dealer—in the same way that patient satisfaction with a physician is related to the character and integrity of the doctor as much as to his professional armanentarium and training.

The versatility, vitality, and intellectual energy of the hearing aid dealers represent one of the great resources of the hearing health team, and we urge this committee to recognize the contributions of the hearing aid dealer in breaking the sound barrier for impaired ears.

Today's problems of health care are infinitely more complicated and come with increasing speed and greater significance to the hard of hearing. We must plan for tomorrow in terms of the tools and services available today, and yet leave ourselves the flexibility to grow and incorporate new techniques and procedures as they develop.

As hearing aid dealers, we don't profess to have any answers to the great problems confronting our Nation in the area of health care. We leave that to the collective good judgment and calm deliberation of your committee. Where hearing health is concerned, however, we have made our suggestions today as to how the Nation may best utilize a strong, seasoned, competent, and splendidly distributed resource. The dealer distribution system has supplied virtually all of America's hearing aid users for over 50 years, and we are now mobilized and in the best position in our history to serve as a provider of prosthetics and services under any national health insurance program.

We look forward with enthusiasm to the opportunity to serve the hearing handicapped under any national health insurance program which your committee and the Congress may develop that incorporates the provision of hearing aids.

Thank you, Mr. Chairman.

We will be happy to supply any additional data the committee may request, and we thank you for the opportunity of appearing.

Mr. DUNCAN. I have no questions, Mr. Chairman.

Mr. VANIK. We want to thank you for your statement, and we appreciate very much your being here.

The next witness is Ednajane Truax, DCNA-DCLN-DCSNA Committee to Study National Health Care. Please identify those accompanying you.

**STATEMENT OF EDNAJANE TRUAX, CHAIRMAN, COMMITTEE TO STUDY NATIONAL HEALTH CARE, OF THE DISTRICT OF COLUMBIA NURSES' ASSOCIATION-DISTRICT OF COLUMBIA LEAGUE FOR NURSING-DISTRICT OF COLUMBIA STUDENT NURSES' ASSOCIATION COMMITTEE; ACCOMPANIED BY DELIA O'HARA, SHEILA HAMEL, AND MARIE HENRY, REGISTERED NURSES**

Miss TRUAX. Mr. Chairman and members of the committee, I am Ednajane Truax, chairman of the DCNA-DCLN-DCSNA Committee to Study National Health Care.

The District of Columbia Nurses' Association is composed of professional nurses, the District of Columbia League for Nursing is composed of health professionals and interested consumers, and the District of Columbia Student Nurses' Association is composed of students of professional nursing.

In January of this year, the boards of directors of these three organizations unanimously passed a resolution to appoint an ad hoc committee to study national health care, its implications for nursing in general, and, in particular, for nursing practice in the Metropolitan Washington area. For the past 10 months, we have been so engaged.

Today, I will not be speaking in support of or in opposition to any specific proposal, but rather to:

- (a) Outline the elements which we feel must be included in a comprehensive health care system,
- (b) Discuss the part which nurses and nursing care must play in a comprehensive health care system, and
- (c) Present the need for extended mental health care.

**ELEMENTS OF A COMPREHENSIVE NATIONAL HEALTH CARE SYSTEM**

After studying proposed health legislation, reviewing the literature, and utilizing our professional expertise, we defined the elements necessary to a comprehensive health care system.

First and foremost, we believe health care is care directed toward the preservation of a state of wellness and/or the treatment of deviations from health, for example, disease, trauma, et cetera. Health care should not be confused with medical care. Medical care, as it has developed in our society, is disease-oriented. Health care must include prevention of deviations from the normal as well as treatment.

For a national health care system to have continued effectiveness, it must make provisions to insure that the quality of care provided is good.

Any system designed to deliver health care should include both episodic and preventive care. My episodic care, we mean that area of health care which emphasizes curative and restorative means, and usually involves patients with diagnosed disease, either acute or chronic. Episodic care should include services for medical care; nursing care; hospitalization for acute, chronic, and intractable conditions, both physical and mental; dental care; eye care; and medications. Further, it should include physical therapy, speech therapy, and related services, and sick pay.

