HEALTH CARE CRISIS IN AMERICA, 1971

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON LABOR AND PUBLIC WELFARE UNITED STATES SENATE

NINETY-SECOND CONGRESS

FIRST SESSION

ON

EXAMINATION OF THE HEALTH CARE CRISIS IN AMERICA

MAY 17, 1971
SAN FRANCISCO, CALIF.

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HEALTH CARE CRISIS IN AMERICA, 1971

MONDAY, MAY 17, 1971

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE,
San Francisco, Calif.

The Subcommittee on Health met at 9:15 a.m. in the University of California Medical Center, San Francisco, Calif., Senator Edward M. Kennedy (chairman of the subcommittee) presiding.

Present: Senator Kennedy.

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

Senator KENNEDY. The subcommittee will come to order.

I, first of all, want to express my very sincere appreciation to Mr. Phil Lee, who I have had an opportunity to know for a number of years and whom now serves with great distinction in his position, for the help and cooperation that he has provided to us in making this facility available to us.

For a period of the last 3 months the Senate Subcommittee on Health has been having hearings. The first 8 weeks took place in the U.S. Senate in Washington. We listened to the experts, the spokesmen for the industry, the insurance industry. We listened to the American Medical Society. We listened to the Hospital Association.

And now, during the period of the last 3 to 4 weeks the Senate Subcommittee on Health has traveled to New York City, to see the health crisis in that area. The next day we went to Nassau and Westchester Counties which are very affluent, to consider the quality of health care.

We traveled to West Virginia, which is our second most rural State in the country, to see the health crisis as it is portrayed in a rural community.

And later we traveled into Cleveland and Chicago; in the Midwest to Iowa—again to try to get some feel for the health needs in rural Iowa.

Today, we are here; and tomorrow in Los Angeles.

I think, of all the testimony that we have taken, none of it portrays the health crisis any better than some of the witnesses that we will hear from this morning, and other consumer witnesses that we have heard from in different parts of our country. I think they tell the story in dramatic detail, and in many instances in tragic terms to the problems that we are facing here in this country.

So, we will go ahead with the consumers; and after we have heard from some of the consumers we will hear from three professional per-

sonnel, and then by the time that is available, we will open up this hearing for comments from the floor. We never have as much time as we like; and usually we have to keep the comments down to a couple of minutes depending on how many people we have.

We will do the best we can. Anyone who does not testify who wants to make a comment, write to us and we will include your comments as part of this record.

These charts, here, reflect in some ways the shortages that we have in terms of health manpower; also, in terms of health status, and, also, the various criteria which are identified in that column.

This chart over here shows inflation on health costs, generally; and although S. 3, my national health insurance bill, is not before this subcommittee, it summarizes very briefly some features of the national health security crisis.

This chart indicates where we are going, in terms of future costs under the present system and under the Health Security Act.

And then, finally, this chart over here is of some significance because it shows how the money is being spent at the present time. Thus you see, by next year, we will be spending a hundred billion dollars for the quest of health—and what we will be spending on national defense—under the administration's program, will be a hundred billion dollars.

Under S. 3, the cost of the Health Security Act is $68 billion; the administration suggests it is $77 billion. I think our figures are more relevant to the cost, that is, $68 billion.

We are finding we will be spending approximately the same amount of money whether we go by the present administration amount—and really the question is whether we are going to attempt to reform the system and try to provide some significant reform within it, or whether we are going to build on the present system and move to the administration program which relies heavily on the insurance mechanism.

In any event, we will hear from our consumer witnesses and then from the professionals—and then open it up for any comments from the floor.

We have until 11:30—and I hope we can have at least 15 minutes for comments from the floor.

I will ask Rita Sklar to proceed. I welcome you. We are very appreciative for your comments, since it is a part of our tradition not to really share our tragedies or personal experiences in public, or even with a Senate Subcommittee on Health—and so it is always a great service that individuals provide.

I think a part of the reason that we have the health crisis is that we have people, particularly consumers, who are reticent to express themselves about the system itself. So, we are very appreciative of those who have come here to make comments on their experiences. Please proceed.

STATEMENT OF MRS. RITA SKLAR, HOUSEWIFE, EXPATIENT AT KAISER HOSPITAL, OAKLAND, CALIF.

Mrs. SKLAR. I am here to talk this morning about my experience at Kaiser Hospital, in Oakland.

My first appointment at Kaiser was November 13, I had just had a baby. I was 7 weeks post partum; I was nursing the baby and I wanted to continue nursing the baby.

When I found out I couldn't take birth control pills because of a change in the hormones and a limit to the amount of milk that I would have, I decided that I would try to get an IUD—intrauterine device.

I called Kaiser and they told me there was only one doctor who would insert an IUD, and that would be in 2 weeks' time. I called them back, because I wanted to find out why this was so, and I wanted to speak to a doctor—which is hard to do. When you call up, you always get a receptionist. So, I got a doctor on the phone. He said that was nonsense and he would take me that afternoon, but, of course, he didn't make appointments and he told me to call the appointment desk. So, I called the appointment desk and they wouldn't believe he wanted me to come in in the afternoon. So, it took a number of other phone calls and different processes like that to finally convince that attendant he did want me to come in that afternoon.

So, in the afternoon of November 13 I went to Kaiser for the first time, and in the course of examining me, prior to putting in the IUD, the doctor put a hole through my uterus by mistake.

I was immediately hospitalized and spent the night in the hospital and I was released the next morning. I was hospitalized because they were afraid I would bleed and that I would have to undergo surgery; in fact, that didn't happen—so I was released the next morning. But a week later, I began to have pain, and the pain began to increase; I began to have diarrhea and vomiting and I finally went to the emergency clinic.

The first doctor I saw asked me a lot of questions and I told him the whole story; and he pressed my stomach, which by this time was very hard and distended and very tender—and he gave me a rectal examination. And at this point, he left. He was off duty and he left with all this information.

And the next doctor that came in asked me all the same questions, pressed my stomach—the routine went on and on—and then they called in a gynecologist who asked the same type questions. He gave me a pelvic examination. He called in someone from surgery, who came in and asked the same questions, and he insisted on giving me another rectal eximination which I just had a half hour before.

And the only person there who had any kind of a human response to me and my husband, as people, was a young intern who happened to be on emergency that night, and who walked in just to talk to us. Of all the people I saw that night he was the only one who was in any way personable and human and was concerned about how I was feeling and about the whole situation. I spent a week in the hospital at that time.

I want to point out the irony of the situation, because originally I wanted to get an IUD because I wanted to continue nursing my baby and here I was in the hospital, unable to nurse the baby and separated from him, and always worrying about whether the milk would stop, whether the baby would get used to the bottle.

So, after I spent a week in the hospital I was put on antibiotics for a week and then as soon as I got off the antibiotics the pain came back and I had to go back to emergency and then I was seen by the chief gynecologist who did a very painful pelvic examination. And I realized, at that point, that he did not know what it felt like to have a pel-

vic examination; he had no idea; he would never know what that was like. And immediately after he examined me, he had an intern examine me for his own practice.

Senator KENNEDY. You had been examined how many times?

Mrs. SKLAR. I haven't counted them.

After awhile—there is another whole element to this, which is that all the while that I was in the hospital I was in the gynecology ward, but they kept saying to me, "Maybe it was appendicitis"—not wanting to accept responsibility for the fact they had caused my illness and always trying to think of something else I might have that they wouldn't be responsible for.

When I went back to emergency the second time and saw the chief gynecologist, he said to me that he realized that it was a part of the infection that was caused from the punctured uterus and he told me to go home and wait and it would go away. Time would make it go away—and that is what I did; until around the middle of January when I had an attack of pain in the night. I didn't want to go back to Kaiser but when it wouldn't go away—I kept taking pain pills—so finally we went in and we saw a gynecologist and he said that he just didn't believe that it had anything to do with gynecology and he told me to go to medical, which is across the street, and a whole different department.

So the next day I went to medical and this doctor I saw said he couldn't believe that it was such a thing, a coincidence, that I would have something else wrong, like a gall bladder or ulcer, and I should go back to gynecology. So, I walked back across the street and I went to see the head of the gynecology clinic and this man wanted to examine me and I explained I had just been examined a few hours earlier by one of the doctors, who suggested I go to medical and I saw no reason to do that again. He insisted he examine me and he found nothing, and he said I should go back to medical.

This was the first time that the doctors had ever gotten together and discussed my case and decided on a course of direction.

I went back to medical and he told me I should go to the X-ray department and get a barium X-ray; so, I went across the street again to the X-ray department and they told me I would have to wait a month. I put my name down, and in fact in a month I did take an X-ray which turned out to be negative—which I knew it was.

At that point, I gave up on Kaiser, and I haven't been back since—and I just decided to get well on my own, because every time I went it was just such an upsetting experience.

So I want to say, also; when I had this interview with the head of the gynecology clinic he said to me, "I can't understand why you have so much trouble. We do this once a week. We perforate a uterus once a week" I think that borders on malpractice; and it sounds incredible.

Well, I would like to share with you some of the conclusions I have come to, from this experience.

One is that I feel that health care is a right that every American has and a right that we have already paid for. Consider if 70 cents out of every tax dollar that we pay to the Government were spent on health care and related services to the people, were spent on maintaining life instead of destroying life, as it was—70 cents in every dollar

that goes to defense in this country—and 70 cents in every dollar—the whole world would benefit from it.

I think this is important. I think that this should be part of your legislation.

I think, from this experience, that women are no longer going to take the fact that gynecology, which specializes in the female medicine, is controlled by men.

Men, as I said before, cannot feel what it is like to have a pelvic examination, to have an IUD, or an abortion, or to give birth.

And I also feel—if you haven't already done so—you should try to visit Berkeley Free Clinic—because there in the clinic they try to educate you about your own body, they try to tell you how it functions, they try to demystify medicine.

One time I went to Kaiser, the doctor was writing out a prescription and I said, "What are you writing?" He patted me on the head and tweaked me on the cheek—something that is good for me. This is really absurd. This is really terrible that doctors have—that medicine has an aura of mystification.

I think this is something that also should go into the legislation—that any kind of medical center should have an educational facility, where people can learn about medicine and their own bodies.

I also feel—and this is very important—that any kind of a health program must service the people.

The problem with Kaiser is that it doesn't service people; its purpose is to make money. And if you visit the Berkeley Free Clinic, which is set up to service the community, you can see there is no comparison at all in the service that comes from it.

I feel that the Government, instead of serving the interest of Kaiser and Blue Cross and the AMA—the Government must serve the people—and what else is Government for?

Senator KENNEDY. Very truthful. I want to thank you very much for coming here this morning. I think you have provided some of the most eloquent testimony that I have heard in this committee about the problems with the health system—its impersonalization, its lack of continuity of care; the fact that the consumer doesn't have any real kind of voice, and very little alternative.

What are you supposed to do after you have been abused? What alternative do you really have? This is why it is so important—as you point out.

Mrs. SKLAR. There is no alternative at all.

Senator KENNEDY. And this is where you point out the consumer has to have it—and you mentioned the fact—Why should there be provided profit in the whole health industry? We don't in terms of education, in primary and secondary schools, and even in higher education.

Why should we provide it in terms of health, in this Nation, as well? I think this is important.

I want to commend you on your statement. It says it all—and there is very little any of us can add.

I want to thank you very much, for coming and sharing with us your experiences.