Preventive care includes resources for the maintenance of health and the early detection of disease. Good primary health maintenance measures should provide the individual with opportunity for health education in the areas of nutrition, immunizations, eye care, dental hygiene, and mental health.

Secondary preventive services are directed toward the early detection of disease. Appropriate physical examinations and multiphasic health screenings are examples of secondary preventive services.

In addition to providing health care, a national health care system should also encourage the most effective and efficient use of health services and professional health personnel. Provisions for insuring an adequate number of such professionals must be considered.

The availability and quality of health care must not be contingent upon the consumer's ability to pay. Further, consideration of the consumer must be made to provide a clear-cut point of entry into the system, to give freedom of choice in his selection of primary health professionals, to eliminate redtape, and to include the consumer in policymaking and evaluation of the system.

#### NURSES AND NURSING IN A COMPREHENSIVE HEALTH CARE SYSTEM

We do not bring up the question of the position nurses will have in a national health care system without reason. As part of a body of 730,000 practicing, trained health professionals who supervise 400,000 practical nurses and 900,000 aides and ancillary personnel, we find no mention has been made of the contribution nurses will make in any of the proposed legislation. We expect that this huge professional work force will have a profound effect on the delivery of health care. Nurses can fully and independently participate as providers of health care.

For example, in a study done in a Florida hospital, nurses functioned in a diabetic followup clinic. Within several months, they were able to decrease hospital admissions of diabetics by as much as two to four admissions per year. A similar study compared regular clinics with the nurse-operated clinics. At the end of a year, more patients in the nurse-operated clinic were back to full and part-time jobs and had fewer symptoms.

Nurses are being educated and trained in a wide range of clinical practices, such as pediatrics, maternal health, family health, mental health, and rehabilitation. The nurse can be the key person seeing a family or individual with a health problem.

Skilled in the normal and prepared in preventive health care, the nurse can provide well-baby care, normal prenatal and postnatal care, and observation, education, and support following diagnosis of a chronic disease such as cancer, diabetes, or heart disease.

We are here not only as advocates of the nursing profession, but also as consumer advocates. Because we have continual and intensive contact with patients and families, we nurses are more aware of the consumer's desires and needs than any other health professional group.

Any national health plan must include provision for utilizing the potential resources of the largest group of health care professionals in the United States—nurses.

#### THE NURSE'S ROLE IN A HEALTH CARE SYSTEM

##### *I. Education and counseling*

The nurse has much expertise. People can come to the nurse to seek help in establishing individual optimum health patterns, reestablishing such patterns, and in defining what constitutes optimum health patterns. The nurse often provides the means for a person to give self-care by assisting, teaching, counseling, evaluating, motivating, and supporting. (Orem, "Nursing Concepts of Practice.")

##### *II. Screening and coordinating*

Nurses can act as primary health care professionals. Nurses can advise in medical, educational, social, or emotional areas. We are taught and equipped to handle all these aspects of patient care. By using our skilled observation techniques, we can determine if a patient's problem can best be handled by a nurse, physician, social worker, or other health professionals.

The State of New York recognizes the scope of our ability in its recent proposed Nurse Practice Act. Their definition of nursing reads:

The practice of the profession of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential health problems through such services as case-finding, health teaching, health counseling, and the provision of care supportive to or restorative of life and well-being, and executing medical regimens prescribed by a licensed or otherwise legally authorized physician or dentist.

##### *III. Preventive nursing*

The nurse, more than any other health professional, provides preventive health measures. In well-baby clinics and schools, nurses advise parents, teachers, and children in matters pertaining to the development of good health habits. Concurrently, she is alert for the early signs and symptoms of health problems.

##### *IV. Hospitals*

Since 65 percent of practicing nurses are employed in hospitals, it is pertinent here to discuss the contributions of hospital-based nurses to a national health care system.