Richard Blackwell. I appreciate your coming, Mr. Blackwell. Tell us your story.

STATEMENT OF RICHARD BLACKWELL, POLICE OFFICER, SAN FRANCISCO, CALIF.

Mr. BLACKWELL. Well, my problem has not been with the medical staff, itself. As far as the medical staff, I have had the best. My problem has been with the hospital cost.

In 1959 my second oldest son was born with a congenital heart defect. I was in the service at the time. I went all over the country, trying to get medical care and no doctors would touch him. No insurance company would touch him. Finally, I came to Dr. Shumway, at Stanford, who said if I could keep him alive for 2 years he would do surgery. By the time the 2 years was up I was $72,000 in debt, 80 percent of that was hospital cost; not due to the doctor's fee.

I worked for years paying off the debt and I finally had to avail myself of the Federal Bankruptcy Act, chapter 13, which is a wage earner's assistance, to get the hospital off of my back. They were bugging me at home, writing me letters at my work; and that was finally the only way I could pay them and keep them from bugging me.

And then October 10, I had another tragedy in the family. My youngest son, 9, was accidentally shot in the head and he was in the hospital from October 10 until the week before Easter. My insurance has now paid $38,000. I paid an additional $7,000.

I have forty more thousand dollars to go.

Senator KENNEDY. You are going to try to pay that?

Mr. BLACKWELL. I will have to pay that; I have no choice.

Senator KENNEDY. How long do you think this will take you?

Mr. BLACKWELL. I paid for 10 years on my other child and I will probably pay 10 years on this.

The hosital is only interested in the dollar. The medical care I think is the best. As far as the medical staff, I have no complaint about them. It is the ridiculous fees that the hospital charges that is bothering me.

My son was in the pediatrics ward, after he was taken out of the intensive-care unit, after two and a half months in the pediatrics ward, in a room with four other boys—it cost $98 a day.

Senator KENNEDY. Did you have insurance during this time?

Mr. BLACKWELL. My insurance paid $38,000 of it, and they wouldn't pay any more.

Senator KENNEDY. What do you mean "They wouldn't pay any more"?

Mr. BLACKWELL. That is the maximum they pay you under the policy. I have New York Life.

Senator KENNEDY. After it reaches some point, they cut you off and you are on your own.

Mr. BLACKWELL. Yes, sir.

Senator KENNEDY. Have you tried to get any more insurance?

Mr. BLACKWELL. Yes, sir; no insurance company will take me. I went to welfare and they just laughed at me. They said, "You don't rate it."

I haven't been able to get help of any type. I have applied to the State; the State has turned me down.

Senator KENNEDY. You are working; they turned you down.

Mr. BLACKWELL. Yes, sir. And my son has three more surgeries facing him.

Senator KENNEDY. Does your wife work, too?

Mr. BLACKWELL. She has to, to pay for the first operation of my other son. Her salary goes to the court each month. We don't see it. We survive on my salary.

Senator KENNEDY. You pay part of that, too?

Mr. BLACKWELL. That supports my three children, my wife, myself—and my daughter needs epileptic medications.

I have been advised to file bankruptcy, but I don't want to file bankruptcy. I would rather pay the people. I have been paying them. It is a ridiculous cost they charge.

I think something should be done to put some kind of a reasonable control on a hospital, for a workingman.

Senator KENNEDY. You have not only experienced that kind of personal hardship—with sick children, an epileptic daughter, an accident to your son; so that you have endured those considerable personal sacrifices and hardships and unhappiness. But, beyond that, the health system worked toward putting you right up against the wall in terms of finances.

Mr. BLACKWELL. Yes, sir. I have had my back against the wall for 10 years and will probably be there for another 10. I see no chance of seeing daylight and enjoying a reasonably comfortable life.

Senator KENNEDY. Wouldn't the easy way out be to go into bankruptcy?

Mr. BLACKWELL. Yes, sir; this would be the easy way.

Senator KENNEDY. You want to pay your bills.

Mr. BLACKWELL. I dont' want to take the easy way. People are entitled to some money, but I don't believe the amount they are requesting. I am willing to pay a reasonable amount. Under the system I have no choice but to pay their fee.

Senator KENNEDY. You have always paid off your obligations and debts.

Mr. BLACKWELL. Yes, sir.

Senator KENNEDY. Your credit is good, too.

Mr. BLACKWELL. I don't believe in credit. I can get credit.

Senator KENNEDY. You can't get insurance.

Mr. BLACKWELL. My children are not insurable.

Senator KENNEDY. Don't you think they should be?

Mr. BLACKWELL. Yes, sir; I think they should be. My 11-year-old son, who had open heart surgery—no insurance company will touch him because he has had heart disease.

And now my son, who is 10, cannot be insured for this accident because the incident is a prior condition. They will cover anything after this, to a degree, but they will not, in any way, assist with his present injury.

Senator KENNEDY. Well, you have got 200 million people. Why shouldn't we be able to spread the risk among the population, rather than have it borne by an individual, in terms of this kind of a hardship? Do you think that would make more sense?

Mr. BLACKWELL. I think it would—if some control was put on these hospitals, to give some kind of relief; not full relief, but a degree to the workingman, to a person who can't afford this type of fee.

Senator KENNEDY. These are collection agencies that bother you.

Mr. BLACKWELL. They are collection agencies.

Senator KENNEDY. They are one of the fastest growing businesses in the country, I understand.

Mr. BLACKWELL. Yes, sir. In this State, if you can't pay a bill, regardless what it is for, a doctor, a dentist, it automatically goes to the collection agency. The collection agencies—they harass you, your employer, they call you at all hours.

The business office at Stanford Hospital calls me—and three times they have been cited in court for contempt, because under the act they are not supposed to contact me in any case.

Senator KENNEDY. What kind of work do you do?

Mr. BLACKWELL. I am a police officer on the Peninsula.

Senator KENNEDY. For how many years have you been a police officer?

Mr. BLACKWELL. I have been with the police force 10 years—and I was an investigator, Marine CID, for the Marine Corps.

Senator KENNEDY. And your wife?

Mr. BLACKWELL. My wife is a lab technician. She makes $480 a month, clear; and the Federal court gets every penny to pay the hospital.

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

Ruthie Henderson, we want to thank you very much for coming down.

STATEMENT OF RUTHIE HENDERSON, CARDIAC PATIENT, OAKLAND, CALIF.

Mrs. HENDERSON. I am Ruthie Henderson, from Oakland, Calif., from one of the worse ghettos. I am here to talk about the Medi-Cal cut.

I am a cardiac patient. I suffer with obesity. I have hypertension and I am a diabetic.

I live on less than $200 a month. I am raising a little granddaughter on $31.50 every 2 weeks.

As a result of the cutback, I have suffered. I have a situation that is called fluid and I have to have Met-hydrine (phonetic) shots at least once a week; and they have been sending a registered nurse to my home every Friday morning for me to take these shots. The Medi-Cal cut that out.

I have to have a certain type of nerve pills—they cut that off. When a doctor wrote a prescription that I had to have this medicine, they sent it to Sacramento, to headquarters. They had to wait 1 month before they had a hearing, and sent it back; so I could receive it.

Every 90 days I have to send this paper back to Sacramento and have it okayed in order to get the type of medicine.

I am partly blind. I need glasses and cannot get the type of glasses that I need. Medi-Cal will not pay for them.

I have a little granddaughter who was hurt at the school site last year, and her eye muscles are turned this way. She has to go to Mt. Zion Hospital to have some surgery on both eyes the last week in June.

Medi-Cal refused to give this kid the type of glasses she needs. I had to request Oakland for something called in-aid in order to receive the glasses and proper nerve medicine this little girl needs.

They finally gave her the first glasses. Now she is up for another pair until the operation. She does not do good work in school because she cannot see very well. And the teachers and doctors have sent to Medi-Cal--have just sent the card that I might be able to use to get this operation. But she will be real sick after this operation. She will not be able to stay in the hospital more than 3 days, and I have been told——

Senator KENNEDY. Why is that?

Mrs. HENDERSON. Because they don't want you to stay in the hospital but a certain amount of days. They do not want her to go to the doctor over twice a month.

Senator KENNEDY. Who doesn't?

Mrs. HENDERSON. Medi-Cal—They will not pay for it, and——

Senator KENNEDY. Who makes that decision?

Mrs. HENDERSON. They have the list and they pay only for certain drugs. The main drugs that you use they will not pay for, and sometime I have to end up buying those drugs like the eyedrops that she used to dilate her eyes before she go for these eyeglasses. I had to buy them because it dilates them when she gets to the doctor and he can take her in.

Another experience I have had—my baby girl is a cardiac patient, also; and she receives $130 a month. She cannot follow a strict diet because it will not pay rent and clothe her and her baby adequate; so she wanted to go to this doctor for a weight problem. He told her if she saw another doctor he would not be able to see her under these terms—and he didn't see her last month because she was taken sick and she had to see a doctor and he wouldn't see her because he sees her twice and you cannot be seen more than twice a month on your Medi-Cal card.

Senator KENNEDY. That is a limitation; is that right?

Mrs. HENDERSON. That is the limit.

Senator KENNEDY. Even though you might be sick or in need of some additional attention, you are not entitled to more than two visits.

Who makes that decision? Is that made by the doctor?

Mrs. HENDERSON. It comes from Sacramento, from headquarters—I don't know who makes that decision.

Senator KENNEDY. How do they know whether you are sick and need it?

Mrs. HENDERSON. I don't know.

Senator KENNEDY. They don't know.

Mrs. HENDERSON. They send a requisition and all your doctor can do is requisition for you and ask for these things and you don't always get it.

With this "fluid" problem I have also my leg I am supposed to buy ointment, and they tell me I can't have this ointment because it is not in the Medi-Cal book--so I have to buy this ointment which is very expensive, to get my leg well in order for me to be able to walk.

Senator KENNEDY. Is Medi-Cal helping people? Or trying to save money? [Applause.]

Mrs. HENDERSON. It is not helping you. It is harming you and a lot of people are suffering because they are poor and have to be on Medi-Cal.

Senator KENNEDY. Thanks, very much.

David Schermerhorn. David, we appreciate your being here. Do you want to tell us your story?

STATEMENT OF DAVID SCHERMERHORN, SOCIAL WORKER FOR HUNTER'S POINT BAYVIEW COMMUNITY HEALTH SERVICES

Mr. SCHERMERHORN. My story is not as dramatic as some of the others we have heard. I think it could get like that.

I am a social worker for Hunter's Point Bayview Community Health Services, which is an HEW-funded project in San Francisco.

My salary is about $10,000 a year, of which I take some of that home.

I am here to testify because I feel that even with what I had always thought would be a good salary for a person—I am married and have two small, adopted children. I thought, with $10,000 a year you ought to be able to live well, and I found I cannot afford good, comprehensive, preventive health care with my salary.

We found out recently that my agency's health insurance has a maximum of $100 a day for hospital charges—and after $100 a day, the patient is stuck with the rest of the cost. One of the staff members' husbands in the office I work in was in the hospital for 3 days and came home with a personal bill for over $500. The insurance had paid $300 and the patient was left with about $280 to pay, after 3 days in the hospital.

I used to have Kaiser coverage which I liked very much. I had a different kind of experience than the lady that testified before.

And I found the Kaiser coverage that we got was very comprehensive. That was when I worked for the Federal Government; but after I quit working for the Federal Government—it was costing me about $450 a month—not a month, pardon me—a year, which is about 5 percent of my salary for the coverage which did not include prescriptions, laboratory tests, or any kind of dental work and I felt it was too expensive for me to carry by myself; so I dropped it.

My two babies are nwo using public facilities for "well baby" care. They go to the city "well baby" clinics. When they get older, and are no longer eligible, then it will get much more expensive.

One thing that has me kind of nervous is that my wife, a couple of weeks ago, had a Pap smear that came out positive—which is a dangerous kind of sign and it is quite possible that she will be having to undergo some serious kind of surgery in the near future. I have the feeling that will be very expensive for me and, in fact, I may not be able to afford it. With the kind of insurance I have now, I don't think it will cover it. We will have to find it out. At this time, we don't know.

Senator KENNEDY. What kind of insurance do you have now?

Mr. SCHERMERHORN. It is called Blue Shield.

Senator KENNEDY. Do you have Blue Cross?

Mr. SCHERMERHORN. It is called Blue Shield. It is very poor. It covers outpatient service after you spend $100 per person per year.

Senator KENNEDY. You get a deductible. That is the famous deductible.

Mr. SCHERMERHORN. Right. And the deductible is $100 per person; after which they pay 80 percent.

Senator KENNEDY. That is to make you cost conscious.

Mr. SCHERMERHORN. I am very cost conscious.

Senator KENNEDY. I find all consumers are—that is why I always have difficulty in sort of understanding why that is such an important feature of the administration's health program.

Mr. SCHERMERHORN. One of the reasons that I feel that I really cannot get good medical care is because of the nature of health coverage, of health care that we have in the private sector which is a fragmentary kind of thing, where we do not have family doctors anymore.

Doctors are all specialized and they don't keep track of each other in the private sector. This is one of the reasons I like group practice, because I feel they are interested in keeping me and my family well, and there was also some guarantee of efficiency.

I think that medical care is much more expensive than it ought to be because of the kind of fragmentation that exists. I think it could be much more efficient and much better than it is.

Senator KENNEDY. Thanks very much, David.

Our next witness is Alexandra Petrich. Mrs. Petrich.

STATEMENT OF MRS. ALEXANDRA PETRICH, RESIDENT

Mrs. PETRICH. What I want to talk about, today, is the kind of health care that people who are not poor enough to be on welfare have.

I don't have insurance, for one reason or another. Three and a half years ago, when I was pregnant, we didn't have any kind of insurance. We weren't eligible to go to Kaiser, or any place like that, and couldn't afford the bill for the payment to a private doctor.

So, I went to the outpatient clinic at Saint Mary's Hospital, which is a very large clinic and has a very large turnover of patients. It is staffed and run, from what I have been able to tell, by interns and it is designed to serve as a learning place for interns.

The women who were coming there to have their babies—they have all kinds of service; but I was just in the place for pregnant women.

The women would all be given an appointment at 9 o'clock in the morning and if you were lucky and happened to get there early you might be able to see a doctor by 10:30—or sometimes you had to wait until 11:30, or so.

After this you see the doctor for 5 minutes. I never saw the same doctor twice. I think maybe once I saw the same person twice but it was always a different person and there was never any kind of an attempt made to treat anybody who is there like they were a person or like they deserved any kind of attention as being a person—it was just being a pregnant being, who had to get this baby delivered.

One time, toward the end of my pregnancy, one of the interns, or doctors, examining me decided there was something slightly irregular about the position of the baby; and so he went out, without saying anything to me, and called in five or six other people, who all proceeded to poke and stick their fingers in me.

I was only 19 years old, and it was my first pregnancy. I sort of resented the fact of a roomful of strange men just coming in and doing this.

Another thing was that at no time was an effort made to explain to me the process of what was happening; and I always was reluctant to ask any questions because the attitude was sort of to get you in and get you out and don't bother us with your questions.

This made it hard. When women are pregnant they get kind of insecure and nervous and I was not experienced and I just felt very uneasy about the whole thing.

When I finally got to the hospital and had the baby the person who delivered it was somebody that I had seen once before. He, I believe, was a resident in obstetrics. The fact of the matter was he was not going to have to come in and see me in my room, a couple of days later. He wasn't really my doctor. He was just delivering the baby.

So, as a result—when he put the stitches in—I don't know what he did, but it was really pretty bad. I couldn't move from the bed for 3 days. The other women were getting up a few hours later. Some of them went home—but I could hardly move. If I complained, they just kind of said, "Oh, yes" and mumbled something and handed me some pills.

Senator KENNEDY. Did you talk with the other women down there, too? Did they share this sort of impersonalization feeling?

Mrs. PETRICH. They seemed kind of—a lot of them, you could tell, were very poor and a lot of them had so many children and they seemed afraid and kind of reluctant to impose themselves on this big, you know, impersonal kind of system that obviously knew so much more than they did.

Senator KENNEDY. Why do you think people are afraid?

Mrs. PETRICH. I just got the feeling I wasn't being told—because I was poor, I was dumb; therefore, I shouldn't bother anybody—and I am not dumb. But that was the kind of impression that I was given. It was obvious that the people who were there were not interested in them and they were just there to serve as experience for these interns who were going to go out into private practice some day.

It wasn't exploitation for money. It was exploitation for other reasons, and there didn't seem to be any kind of empathy on the part of the doctors toward the patients.

I just thought it was kind of a bad way to have a baby, but I didn't have any other choice, and my attitude was, "You are lucky to be here. You are lucky you don't have to have your baby in a hospital with a big ward full of 50 people."

Senator KENNEDY. Your husband works for the Post Office.

Mrs. PETRICH. Yes; he was making about $2.65 an hour, which isn't enough. I didn't want to get a doctor bill of a thousand dollars—which it would cost, close to that, for a private doctor.

Senator KENNEDY. Wouldn't he be covered with some program?

Mrs. PETRICH. I can't remember why—he wasn't covered, for some reason. There was some kind of reason; there was some problem and he wasn't covered—but I am really not sure why.

Senator KENNEDY. But, in any event, you went to the outpatient clinic.

Mrs. PETRICH. I went to the outpatient clinic. It was considered a very good one. It was referred to me by several people—and it just turned out to be a bad experience.

Senator KENNEDY. As I understand, a lot of insurance policies require you to wait 10 months before they cover you for pregnancy.

Mrs. PETRICH. I am not sure. If the carrier does that, they are sure all these people are going to sign up as soon as they find they are pregnant. It's oriented to get——

Senator KENNEDY. We were talking about cost consciousness, before. It seems the insurance companies are cost conscious. They make you wait 10 months, in many instances.

Mrs. PETRICH. They are in it to make money. They are not a public service.

Senator KENNEDY. Do you think they ought to make money on health?

Mrs. PETRICH. I don't; but——

Senator KENNEDY. That is an important opinion.

Mrs. PETRICH. Yes, sir; I guess so.

Senator KENNEDY. You have experienced the system—and you do have a strong opinion about some of its obvious defects. Thank you, very much.

Mrs. Ichiyasu, we want to welcome you. Would you like to tell us your story.

STATEMENT OF MRS. SHIZUKI ICHIYASU, RESIDENT

Mrs. ICHIYASU. It was about 18 months ago—about 18 months ago my husband was injured on the job; and at the time he felt it wasn't too serious since it didn't incapacitate him, in any way.

Senator KENNEDY. Where does your husband work?

Mrs. ICHIYASU. At a hardware store.

Senator KENNEDY. For how many years?

Mrs. ICHIYASU. Since 1952.

Senator KENNEDY. Eighteen, nineteen years.

Mrs. ICHIYASU. Not taking the injury very serious, he just mentioned it to his employer; but he continued working.

Gradually the discomfort became worse and worse and finally he decided he had better be examined by a doctor. He was told that since it was an industrial accident that he must go to a doctor that was designated by the insurance company, and——

Senator KENNEDY. They had an insurance program, a medical insurance program for the hardware store where he worked?

Mrs. ICHIYASU. Yes—for this type of liability.

The inference was very strong if he did not go to the doctor they designated, he may end up assuming the full financial responsibility for any expenses that might be incurred—so he went to the insurance doctor, who diagnosed it as bilateral hernia. He had surgery. The doctor's report stated a slight hernia on one side, no hernia on the other.

But after a period of convalescence my husband felt increased discomfort of the back, the left leg. The doctor tried to tell him he had gout, at that point.

Senator KENNEDY. Which doctor is this?

Mrs. ICHIYASU. This is the insurance doctor.

Senator KENNEDY. They told him he had gout.

Mrs. ICHIYASU. A series of uric tests indicated that he had gout and, therefore, this doctor said he would recommend a certain type of medical treatment, or medication, to correct this situation.

Since it was not related to the injury, my husband felt at this time, if he did have gout, he would rather be treated by his own personal physician.

We consulted our doctor, and he sent my husband for a series of uric acid tests. The results were completely in contradiction to what the insurance doctor had indicated, so my husband refused to continue the treatment. So this insurance doctor said, at the end of December, "So far as I am concerned, you are ready to go back to work."

Senator KENNEDY. Do I understand when he went to the doctor that was recommended by the insurance company he diagnosed it as gout?

Mrs. ICHIYASU. Initially it was diagnosed as a bilateral hernia; and when the pain did not go away, he diagnosed it as gout.

Senator KENNEDY. When the insurance doctor said it was gout, your husband thought it wouldn't be covered, so he went over to his own doctor and he diagnosed it and said it wasn't gout.

Mrs. ICHIYASU. If it was related to his injury, it was covered; but the gout, which is a total medical——

Senator KENNEDY. How is your husband supposed to know—if one doctor says he has gout, and the other says he doesn't have it, what is he supposed to do?

Mrs. ICHIYASU. He had his personal physician perform a health examination periodically and he figures his own doctor knew more about it than a new doctor coming in out of the cold, treating him for another condition.

And the lab report was done by another pathologist, not our own internist and, therefore, this is two doctors' opinion actually contradicting the gout diagnosis.

The pain persisted and with much negotiations with the insurance company, we finally got them to go along with the idea of having my husband examined by a back specialist who diagnosed it as some kind of muscle injury related to the back.

He had physiotherapy for about 2 months, during which time the condition worsened and the doctor, at least, was honest to report that he was no longer able to help my husband and so he was referred back to the insurance company who, in turn, contacted a neurosurgeon.

Senator KENNEDY. I am sorry to interrupt.

Your husband has been told he has a hernia and gout and a muscle sprain by three different doctors; is that right?

Mrs. ICHIYASU. No—the hernia and gout was one doctor. He has enough doctors without adding any more.

Senator KENNEDY. Two doctors and three opinions.

Mrs. ICHIYASU. He was hospitalized, after various tests—electromyelograms, and so forth. They determined it was disc damage.

May 1 he had surgery done. Immediately after, they noticed that there was some infection which they weren't able to pinpoint to any other cause and the reports indicated that it possibly was related to the back surgery, although there was no visible signs of that as far as X-rays and tests were concerned.

He was put in a body cast in which he remained for about 2 months. Most of the time he spent at home.

Now, if you visualize the body cast from, say from the chest down to, almost to the knees—you realize that a man is not able to sit. For his meals, he would have to stand.

In order to go to the hospital to have the cast removed and have further evaluation we had to purchase a car, in which he could recline in.

He had the cast removed, had other tests done, evaluations—and he was discharged, and from the late summer to December of 1970 he remained at home.