Nurses in hospitals are responsible for the nursing care of patients, executing prescribed medical regimens, and coordinating the care of groups of patients.

They provide considerable expertise in assessing, planning, and implementing patient care. This can clearly be seen in the case of a person who has had a heart attack. In the coronary care unit, a nurse monitors cardiac functions for irregularities and decides when to adjust or initiate prescribed medical regimens. Simultaneously, she assesses the patient's response to his illness and offers appropriate

support. As he improves and moves to a less acute unit, the nurse advises him in the gradual resumption of activities, diet, medications that have been prescribed, and signs which will alert him to seek future health care. Such nursing care saves lives and promotes health habits which can prevent future hospitalizations.

The few examples we have given illustrate the contributions nurses can make toward the maintenance of health. It is obvious that any national health plan must include provision for utilizing the potential resources of this, the largest group of health care professionals in the United States.

#### THE NEED FOR COMPREHENSIVE MENTAL HEALTH CARE

The need for comprehensive mental health care is directly related to society's attitude toward the emotionally disturbed and the mentally ill. The stigma attached to such physical diseases as tuberculosis and cancer has all but disappeared, but the stigma remains with mental illness. Physical illness is still far more acceptable to the public than mental illness. This rejection by society of the mentally ill is reflected in all the national health insurance proposals now before the Congress. It is for this reason that we wish to speak to the need for comprehensive mental health care.

##### *I. The obvious need for comprehensive mental health care*

Emotional disturbances and mental illness are costly to society in terms of money, the decreased or actual loss of productivity of those afflicted, and the social problems which are believed to stem from poor mental health. The costs are great, and in many instances are increasing.

The estimated total number of people recognized as sick and referred for treatment has almost doubled since 1955. At that time, there were in all facilities 1,675,352 patients. By 1968, the figure had risen to 3,380,818 patients, including in- and out-patients. The estimated cost of their care for the year 1968 was \$1,739,258,000 (World Almanac for 1971).

In 1968, 11 in every 100,000 people in the United States were disturbed enough to attempt suicide. The attempts resulted in the deaths of 21,000 people (World Almanac 1971). Those who lived returned to society for the most part untreated, because of the high cost of treatment, and the reluctance of individuals to be identified as having an emotional or mental problem.

The loss of lives and the limited productivity of those who live following a suicide attempt is only part of the cost to our society. The measures taken to save the victims of suicide attempts can be great. For instance, the treatment of a person who has consumed gross amounts of a drug costs: \$758 for the average 3-day stay in an intensive care unit; \$300 for medical care; \$150 for use of the artificial kidney; \$200 for a respirator to aid or maintain breathing: Total, \$1,408.

Suicide clearly has many ramifications.

Other untreated emotional and mental problems are evident: rug addiction is believed by many experts to be rooted in emotional dis-

turbances. Today, drug abuse and addiction have reached astronomical proportions. The cause of alcoholism has long been debated: metabolic versus mental. There is much evidence showing a strong mental health component in those afflicted with alcoholism.

"Divorces have been increasing since 1962, but provisional data indicates that the increase in both the number and rate became more pronounced in 1968 and 1969" (World Almanac 1971). The question of divorce resulting from mental health problems has not been answered. However, that the rearing of children by a sole parent may endanger the mental health of the parent and the children has been more clearly documented.

### *II. Measures to date*

Efforts put forth to deal with these problems have, for the most part, attacked each problem as a separate entity. For example, suicide prevention centers, drug addiction programs, Alcoholics Anonymous. However, these problems have a common denominator, the inability to cope with the stress of life, the failure to develop the strength of mind so valued by our society.

We do the Nation a disservice by not promoting good mental health as a primary effort, rather than simply creating agencies to deal with the many different products of poor mental health habits.

### *III. Means of remedying the situation*

A national health care system should include both episodic and preventive mental health measures.