We had a physical therapist come to the house for a couple of weeks. The treatment was very minimal and the results were absolutely nil, so he explained to the doctor that he didn't think it was helping him any.

In December, he was hospitalized, again, for further evaluation, and discharged.

And from January through March he went to a physiotherapist twice a week.

And from March, the insurance company indicated they had wanted him to go every day, but the doctor—this is the insurance doctor—said this was too much and suggested trying three times.

Up through April 9 he was going thrice weekly.

The following Monday, he was admitted to the hospital for psychotherapy because they felt that possibly some of this was psychologically induced; they said there was probably nothing physically wrong with him any more than due to the depression and things of that nature. And he was not getting along well; he didn't get along with the medicines, and there was a fight for about 10 days after he was abruptly discharged. All medication was suddenly cut off—and out of desperation I consulted my own doctor who recommended we taper off the drugs.

After 10 days at home, he developed bladder and lung congestion, I feel after two much drugs. By then he had lost about 40 pounds and he wasn't eating—— [Emotionally upset.]

Senator KENNEDY. Now, you just take your time, Mrs. Ichiyasu.

Mrs. ICHIYASU. I consulted my own doctor and he said it sounded like a very serious medical condition, but he said it is all related to his original condition and the fact that he was not able to get well.

So, he suggested I call the insurance doctor. And in turn, this doctor was very good about it and said, "Knowing your husband, I feel that you have more confidence if your own doctor were called in."

And at his recommendation the insurance company called in our own doctor who, in turn, called in a urologist—the urologist—and things of that nature.

He was admitted Friday, April 30. He was extremely violent and they thought that he would have to be institutionalized.

By midmorning, Saturday, he was comatose and they found a lung infection and things of that nature. So realizing it was a critical medical condition brought on by all this, our doctor started the proper treatment and after 2 weeks of hospitalization he came home with the acute medical problems corrected.

The urinary problems they found wrong—and the doctor's opinion was that because of the drugs that he had lost control of his bladder so that he was not able to eliminate and being in the bed I imagine would create a lung congestion.

He is home now and he is still in bed and the doctor was out yesterday and he said that we will see what transpires.

So I asked him to see if they could follow up on the neurologist's report and get the insurance company to not wait so long and take some definite action so that they can get my husband on the mend for a change.

A year and a half for a person who has been very active is quite an ordeal. And I have three growing boys and they have been very good, but I am afraid that it has some kind of a chain reaction to the whole family.

Fortunately, through the union, over a number of years, the Retail Clerks Local 1100, I have been able to negotiate and get very comprehensive coverage for a union member and their family and currently I believe it covers your basic IAH, plus your medical, it covers about 90 percent of prescription drugs, it covers about 70 percent of dental, it covers corrective glasses, ophthalmologist's fees, doctor's office visits; it's just a percentage, but still it helps.

However, because my husband was off for a maximum period of 1 year, with total coverage, and 6 months with the coverage paying the premium, after 1 year it lapsed.

To backtrack a little—about 7 years ago, one of our sons had lymphosarcoma surgery. We hope it was successful. He is very well, but the insurance companies would not risk covering him, except with the exclusion.

Because of these various things, my husband is very conscious for the need of ample coverage for the family—insurance, some form of security. And so when he was not able to go back to work he decided we had better find an alternative coverage.

We have found some coverage that will be of some help if anything should happen to the family. My husband actually is not insurable, but if anything should happen to my husband, medically speaking, that is not related to the accident, it would wipe out our assets, what little assets we have.

So far we have been able to manage, but I feel that insurance should be for those who really need it.

Those who have preexisting conditions get eliminated from insurance coverage. This is a terrible mental strain on families and the reason people take out insurance is to alleviate that anxiety.

National health plans—I really haven't been up on the various ideas by the different Congressmen, the ones that they have presented or have been thinking about; but you hear pros and cons about various national health plans that have been incorporated in England or Japan—because I am more familiar with that.

Possibly there are many advantages and disadvantages, but I feel a person has a right to this, and is entitled to this. I think good health care should be made available to all who need it.

And like people before me have said—those who are wealthy probably don't have that anxiety. Those who have no means of income

possibly have no recourse but to go to welfare and depend on the State for whatever they need. But those of us in the middle class, who would like to still pay their own way, if it could be made a reasonable rate and good coverage made available to them, I am sure they would all be much better off.

Senator KENNEDY. Thank you, very much. Let me ask—you must have undergone great personal anxiety when you had these different diagnoses made of your husband's illness, did you not, when you had one doctor tell you one thing and another doctor tell you another?

Mrs. ICHIYASU. Yes.

Senator KENNEDY. And even considering a third—muscle sprain. How is any consumer to know whether you are getting the right diagnosis?

Mrs. ICHIYASU. Well, this is why I feel that it is so important—no matter what insurance, whether it is industrial insurance, or whether it is your own private form of insurance—that a person should have a choice of a doctor. Usually the doctor who has treated the family over a number of years can take into consideration all factors and better evaluate what the condition is; and if a person has a history of any kind of a related condition, then he may take that into consideration.

Another thing—my husband has gone to many hospitals, and there are hospitals that have a very excellent staff and give excellent care. Yet you have those who absolutely lack compassion and they don't seem to realize they are treating people who are there because they need understanding and care. And I imagine all too often the people who take up any profession or seek employment in any of these hospitals—to them it is just another source of income; it is not a profession or a position that they take personal pride in, personal interest.

But I do have to say, in all fairness to our own doctors, our family doctor, pediatrician, gynecologist—they all take into consideration the fact that my husband is not working right now and they have been more than good to us.

And I hear too much criticism about doctors and nurses lacking this, but I don't think that I am the exception—but we do have good, compassionate, understanding doctors as far as our own family.

Senator KENNEDY. Would you have to pick up and pay some of the expenses beyond those covered by insurance?

Mrs. ICHIYASU. When the union obtained for us the limited coverage—my three sons required some sort of treatment—and currently I have two still going to an orthodontist—but with the termination of the insurance that coverage stopped and it is up to us whether we would like to continue it on our own, or whether we would like to drop it at this point.

But it does boil down to dollars and cents—and we do have to consider how much it might cost; so that we haven't acted upon it as yet.

But aside from the normal periodic physical examination for the rest of the members of the family, we have been quite fortunate.

Senator KENNEDY. Is your husband covered by insurance at the present time?

Mrs. ICHIYASU. No; only for his back injury, or any condition related to it.

Senator KENNEDY. He can't get any insurance.

Mrs. ICHIYASU. Through our Japanese-American Citizens League, which has an open period beginning each year, we took out group coverage. That is a family plan; but it is not as good as the one with the Retail Clerks.

Senator KENNEDY. He could become a member of that.

Mrs. ICHIYASU. Yes; we have been members all along and they have some certain waiting period—but it is not that long—10 months, possibly—but it isn't that long.

It is just when my son becomes ill, or gets a stomach ache you often wonder "Goodness, a return of his previous condition."

But aside from that, we have been quite fortunate. I imagine there are those that are not quite as fortunate because their company doesn't have a union providing this type of coverage for their members.

I would like to see them make certain exceptions for persons who are in the category in which my husband finds himself, that they would make allowances and give us coverage, even if the family had to pay the total premium.

Senator KENNEDY. Do you think your husband could get coverage now, if he wanted to?

Mrs. ICHIYASU. No, he is uninsurable and even if they did insure him, they would exclude his present condition and they would exclude many things and there would be an automatic waiting period.

I am not saying that the insurance companies are wrong, but since there are people who do have past medical problems, those are the ones that need the insurance and the system should take that into account.

Senator KENNEDY. They are the ones that usually can't get it.

We will have one final consumer witness, and then we will have three professional witnesses, and then we will open it up to the floor.

Mr. Espinosa.

STATEMENT OF JOAQUIN ESPINOSA, RETIRED ELECTRONICS TECHNICIAN

Mr. ESPINOSA. There isn't much that I can say after all that was said already, but when you reach the age for medicare, you find that through the years the cost for medical aid has been exorbitant. Therefore, when you are not working, you are unable to pay.

I have refused to pay for medicare. I have not contributed the $5.66 per month for the reason that I paid in the organization, in my union, maybe 40 years ago. With the Kaiser plan I paid for 22 years and as the rate increased I finally dropped out, hoping that medicare would solve my problem.

Senator KENNEDY. You are a retired worker.

Mr. ESPINOSA. I am a retired free lance electronics technician.

Senator KENNEDY. And you have retired under social security, is that right?

Mr. ESPINOSA. That is correct.

Senator KENNEDY. You get a little over a hundred dollars a month?

Mr. ESPINOSA. A little over—and because I am unemployed I must depend upon my friends so that I continue to survive. And so I resorted to the tactic of organizing the Liberty Hill Defenders in my

district, which is in the mission and now contains 40 percent unemployment. And acting with the Liberty Defenders I am in the capacity of a political adviser.

Senator KENNEDY. You are married?

Mr. ESPINOSA. That is correct.

Senator Kennedy. And your wife is not eligible for medicare because she is not old enough.

Mr. ESPINOSA. Until she reaches 62 she is not eligible.

Senator KENNEDY. How is she now?

Mr. ESPINOSA. She is seriously ill. She has been passed from hospital to hospital and has had nine doctors; and finally we were convinced, between the two of us, that we will solve the problem ourselves, and consequently she is recuperating. And that is 16 years of illness.

Senator KENNEDY. She has had 16 years of illness?

Mr. ESPINOSA. That is correct.

Senator KENNEDY. You had medical bills during that period of time?

Mr. ESPINOSA. That is correct.

Senator KENNEDY. Did you try to pay some of these off?

Mr. ESPINOSA. I had to pay them off.

Senator KENNEDY. Do you expect you will have other medical bills now?

Mr. ESPINOSA. Well, I expect so, until we have completely free medical assistance.

Senator KENNEDY. You get just a little over a hundred dollars a month?

Mr. ESPINOSA. I have a little work on the side. I act as an electronics instructor and adviser.

Senator KENNNEDY. From that you pay, obviously, your living expenses.

Mr. ESPINOSA. With the ownership of my home, which is rent free, and with the help of relatives who pay the taxes, I can survive on around $200 a month.

Senator KENNEDY. But you can't afford the medicare payment—is that right?

Mr. ESPINOSA. I refuse to pay them because I know too many people who are unhappy about medicare.

Senator KENNEDY. Have you had any coverage by any insurance program?

Mr. ESPINOSA. I was covered by Kaiser Plan for 22 years.

Senator KENNEDY. Did that serve your needs?

Mr. ESPINOSA. Yes. Through the birth of three children, and as a consequence of the loss of the first one we decided the medical plan was an alternative.

Senator KENNEDY. But after you retire you don't get any coverage on that?

Mr. ESPINOSA. I have no coverage now. I am solely on my wits at age 66.

Senator KENNEDY. You have paid in premiums on various programs for how long?

Mr. ESPINOSA. Twenty-two years with the Kaiser Plan—which was stopped about 2 years ago.

Senator KENNEDY. Those premiums, I would expect, would keep going up.

Mr. ESPINOSA. They have.

Senator KENNEDY. You have stopped it?

Mr. ESPINOSA. They have—in anticipation of medicare taking care of any problem.

Senator KENNEDY. Do you think other people will have to drop out if those rates keep going up?

Mr. ESPINOSA. Undoubtedly they do.

Senator KENNEDY. What do you think of that kind of a health system?

Mr. ESPINOSA. I think it is "lousy."

Senator KENNEDY. So do I.

Thank you very much.

Mr. ESPINOSA. Thank you, sir.

Senator KENNEDY. Dr. Fenlon.

Dr. Fenlon is president of the California Medical Association—and she is a private practitioner who has specialized in internal medicine in San Francisco for the past 26 years.

She is a past president of the San Francisco Medical Society and currently is a clinical professor of medicine at the University of California in San Francisco, and an active staff member of Childrens and Franklin Hospitals here in the city.

Welcome.

STATEMENT OF ROBERTA FENLON, M.D., OF SAN FRANCISCO

Dr. FENLON. Mr. Chairman, my name is Dr. Roberta Fenlon. I am in the private practice of internal medicine in San Francisco. As president of the California Medical Association, I speak for an organization representing 25,000 physicians. There are approximately 27,000 practicing physicians in our State.

First, let me thank you for the opportunity of speaking about some of the health-care problems in California and some of the solutions we have developed. I might add that our experience in California should provide sound information for use on a national level. In many ways our State acts as a representative cross section of the country—in the types of economic levels of our population, urban and rural distribution of our people, and the diverse geographical features of our State.

We realize that the amount of time available for this hearing is limited. Therefore, considering the amount of relevant material we feel must be presented, we are submitting more lengthy written testimony in addition to my comments today.

We are not here to claim that our present health-care system is perfect. It contains significant deficiencies. Some people who cannot afford adequate care often go without it, because it simply isn't as available to them, or because they don't know how to obtain it, or because they lack the education to use what is available.

Government health programs promise full health care, but don't budget enough to provide it.

Furthermore, catastrophic illness can hit any income level. Even those with incomes well above poverty levels can be wiped out financially by a prolonged family illness.

In addition, certain people living in remote rural areas or in urban ghettos have no readily available access to the health-care system.

But these factors do not constitute a health-care "crisis." Rather, they represent deficiencies that must be eliminated.

The inability of any American to get proper medical or health care, for whatever reason, is a totally unacceptable situation to all of us. But the largest measure of Americans today do receive excellent medical care as soon as they require it.

[Vocal audience reaction.]

Senator KENNEDY. We will have order.

Dr. FENLON. Therefore, we should not destroy the present health-care system, but rather extend it to those people it has previously bypassed. In addition, we firmly believe that deficiencies in health care can be eliminated effectively only through well-reasoned and proven mechanisms.

What steps are physicians in California taking to insure high-quality care and realistic cost? Our "peer review" program on behalf of Medi-Cal serves as a good example.

Briefly stated, it includes: county medical society review of physician claims, hospital and nursing home utilization review committees, a State association appeals review committee, survey teams composed of physicians who continuously review medical staffs in hospitals and nursing homes, and the many hospital committees required by the Joint Commission on the Accreditation of Hospitals and by CMA.

One might truthfully say that a physician's colleagues are continuously scrutinizing the professional activities of each individual doctor——

[Vocal audience reaction.]

Dr. FENLON (continuing). Both in regard to medicaid and to Medi-Cal practice generally.

Another CMA activity that should interest this subcommittee is our recently launched program in continuing medical education. It consists of "certification" for physicians participating in a minimum of 200 hours of continuing medical education in a 3-year period. It provides specific mechanisms for accreditation of educational programs and acts both to improve educational quality and make it more effective as a means of improving patient care.

California doctors are also working to make more and better health care available to all our citizens.

I will give just a few examples. CMA runs a Physician Placement Service created specifically to place physicians in locations where medical services are needed. San Francisco Medical Society is working with OEO in bringing medical care programs to the "inner city." Kern and Sacramento Medical Societies are operating mobile clinics for the treatment of rural migratory workers.

Senator KENNEDY. What sort of success have you had in the placement of physicians?

Dr. FENLON. I would like to finish my testimony before answering your question.

Monterey has an innovative rural health project in King City using the health-team approach.

CMA is working to increase medical school admissions from minority groups, and we sponsor preceptorship programs at California's eight medical schools.

We are working, to make Medi-Cal care available.

The CMA is also moving ahead with establishing the new occupation of health care assistant—sometimes referred to as a "Physicians' Assistant." We are developing criteria for education, working on legislation for certification, providing means for recruitment, and suggesting the best possibilities for employment. This new breed of trained and licensed health-care professional, working under the supervision of a physician, will be able to handle much of the routine—freeing the physician for critical diagnoses and treatment. In this way, more patients can be served and health manpower shortages reduced.

In another approach, we are working to increase the efficiency of the health-care team through better communication.

CMA now maintains 19 advisory panels to different medical specialties in order to bridge the inevitable communication gaps. In addition, we are working with such differing groups as hospital administrators, dentists, nursing home administrators, ambulance drivers, nurses—to name only a few. Perhaps the best way to demonstrate CMA's general outlook regarding health and medical care is to tell you about my organization's proposal for American health care.

The CMA "universal-voluntary" plan would offer benefits to all families and individuals on a voluntary basis, with financial assistance geared to need. Benefits would include all areas of health care. In fact, our program would be so attractive that every economic level would participate because it sets guidelines for adequate health care coverage.

To avoid the usual problems of unrealistic funding, the budget for the program would be updated biannually for all areas of the country on a basis allowing for inflation. Under CMA's proposal, all plans or programs must furnish evidence of effective peer review activities. It also would provide for demonstration and experimental approaches to the organization and delivery of health care.

Certainly one of the most significant aspects of CMA's proposal is the fact that it is a comprehensive, long-range program.

Today—I don't need to remind this subcommittee—there are more than 100 Federal health programs for specialized sections of the population—Indian affairs, crippled children, OEO, medicare, medicaid, and so forth.

Our program would immediately absorb the functions of most major Government health programs. On a longer range basis, it would ultimately incorporate the medical aspects of the Veterans' Administration and other Federal programs providing or financing medical services. In other words, it would create a single, coherent, integrated approach to health care.

In conclusion, may I impress upon this subcommittee that no one has a deeper concern about health care than the medical profession. As practicing physicians, we live with our patients' health problems and illnesses every day of the week.

We will continue our efforts to improve health care, our experimentation, our pilot projects. We firmly believe there is no single, simple solution to the widely varied health difficulties of the American Nation. We firmly believe that a pluralistic system is essential. We plan to continue our search for improved methods in the delivery and financing of health care—and we respectfully ask the support of this subcommittee.

I wish to thank the subcommittee once again for the opportunity of presenting this testimony.

Senator KENNEDY. I would like you to answer the question I asked about placement services.

Dr. FENLON. We have had a placement service for many years, and many physicians have been placed in areas in which there has been a crying need, or we have placed him in an area vacated by some physician who has left or passed away.

Unfortunately, some of the areas in our State are not conducive for family life, and shall I say, raising of children—which is one of the problems that I think, we as a socially minded Nation, have to face.

These are not primarily health problems, but these are social problems which I think could be solved, with great help from everyone concerned. But it is not necessarily a problem in health, but we would like to see some of these problems solved.

Senator KENNEDY. I want to express our appreciation for your comments.

Earlier today we listened to some of the consumers of health and health care. And in our visits around the country we found that these are not really extraordinary circumstances—I don't think they are.

They are really what we have heard today—the police official faces longtime financial obligations; the retired union member whose wife is ineligible for medicaid, she hasn't reached the age; the young newly married wife, who is having her first pregnancy; another who had a contact with the Kaiser program and was moved from place to place; another man who was given two or three diagnoses.

In terms of their own kind of a problem—you can imagine the frustration and confusion. This is usually the quality—and this is usually the financial obligation.

These are people we heard this morning who are the real mainstream of our society; and they are describing quite a different system from what you outline in your comments.

And I suppose my question would be—Which is reality? [Audience applause.]

Order.

Dr. FENLON. Senator Kennedy, thank you.

I think that I listened to all of this testimony this morning and it was most impressive and I think this is why the California Medical Association has been working on the plans that they have been working on.

No. 1, it is most important that there be a personal health approach to this problem—and I think you heard repeatedly from each one of these individuals, practically without exception, that the thing

that they really want—and they went back to this—what they really wanted was their own personal physician. The clinic, the big clinic—and this impersonalization was one thing they did not like.

I think, secondly, their trust was in their own personal physician and this is why we are trying to say that a pluralistic approach to this problem is a most important one.

I am sure there are individuals in the world who are going to clinics who are happy with these clinics.

And we see these people all the time in our clinics, here in the university and throughout the city, because they have felt a rapport and they had a contact, that they enjoyed this sort of relationship.

But there are others totally unhappy.

I think we listen—and if we had one system of health care in the United States it would not solve everyone's problem—it might solve some, but it could not solve everything.

Senator KENNEDY. Suppose we had comments from those not getting to see physicians. We are getting complaints about impersonalization and the kind of situation with Mrs. Henderson, how her little granddaughter can't see a physician.

This is one thing about impersonalization—and I am sure you and I know prepaid, group practitioners which give personalized attention.

But you are also getting complaints from those that aren't even seeing a physician—and how the system works to discourage people from coming in and having any kind of contact.

Dr. FENLON. Senator Kennedy, I listened closely to Mrs. Henderson. She has a medical problem.

Senator KENNEDY. She has a health problem.

Dr. FENLON. This is a problem that we have in our State.

Senator KENNEDY. We have it in the Nation.

Dr. FENLON. Medicaid throughout the Nation is in trouble—and this is a fiscal responsibility which has not been taken over—as you may or may not know, we in the California Medical Association are suing the State of California for patients just like Mrs. Henderson.

Senator KENNEDY. I noticed you were careful not to mention the word "crisis" but one time. And I noticed that in other statements before the Senate subcommittee by professional groups, that they were always careful not to mention it; although there are differences in medical societies with respect to this. For example, in Chicago, they testified that they felt there was a "crisis."

And the President has recognized there is a "crisis"—and the Secretary of HEW. And I think these consumers have more eloquently testified to this than any other kind of expert witness we could possibly expect to hear from. I think they were describing the extent of the "crisis."

And I suppose the question which we in the Congress and the Senate have to think about is whether we ought to be relying upon some of the institutions that have brought us into this "crisis" situation—the insurance industry, the attitude of organized medicine—to bail us out of the "crisis" we are in. Why do you think we should?

Dr. FENLON. Senator Kennedy, did I understand you to say that the health insurance industry and the medical profession brought us to this problem?

Senator KENNEDY. I think it contributed heavily, yes. I think that is right, yes. [Applause.]

I think, if I can elaborate on that—you have had the insurance industry working in the health field for 37 years, and I don't think you need any more eloquent testimony than the comments of how they failed to aid these people in greatest need. I think these companies failed us.

Dr. FENLON. Senator Kennedy, this is a matter of personal opinion. As I say, the physicians do not believe the insurance companies have failed the American people. We have provided programs—the insurance companies have provided programs.

Some of these were business negotiated, and some of these were plans in which there was not adequate planning.

In our planning for the California Medical Association, we have set the criteria for adequate health insurance planning, and we believe it is very important.

Senator KENNEDY. We have been hearing that, with all due respect, since 1946.

We have heard about it from the insurance company representatives who come down and appear before the Congress. Representatives of the AMA tell us we can solve this particular problem of health care needs.

And we heard the same kind of statement in the medicare fight—"We don't need medicare. And the AMA is going to develop a new kind of comprehensive program to meet the 'crisis'." What do you see? Now we come back to a new national debate, and we hear different personalities from the same organizations saying one thing, "we can do it, we can rely on our good, old friendly insurance company to provide the means of a mechanism to bail us out. The system and our organizations are going to develop new types of programs to meet the needs of the people."