Episodic care includes promoting the availability of treatment and providing for the long periods necessary for successful treatment. A person who has had a heart attack may be fully recovered in 3 to 6 months, but a person who attempts suicide may need 3 to 6 years to attain full recovery.

Preventive care includes primary and secondary measures. Primary care calls for mental health measures aimed at promoting strength of mind. Good mental health habits must become an integral part of our being.

Secondary preventive care refers to early detection of emotional disturbances and mental illness. Attention to mental health should be an integral part of all health examinations. As with physical deviations from health, problems should be referred for appropriate treatment.

### SUMMARY

In summary, a comprehensive national health care system must include both episodic and preventive care. Appropriate emphasis must be given to mental health. And, certainly, provisions for the utilization of nurses, the largest group of health professionals in the United States, are necessary.

(Appendixes A and B to statement follow:)

## APPENDIX A

## ELEMENTS OF A COMPREHENSIVE NATIONAL HEALTH SYSTEM

## DEFINITION

Health care is care directed toward the preservation of a state of wellness and/or the treatment of deviations from health, e.g., disease, trauma, etc. Health care should not be confused with medical care. Medical care, as it has developed in our society, is disease-oriented. Health care must include prevention of disease as well as treatment.

Therefore, any system designed to deliver health care should include episodic and preventive care. *Episodic care* is that area of health care which emphasizes curative and restorative means and usually involves patients with diagnosed disease, either acute or chronic. It includes:

- Medical Care;
- Nursing Care;
- Hospital Care (For acute, chronic, and intractable physical and mental illnesses);
- Dental Care;
- Eye Care;
- Medications;
- Physical therapy, speech therapy and related services;
- Homemaker services; and
- Sick Pay.

*Preventive care* is that area of care that facilitates maintenance of health and prevention of disease. It includes:

Health teaching in the areas of:

- Nutrition;
- Immunizations;
- Eye care;
- Dental hygiene; and
- Mental health.

Early detection of physical, mental, and emotional problems.

Further, a comprehensive national health system should:

Encourage the most effective and efficient use of health services and health professionals (physicians, nurses, dentists, speech therapists, et al.) and include provisions for expanding the supply of health professionals, especially nurses.

Provide a clear-cut point of entry for the consumer into the health system.

Permit the consumer freedom of choice in the selection of primary health professionals.

Include the consumer in policy making and evaluation of the system.

Eliminate red-tape.

Provide that the quality and availability of health care is not contingent on ability to pay.

Include effective surveillance of the quality of care provided.

## APPENDIX B

## REFERENCES

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3. Orem, Dorothea E., *Nursing Concepts of Practice*, McGraw-Hill, Inc. N.Y. 1971
4. Jordan, Dorothy C. and Shipp, Joseph: "The Primary Health Care Professional Was A Nurse" *American Journal of Nursing* May, 1971 Vol 71 No. 5
5. ——— "The Nurse as a Practitioner" *N.E.J.M.* March 20, 1969
6. The 1971 World Almanac. The Washington Daily News.

Mr. VANIK. Thank you very much, Miss Truax.

Do any other members of your panel desire to add to your statement?

Miss TRUAX. No, sir.

Mr. DUNCAN. May I thank you for the study you have given this subject, and for your excellent presentation. I am sure that your views and thoughts will be given the most serious consideration by the committee in finalizing a bill. Thank you.

Mrs. O'HARA. You mentioned earlier, and questioned some of the witnesses whether a comatose patient can be treated in the home. I can say from experience as a nurse that I have seen comatose patients treated in the home.

Mr. VANIK. Is that by constant surveillance of a nurse or a visiting nurse?

Mrs. O'HARA. It is a matter of teaching and supervising members of the family to give the care to this family member.

Mr. VANIK. And the nurse would come once a day?

Mrs. O'HARA. At least once a day and spend approximately an hour a day with the family of the comatose patient.

Mr. VANIK. To check the needs of the patient. Some of these patients are recoverable and some are not. It is hard to say because the recovery period is so long.