I say, why should we rely on them? And this, I think, is part of the problem.

Even the President says that the insurance industry is going to have additional, heavy regulation. Now, he is not saying that, not the President——

Dr. FENLON. Senator Kennedy——

Senator KENNEDY. He is not saying that because he thinks they have been responsive in this area.

I am all for it if they want to go out and sell life insurance, insurance on my boat.

Why should they do it in terms of health? Why should you permit people to make a profit? Every time a person has a claim it is a threat to the profit of the industry. Why should we have to do that? We don't do that for the education of the young. We don't do it in education. Why should we do it in health?

Dr. FENLON. Which one do you want me to answer first?

Senator KENNEDY. Make your response to any of those.

Dr. FENLON. Senator Kennedy, we heard this morning an indictment of the Medi-Cal system. Do you believe there is a Government program where you would like to sell——

Senator KENNEDY. It is a State program.

Dr. FENLON. It is also a Federal program—50/50 reimbursement; right?

Senator KENNEDY. Right.

Dr. FENLON. We have found with Government programs that the financing aspect is where we run into many problems participating in the State of California. The reason is we have many fiscal responsibilities in this State, and as a consequence we have great difficulty in getting these programs funded.

Medi-Cal is in the problem it is today because it has a closed-end budget in this State and an open-ended welfare State—and we have that problem, Senator Kennedy.

Senator KENNEDY. Is the fee for surgery any part of that? Do we have four times more surgery on medicaid patients as we do for other people in this State?

Dr. FENLON. Senator Kennedy, you read incorrect figures in the article in Medical World News.

Senator KENNEDY. I am taking the President's message.

Dr. FENLON. The President's message took it from that, too.

Senator KENNEDY. Well, I have to rely on the President sometimes.

Dr. FENLON. If you will look at the Department of HEW figures, as of 1968 it was 1.7, or thereabouts—and these are HEW figures; so somewhere or another these figures got twisted.

Senator KENNEDY. Do you think we have too much surgery today?

Dr. FENLON. Well, I think everyone has been telling us we have a manpower shortage in medicine.

Senator KENNEDY. The question is: Do we have too much surgery?

Dr. FENLON. I don't think so.

Senator KENNEDY. You don't think we have too much surgery.

Dr. FENLON. No; I think we have the necessary surgery.

I would point out that there is no nation that has the health care that our United States has.

Have you read the later material? Even Sweden is in trouble. We know that England is. We know that England is bankrupt, practically, from their social system. And I would dislike very much to see our United States come to this point.

Senator KENNEDY. You were making an observation earlier with the situation out here in California. One of the questions that must come to mind is: Why are the medical societies so worried about money and not worried about health?

Dr. FENLON. We have always been worried about health and our plan we presented to you this morning was a good example. That is originally why the AMA and the CMA originated it—it was for the care of patients.

Senator KENNEDY. I think the question is whether you think the people who commented here really represent what is happening to the American people—or whether you think they represent some kind of freak accident.

If you feel that is representative, I think you have a "crisis" of major proportions. If you do, then you are going to reform the system, and you are not just going to approach it with a Band-Aid and patchup kind of legislation.

If you don't—and I know there are those that do not think we do have a "crisis," then you are just going to try to patch up the existing system.

Dr. FENLON. This is not the way I stated this in my statement—and perhaps I should restate it—it is that we know there are problem areas and we are trying and we hope that some of these will be covered.

But we do not think replacing it with an entirely new Government program, in which the responsibility lies with the Government—and with the changes in administration, that we have in Government—that we can depend on fiscal support, necessarily.

This is one of the reasons education has problems today. This is the reason the postal system has problems.

We would rather see it remain in the private sector.

Senator KENNEDY. But the mail gets delivered—and that is what we would like to do with regard to health care. Thank you, very much.

(The prepared statement of the California Medical Association follows:)

STATEMENT OF THE CALIFORNIA MEDICAL ASSOCIATION

Submitted to the Subcommittee on Health
Labor and Public Welfare Committee
United States Senate

by Roberta Fenlon, M.D.
President, California Medical Association
San Francisco, California
May 17, 1971

The California Medical Association, founded in 1856, represents approximately 25,000 doctors of medicine in California. There are approximately 27,000 practicing physicians in our state.

In many ways, California acts as a representative cross section of the nation as a whole. Perhaps more than any other state's, California's population represents every section of the country, every social and political view, and every economic level.

In addition, the fact that one tenth the population of the United States -- 20 million people -- lives within California's 158 thousand square miles is a singular health-care situation in itself. It is estimated that California's population may reach 40 million by the year 2000. The California Medical Association realizes that the size of our job and the complexity of the problems will increase as our population grows. We are deeply involved in planning for the future.

We have had wide experience studying the health-care problems associated with such a large and diverse population and such an immense area. It is our feeling that familiarity with these problems cannot help but provide sound information for the whole country. We have arrived at many innovative solutions. Yet, in spite of the dramatic progress made in the last few years, the job of providing efficient and effective health-care to all our population is massive.

Since the inception of our Association, we have actively worked for the improvement

of health standards in our state. We can proudly point to the fact that the CMA is responsible for the introduction and passage of a large proportion of legislation passed to insure good health-care in California during the one hundred and fifteen years of our existence.

Our Present Health-Care System And Its Deficiencies

To state an obvious fact, the purpose of any system of medical and health-care is to bring together one patient who needs help and one physician who can see that he receives help. It can never be forgotten that medical care is given to one individual at a time. In fact this framework of individual attention is the only one which allows adequate medical care to be given.

Within this framework, Americans have developed a medical and health-care system that continues to do an excellent job in many respects. But it does contain some very real inadequacies. People who cannot afford adequate care many times go without it -- because it simply isn't as available to them, or because they don't know how to obtain it, or because they lack the education to use what is available. Government health programs promise full health-care, but have not budgeted enough to provide it. Furthermore, catastrophic illness can hit any income level. Even those with incomes well above poverty levels can be wiped-out financially by a prolonged family illness. In addition, certain people living in remote rural areas or in urban ghettos have had no readily available access to the health-care system.

The inability of any American to get proper medical or health-care --for whatever reason -- is a totally unacceptable situation to all of us. But solutions to this problem must be developed with the awareness that a substantial percentage of Americans today do receive excellent medical care as soon as they require it. Therefore, it seems to us that the need is not to drastically restructure, or further control, or destroy the system. Instead, the need is to expand it. It must be extended so that it is put within the reach of those who do not now receive its benefits and services. At the same time, it must educate those people who do not know how to gain access to it or use it properly -- and this is the responsibility of all our society. In other words, we firmly believe that our country must

bridge the gaps in the present system without discarding those aspects of it traditionally doing a good job. However, we believe just as firmly that these inadequacies can only be eliminated effectively through well-reasoned and proven mechanisms. In addition, there is an obvious necessity for instituting such mechanisms under the guidance of some overall, long range concept which considers the effect of one program upon another and upon the system as a whole. In addition, we cannot afford to ignore the impact of any program on our nation's economy.

California's Medicaid Experience and the Future

Our state's Medicaid program -- Medi-Cal -- provides a prime example of what can happen when attempts are made by government to solve health problems piecemeal, without consideration of the effect on the system generally, and without the essential independence from political considerations in operation and funding. It should be noted for the record that, from the beginning, CMA strongly supported and sponsored the state bill that became Medi-Cal. One reason for our support was that the bill embodied a concept we physicians feel is essential to good medical care for our patients -- the concept of "mainstream medical care." The law cites this concept as one of its objectives: "to allow eligible persons to secure basic health-care in the same manner employed by the public generally and without discrimination or segregation based purely on their economic disability."

However, in the approximately five years since the implementation of Medi-Cal the intent of this compassionate program has been compromised for political expediency, diminished by fiscal demands, and eroded by administrative regulations. Today, instead of realizing its stated intent of mainstream care for all Californians, the Medi-Cal program has deteriorated to the point that it restricts access to medical care. And as you all are aware, California is not alone in its Medicaid difficulties. Many other state are experiencing equal or greater problems. Clearly, California's Medicaid experience demonstrates the danger of inadequate safeguards for separating politics from funding in any government health program.

One effort by physicians to make our Medicaid program operate effectively is the CMA proposal, introduced in the California Legislature last Thursday. It would remove our state's Medicaid program -- Medi-Cal -- from the political difficulties referred to earlier. Under our plan, California's Department of Health Care Services would be replaced by an appointed 15-member Medi-Cal authority, responsible for administering the health-care program for the poor. The authority would serve as a contract agency for the state and would provide no medical services itself. It would contract with a carrier to provide a scope of medical benefits. Possible carriers are insurance companies, Blue Shield, Blue Cross, county foundations for medical care, counties directly, health maintenance type organizations, and so forth. The state authority would also be responsible for obtaining operating funds from the Legislature and accumulating adequate reserves to take care of financial peaks and valleys from year to year.

California's Experimental and Pilot Programs

Of signigicant interest are various approaches taken in California to experiment with different methods for the delivery and financing of care. The San Joaquin Medi-Cal Pilot Program serves as one example. It was established to determine whether savings to the state could be realized by putting physicians' services on a "prepaid" basis. A premium rate per recipient per month was established for all physicians' services within a specific geographic area. A system of medical claims and utilization review by profiles of providers and recipients was put into effect. The project is designed to determine if a greater percentage of the eligible beneficiaries would be seen by a greater proportionate of physicians under this approach. In this way quality medical care would be assured and at the same time supplied for less cost. Again, let us emphasize that this is only one of several existing innovative projects we could cite.

A further example of the medical profession's efforts in California to improve cost and availability of health-care, without sacrificing quality is the proposed Big Valley Project, recently endorsed by the CMA Council. It would encompass the Sacramento, San

Joaquin, and Santa Clara valleys in California, an area including the widest possible range of environment, population types, and socio-economic levels. The proposal is composed of three parts: a proposal to the Social Security Administration to cover those patients under Medicare; a second proposal to the state of California to cover those patients on Medi-Cal; and a bridging proposal developed so as to correlate the coverage in both of these programs.

This pilot project proposes to assume prepayment risk for all recipients of Title XVIII (Medicare) and XIX (Medicaid/Medi-Cal) benefits. It would employ an "overlay" concept, giving all recipients the advantages of good claims review, quality control, progressive patient care, and an easier entry into the medical care system. A third objective of the proposal is to create a realtively simple administrative organization, enabling both federal and state governments to provide a prepaid program for a large area and a large number of recipients. A single administration would be able to make decisions based on the total medical care objective. A fourth objective is that of research. The program would be large enough to require computer involvement and yet small enough that the results could be easily analyzed. In addition, there seems to be possibilities of developing private funds for research. It is the intent of the proposal that a developmental contract would be amended effective July 1, 1971. The California Medical Association has authorized a loan to assist in meeting start-up costs of the Big Valley Project.

Pilot Projects Necessary for HMO Concept

It seems to the California Medical Association that the concept of Health Maintenance Organizations, as emphasized so strongly by the present administration, includes several specific dangers that could be avoided through pilot projects. The potential exploitation of health-care when individuals -- whether health oriented or not -- can form an HMO and contract with providers for comprehensive health services could be catastrophic. We have witnessed a similar situation after the passage of Medicare with the great influx of poor quality nursing homes.

Among other potential dangers of HMO's is the fact that they have no provision for

discouraging patient over-utilization. There also is no provision for freedom of choice -- a State could be an HMO or the only hospital in a community might be an HMO. Personal patient records, under the concept, must be available for government audit for any purpose the government deems advisable. There would also be unwarranted, and conceivably arbitrary, control of all providers of service -- including the para-medical groups -- by both the owners of the HMO and the government.

One can only be deeply concerned over the direct control which the federal government, acting through the Department of HEW, would have over premiums, costs, providers, and other components. This control would appear to encompass the setting of rates, standards, and regulations which will affect a segment of the public for whom the government now has no direct financial responsibility -- community enrollment.

Furthermore, these HMO's -- with their government subsidies -- would be in direct competition with all other insurance plans and thus might well cause the gradual elimination of private health insurance.

In short, the capacity of such a program to accomplish its purposes must be determined. For example, there are questions regarding in-fact cost savings, as well as the quality of health-care which may be provided when there are economic incentives to providers to reduce utilization. Furthermore, it should be realized it is extremely unlikely that those outside the medical profession could effectively evaluate either the quality or the cost of care.

It is CMA's feeling that any approach to the delivery of medical services must be pluralistic to be successful. This is true whether we are discussing services furnished by group practice, by the individual practitioner, or in some other manner. The HMO concept would be best tested and modified based on pilot projects.

Physicians Tackle Medical Costs

The escalating cost of medical and health-care today is perhaps the most criticized and least understood aspect of our health-care situation. For a moment, let us concentrate

on the physician's share of increased cost. Obviously, the medical community is no more immune from the economic forces at work today than any other segment of our society. Physicians face the same problems others do: rising labor costs, rising equipment costs, rising office costs -- spiraling inflation in general. Also obviously, these increases are coupled with increased expenses resulting from continuing medical and scientific research: new drugs, new equipment, newly developed and highly complex procedures, and so forth.

All of these factors are easy to comprehend. Less obvious to the public as a cause of increased medical costs is the soaring expense of professional liability premiums -- largely a product of unrealistically high awards by juries in liability cases. Not only has the situation significantly affected medical costs, but it has greatly increased the difficulty of patient care for the physician.

The California Medical Association has been tackling this complex problem in several ways. One of our approaches is to make use of education. With the California Hospital Association, California Nurses Association, Hospital Councils of Northern and Southern California, and the insurance carriers -- CMA has sponsored a unique series of malpractice prevention workshops throughout California. These workshops have sought ways to alleviate the present malpractice situation by confronting the practical problems related to the everyday provision of health-care.

With the CHA and others, we have also approached the problem from the standpoint of possible arbitration. Eight southern California hospitals have embarked on a demonstration project in the use of arbitration as an alternative to court litigation of claims against hospitals and attending physicians. We feel that this mechanism may very well provide one way -- in the future -- to greatly reduce liability premiums and therefore medical costs.

Also, CMA has maintained a comprehensive and continuing legislative program in regard to professional liability. This program -- active since the 1968 Session of the Legislature -- has the basic objective of curtailing the trend toward unreasonable liability insurance rates -- and, again, reducing medical costs.

Yes, the problem of rising costs plagues physicians, as it does everyone. Our peer

review system checks on the charges for, as well as the quality of, care rendered. This is a voluntary system whereby physicians review their colleagues in terms of charges made, treatment given, length of hospital stay (utilization) -- the whole picture. We are greatly concerned about costs and are taking all possible steps to keep them at a minimum.

The problem of medical costs is also compounded by increased hospital costs. The physician, often unfairly, is tarred with this brush. Patients seem to equate a hospital bill with the doctor's charges, although they are separate. Hospital costs have risen considerably but unavoidably. About 70% of a hospital's costs are labor-related. Nurses and other hospital employees have received major increases, and these increases must be reflected in the hospital bill. Hospitals have installed sophisticated medical equipment, and this life-saving equipment is expensive. In addition, the numbers of health personnel have constantly increased to further improve the quality of hospital care.

Increased utilization by the public of the health-care system is a further factor. Obviously, for a variety of reasons, more people are making use of medical care today than ever before. Not the least important factor in this growing trend toward utilization is the advent of Medicare and Medicaid. And not only is greater utilization per capita a result, but every year the number of eligibles increases. For example, in the roughly five years Medi-Cal has operated, the total number of persons eligible for Medi-Cal increased 76.7 percent. During the same period, the total cost of care increased more than 104 percent . . . an increase of more than 530-million dollars.

California's population, of course, has grown during the past five years . . . an average of 1.5 percent a year. But the increase in the number of beneficiaries under Medi-Cal far outstrips the population increase. At the outset, during fiscal 1966-67, one Californian in 15 received Medi-Cal benefits. During the current fiscal year this ratio is estimated at one person in eight . . . nearly double the original rate.

Physician Efforts to Assure Quality Care

Quality and cost are two areas of health-care which bear an especially close rela-

tionship. Nonetheless, what steps are physicians in California specifically taking to insure high quality care? For the purposes of illustration, and since government health programs are important to this discussion, the profession's efforts to insure high quality care -- and hold the line on costs -- for the Title XIX program might be used as examples.

To even further strengthen the recommendations forthcoming from "peer review" committees, the California Medical Association has strongly supported several legislative measures in this area which have been enacted into law. Examples deal with disclosure of possible conflicts of interests in referral of patients to facilities; carrier authority to place a provider on prior authorization; making false or fraudulant claims a felony; and making suspension of a provider from participation in Medicaid a grounds for suspension or revocation of license.

The California Medical Association and its component county medical societies have in fact initiated an extensive and comprehensive system of "peer review" that applies to the Title XIX program (Medicaid/Medi-Cal). Briefly stated, it includes: county medical society review of physician claims; hospital and nursing home utilization review committees; a state association appeals review committee; medical staff survey teams, composed of physicians and sponsored by the state association, that conduct surveys of medical staffs in hospitals and nursing homes (ECF's) to insure quality care; and the many hospital committees required by JCAH and CMA. One might truthfully say that a physician's colleagues are continuously scrutinizing the professional activities of each individual doctor -- both in regard to Medi-Cal and to medical practice generally.

Carel E. H. Mulder, past director of the California Department of Health Care Services, expressed his special appreciation for the arduous task of those doctors who, without compensation or other material gain, devote many hours to the review of suspected claims and courageously decide whether or not the services claimed to have been performed conform to established community practice.

CMA has very recently developed a statewide peer review program to further coordinate and strengthen peer review activities. Under the plan, the scope of existing peer review mechanisms, which have proven highly effective, would be enlarged using a variety of local

approaches to assure quality care for the public in the most economical ways. This approach embodies such factors, among others, as a State Advisory Council consisting of representatives of the public and representatives of appropriate provider organizations.

To give a few examples of the plan's advantages, on the local level it is designed to provide for regional seminars and workshops on peer review; encourage continuing medical education; and work toward the widest possible innovative and constructive exploration, by the local review units, of improvements in the various peer review mechanisms.

This CMA plan illustrates both the long-range value of California peer review -- and its inherent genius. Not only has peer review traditionally served California's needs through such services as hospital review boards, but it provides an overall mechanism capable of constant improvement and change to meet changing needs. One can cite few better examples of the medical profession's active commitment in California over the years to assuring high quality medical care at the most economical price.

Three other continuing CMA projects deserve the attention of this Subcommittee. They provide a fair estimate of the determination and success characterizing CMA's efforts in the area of insuring quality care to the citizens of California.

Many of these activities receive very little public acknowledgement. For one example, our Medical Staff Survey Program -- assisting quality care in local hospitals through continuous supervision and review -- is currently beginning its 11th year of operation. In the last 10 years it has contributed immensely in assuring high levels of hospital treatment to Californians. During this period, we have surveyed 644 hospital staffs.

Secondly, we are proud to note that CMA -- after extensive preparation and in conjunction with the California Joint Council to Improve the Health Care of the Aging -- has just seen the adoption of the "Long Term Care Review . . . a statement of principles." This document, embodying principles and standards to be used in surveying the level of care in these institutions, is equivalent to our "Guiding Principles for Physician-Hospital Relationships"-- now a national standard for hospital surveys. With the adoption of the "Long Term Care Review," we are embarking on a program of review to insure the quality of care in nursing

homes.

A third CMA activity that should interest this Subcommittee is our recently launched program in Continuing Medical Education. It consists of "certification" for physicians participating in a minimum of 200 hours of continuing medical education in a three year period.

An additional aspect of the program is its "Accreditation" of the continuing medical education programs of health facilities, making the California program unique. Instead of merely counting hours, the emphasis has been placed on actually improving the quality of such education, on making it responsive to the needs of practicing physicians, and on making it effective as a means of improving patient care.

The act of accreditation entails strict guidelines, requiring that the entire educational environment be evaluated. Our Accreditation Program for continuing medical education is just getting under way. Accreditation applications now total approximately 1,700, and more are coming in daily from hospitals throughout the state. CMA's long term plan is to accredit all programs and activities of merit within three years.

The California Medical Association also holds five annual regional postgraduate institutes, three circuit courses in rural areas, and extensive annual scientific sessions.

In addition to the activities we have outlined, CMA seeks to improve the public health through an extensive program of printed health-care material and radio health-care news and public service announcements in the California media. Furthermore, we could give a long list of specific CMA programs dealing with specific health and safety problems -- maternal and child health, drug abuse, alcoholism, highway safety, aviation safety, and so forth.

Making Health-Care Available To All Californians

In focusing on CMA efforts in the area of promoting availability of care, we must comment that no single element of any health-care system can be understood in its proper prospective if it is completely divorced from various other elements of the system. Therefore -- and we hardly need to impress this fact on the Subcommittee -- our efforts necessarily

have included a wide range of activities.

Stated simply, "availability of health-care" might be said to concern the fact that doctors and other health professionals are not equally available in all locations and to all sections of the population. This lack of doctors is especially acute in ghetto and rural sections. And in both these sections, the problem is further complicated for many people by language differences, by people not knowing how to seek and use health-care services, and by lack of transportation.

What are California doctors doing to meet the challenge of making health-care available to all Californians? A few examples will serve to illustrate these efforts. CMA runs a Physician Placement Service created specifically to place physicians in locations where medical services are needed; San Francisco Medical Society is working with OEO in bringing medical care programs to the "inner city"; Kern and Sacramento Medical Societies are operating mobile clinics for the treatment of rural migratory workers; Monterey has an innovative rural health project in King City using the health team approach; CMA is working to increase medical school admissions from minority groups; and we sponsor preceptorship programs at California's eight medical schools. We <u>are</u> working to make medical care available to all.

California Medical Association made an all-out effort in behalf of Proposition One in the June, 1970 election with financial aid and service. But the voters narrowly turned down this bond measure that would have provided funds for completion of three medical schools and facilities to train dentists, nurses, public health professionals and other needed health-care experts. The CMA will continue to support such bond measures in the future. In the meantime other things are being done to meet the challenge of providing more physicians and other health professionals.

We are giving college scholarships to many deserving students -- 35 so far -- who plan careers in the health field. Wherever practical, we are urging medical schools to expand their enrollments and to actively seek out and financially assist interested and potentially qualified minority students who desire educations in the health fields.