Mrs. O'HARA. In the case where recovery is not possible you do not necessarily have to provide hospital care for the patient who is going to die. They could die at home, with many of the services that are necessary provided by nurses coming in from the outside.

Mr. VANIK. How would you feel about a fee for service? Do you feel that would be desirable?

Miss TRUAX. I have no particular feeling one way or the other. This is a personal opinion. As long as I receive money for what I am doing, it could be fee for service or any other way.

Mr. VANIK. Is it not an established fee service now; some nurses are on salary in institutions and others are out in the private practice as special-duty nurses. I feel very sorry for the special-duty nurses. They empitomize small business under the most difficult circumstances.

First of all, their work is uncertain. As I understand it, the rate is fixed. Who fixes the rate for special-duty nurses? Is it a matter of contract or custom?

Miss TRUAX. It is usually fixed by the local nurses association and the local registry.

Mr. VANIK. Then the nurse has to have her own billing system and there are frequently times when she does not collect her money.

Suppose you were on duty from 11 o'clock at night until 7 in the morning, or some such thing, and the family or no one else is present at the time the nurse goes off duty and she sends a bill. The chances are she may or may not be paid. Isn't there any system whereby special-duty compensation or payment for the service could be handled in some special way so the nurse would not have to run her own system of bookkeeping and auditing?

Miss TRUAX. Generally speaking, the nurse is in business for herself. It is a private contract between her and the patient.

Mr. VANIK. Then what is wrong with her fixing any rate? That would leave her free to negotiate on rates.

Miss TRUAX. I hope some of the private-duty nurses are still here. They may be interested in doing so.

Mr. VANIK. I feel there ought to be some regular system whereby the services could be included on some other bill, particularly if the

services are rendered in the hospital. It would seem to me that it would be just a little more of an effort for the hospital to collect for it and be paid for it. I assume there is quite a backlog of unpaid bills for private nurses?

Miss TRUAX. I do not have these figures.

Mrs. O'HARA. You say the hospital could collect the money from the patient, but the private-duty nurse, as I understand it, is employed by the patient rather than the hospital.

Mr. VANIK. I understand that many private-duty nurses work in a given hospital. I was just hoping that a better system of nurse reimbursement could be developed.

As a lawyer handling the administration of estates, it seems sometimes that the last bills coming in for payment are those of the private-duty nurse who has not been paid. I don't feel that the nurses should subsidize health care any more than the doctors or anyone else. If we are going to encourage private-duty nursing and give the profession the esteem it ought to have, then we ought to be able to assure some system of payment to the provider of the service.

Miss TRUAX. We appreciate your concern for private-duty nurses. This is one small segment, though, of nursing, and we are primarily concerned with the other aspects which have been outlined. Even though we are concerned with our fellow colleagues getting paid.

Mr. VANIK. As far as this variety of plans is concerned, have you indicated any special preference for a plan that you feel would be most satisfactory to your profession and provide the greatest amount of service to humanity?

Miss TRUAX. We do not speak for or against any bill at this time.

Mr. VANIK. If you do develop an opinion let us know. We are trying to arrive at a conclusion and everyone is telling us what would be good and what would be helpful to their profession, and how we could best legislate to provide for their special dimensions of service. When it comes to the key question as to what should the Ways and Means Committee do, we are still left with a great many experts who testify before us without really giving effective guidelines on what direction we should be taking.

So we have to choose between seven, eight, or nine or 10 plans that have been put into the hopper and out of them evolve a national health plan which best serves the American people.

Miss TRUAX. One of the major reasons we do not support any of the proposed legislation is that none of them really answers the full national health care problem.

Mr. VANIK. All of the plans leave out areas of action that should be included. The statement of such omissions is a very important contribution, for which Mr. Duncan and I and other members of the committee are extremely grateful.

There being no further witnesses, the committee is adjourned until 10 o'clock tomorrow morning.

(Whereupon, at 5:05 p.m., the committee was adjourned, to reconvene at 10 a.m. Friday, November 5, 1971.)