The CMA is also moving ahead with establishing the new occupation of Health Care

Assistant -- also sometimes referred to as the "Physicians' Assistant." The Santa Clara County Medical Society pioneered in this field with a unique training program for recently discharged medical corpsmen. It is hoped that this new breed of trained and licensed health-care professional, working under the supervision of a physician, might handle much of the routine -- freeing the physician for critical diagnoses and treatment. By augmenting and increasing the efficiency of the health-care team, more patients could be served and health manpower shortages reduced.

CMA is taking the lead in establishing this new health worker: developing criteria for education, working on legislation for certification, providing means for recruitment, and suggesting the best possibilities for employment.

In another approach, we are working diligently to improve the efficiency of the health-care team through cooperative work and better communication. But this is not an easy task. Not the least of the problems is the vast number of professions and individuals involved in the health field. And the constant move of our nation and society toward specialization in every area causes this problem to increase with every year.

Because of the growing number of medical specialties, it's a full time job just insuring that good communication exists among physicians. The California Medical Associatic now maintains nineteen advisory panels to different medical specialties in order to bridge the inevitable communication gaps.

The California Medical Association also is working with such differing groups as hospital administrators, dentists, physicians' assistants, nursing home administrators, ambulance drivers, nurses -- to name a few -- to solve mutual problems. We are making definite progress toward effective coordination of efforts among all health professionals as a matter of course -- coordinated research and sharing of information, coordinated long range planning.

CMA Develops National Health Proposal

Perhaps the best way to demonstrate CMA's general outlook regarding health and medical

care is to tell you about our proposal for American health-care.

The CMA "universal-voluntary" plan would offer benefits to all families and individuals on a voluntary basis, with financial assistance geared to need. When feasible, patients would share in the financing -- along with state and federal governments. Benefits would be provided through vouchers or tax credits for the purchase of insurance coverage defined as acceptable. Full use would be made of existing insurance industry experience and mechanisms. At the same time the plan would make it highly advantageous for the industry to provide realistic programs that extend coverage to far more people.

The plan would be open to everyone -- regardless of income, age, or employment status. Every family and individual, of whatever income level, would have incentives to participate. It sets standards for health care coverage.
Benefits would include all areas of health-care. The plan would permit each recipient to choose his own physician and choose the programs that best fit his needs. In fact, our program would be so attractive that people in every economic level would participate.

The program would also provide non-political administration. It would be supervised by the United States Civil Service Commission, a non-political body with more than a decade of experience in the successful federal employee's health insurance program.

To avoid problems of unrealistic funding -- such as encountered in Medi-Cal and many other government health programs -- the budget for our program would be updated bi-annually for all areas of the country on a basis allowing for inflation. Under CMA's proposal, all plans or programs must furnish evidence of effective peer review activities.

Another important feature -- our plan provides for demonstration and experimental approaches by health-care professionals. These would include programs in the organization and delivery of health-care, including the utilization of new types of manpower . . . such as the health-care assistant. Liaison with comprehensive health planning agencies in inaugurating these new programs would provide for community participation.

Certainly one of the most significant aspects of CMA's proposal is the fact that it is a comprehensive, long-range program. Today there are more than 100 Federal health programs for specialized sections of the population . . . Indian Affairs, Crippled Children, OEO,

Medicare, Medicaid, and so forth. Our program would immediately absorb Medicare, Medicaid, and every other program at all feasible. On a longer range basis, it would ultimately incorporate the medical aspects of VA and other government programs providing or financing medical services. In other words, it would create a single, coherent, integrated approach to health-care. It would not be a stop-gap measure treating only the symptoms of the health problems as they confront us. On the other hand, it would not require massive federal financing. Nor would it require dependence on an entirely new and untried system of health and medical care.

In conclusion, may we impress upon this Subcommittee that no one has a deeper concern about health-care than members of the medical profession. As practicing physicians, we live with our patients' health problems and illnesses every day of the week.

We will continue our efforts to improve health-care, our experimentation, our pilot projects. We firmly believe there is no single, simple solution to the widely varied health difficulties of the American nation. We firmly believe that a pluralistic system is essential. We plan to continue our search for improved methods in the delivery and financing of health-care -- and we respectfully ask the support of this Subcommittee.

I wish to thank the Subcommittee once again for the opportunity of submitting this testimony.

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Senator KENNEDY. Dr. Gibson.

Dr. Count Gibson has been an old friend and adviser for many of us in the Senate, on health matters. He is presently chairman and professor of the Department of Preventive Medicine at Stanford.

He previously served as a professor and chairman of the Department of Preventive Medicine at Tufts, Boston.

He was of enormous help in getting Columbia Point Health Center started up in our community in Boston—and the Tufts-Delta Health Center in Mout Bayou, Miss.; and he engineered a number of others.

I think he has brought an enormous interest to the whole delivery of health care.

We miss you back East.

STATEMENT OF COUNT D. GIBSON, JR., M.D., CHAIRMAN, DEPARTMENT OF PREVENTIVE MEDICINE, STANFORD, CALIF.

Dr. GIBSON. Senator, thank you very much for inviting me here today. I think this was a very moving set of experiences we heard this morning, for those of us interested in medical care here.

They are far from the exceptional or unusual. With due respect to my colleague who just testified, I think the data on the charts, as well as many other indices, suggest to us not merely that we could do better in our own rights, but in comparison with other nations of the world we have much more progress that we can make.

As a matter of fact, some of the experiences we had in Boston, and which you shared with us, back in 1966, gave us a few clues to how we can approach the problems today.

I would like to suggest two ways in which I really feel problems are clearly getting worse.

The first one is the dilemma of success—the technologic advances that have been made now pose a challenge to us as to how to make these available to everyone in the country.

Dr. Shumway certainly represents some of the most remarkable technologic skill in the country, in cardiac surgery which is carried on. We see what dilemma this poses. Twenty years ago there wouldn't be the question of cardiac surgery. The patient would have died. That would not represent a medical care cost.

With all the research money poured in, we now have the ability to lead the world, if we find the mechanism to spread it around.

But I think the very point that we do research makes it all the more painful, not only to those who attempt to receive care through the old ways, but for the large numbers who cannot get to it, or don't know about it.

I would say there is another measure of the way in which we are failing, today, and that is in regard to the distribution of physicians.

Dr. Fenlon pointed out the experiences of a placement service in California. Most States have had placement services. And with the best efforts of the placement services, the physicians are getting more and more concentrated in suburbia and less and less in towns and rural areas and our great cities. So, we slide in numbers, year by year, further and further behind.

I see this "crisis" in California, not only in our great cities but in our valleys, in small towns, that have always prided themselves on keeping physicians—who have slowly slid from 30 to 24 to 21 to no physicians in the community.

In a sense I profoundly do not believe in a Federal, licensed system of health care, in which Washington figures out these problems for us all. We have many different kinds of people and we have many different parts of the country.

The solution which seems to me important to foster is increasingly the development of consumer control of health care.

Now, you had the opportunity to see, with us ,what at that time was a very strange notion, at Columbia Point. We were talking about a consumer voice, at that time, or an opinion.

I think most of us physicians have had very little experience with what that means.

As time has gone on, we have attempted to develop an OEO center, to develop a National Consumer Health Committee. It seemed that was something that related to minority Black people or poor people.

Since I have been in California, I have had the good fortune to see this is very relevant for everyone.

The town of Livingston, in the San Joaquin Valley, was faced with the loss of its one doctor and asked us, at Stanford, how they might try to solve their problem—and we had them form a nonprofit community corporation.

This is a community that has poor people and it has well-to-do people. It is a very multiethnic community. And so a community board was formed, representing all the economic segments in the community—the farmworkers, the people in town, the people in the rural areas.

With this nonprofit corporation, they have, for the past year and a half, poured all of their health care dollars in the area and redistributed them so that the need of everyone in the community can be met.

The board consists of 30 people, and there are another 50 throughout the community, solving many of the different kinds of health care problems with their staff.

This is an answer, as I see it—control by the community.

We have been talking about the schools—and I think schools will solve their problems to the degree that their community controls developing what the needs of the community are and that they are financed adequately.

It seems that S. 3—and H.R. 22—are the only proposals before the Congress, at this time, that foster and promote a reworking and restructuring of our health-care system—and this is why it seems to me that not only in terms of a financing mechanism, but as a restructuring, that this action is so important.

I would like to give one local example. You have some really wonderful examples at the hearing—and there are several ladies from the American Indian Health Board.

Now this group of native Americans approached the Department of Interior, because for the first 6 months after a native American leaves a reservation and comes to the city, the Department is responsible for his health care.

So, they wanted to figure how to carry out this responsiblity. They offered to purchase insurance in Kaiser, saying this is one of the broadest, most comprehensive programs available. They said, "Let's meet the Kaiser folks." And they were told this was broad, comprehensive coverage.

And they said, "We have a few things of concern. Ever since you Palefaces introduced to us firewater, we have some real problems with alcoholism."

And they would like to know the coverage. "But, unfortunately that is one of the exclusions." Otherwise, we are very comprehensive.

We have another kind of condition—trachoma, which causes a great deal of blindness and we have a need for special glasses and special lenses of other sorts. Could you tell us what is covered? "Well, that is another one of the small exclusions."

And we have a great deal of deafness—and we know if you are going to make it in the city life you have to have good hearing. We assume your plan will take care of a hearing aid. They said, "That is one more exclusion."

And at that point they said, "Couldn't you please provide us with the money and we will work out a health program that will meet our needs?"

I think that is an example of a Kaiser program that meets the needs of many people very well, and fails to meet the needs of special people. And this is where we come back to the crucial voice of the community in health coverage.

I would like to conclude my remarks by registering one great cause of complaint.

The case has been made about retaining health care primarily in private enterprise. So far, there has been private enterprise and it has been good—but just as I think, in our times today, it can produce great good in the society, I think it is also capable of causing great harm.

In the HMO proposed, the planning specifically envisions the possibility that HMO's can be operated by proprietary interests that aren't even physicians. This is what is called a consumer prescribed patient program—and I think, not only is it important that we see the development of health centers controlled by consumers, but also guard carefully that we do not get off in the private corporate sector that provides against health care. I think we have to guard against that one.

I think as we need to move toward the particular advantages of permitting a restructuring around the community oriented health center—that is a very crucial part of what we need.

Senator KENNEDY. Thank you, very much. Just a couple of questions, because we want to move along.

What do you think about the question of—Do we have too many operations?

Dr. GIBSON. Well, we have very good data on this. My colleague, Dr. John Bunker, who is a professor of anesthesiology at Stanford, has made a very careful comparison between Great Britain and the United States—and his data which have been widely attacked, analyzed, and strongly supported, suggest we are doing twice as much surgery per thousand population in this country as is done in England. And this

was with a large segment of our population that doesn't have access to surgery at all.

I think the data is quite clear—we have an excessive amount of surgery.

Senator KENNEDY. Why don't you conclude maybe they aren't getting enough surgery done in England?

You better be able to answer that one.

Dr. GIBSON. I would say with their health situation and an analysis of what goes on—in terms of who is walking around with a hernia that should be repaired and doesn't get repaired—maybe they are not getting as much as they need.

Senator KENNEDY. What is your feeling about the profit motive in terms of meeting health needs? You referred to this just briefly in your comments. Do you think that ought to be a feature in terms of our system? Would you make any comments about the fee-for-service concept; whether this helps to keep cost down?

Dr. GIBSON. I know from the time I trained to be a physician, I saw this as an opportunity for providing service to an individual. I think this is some of what has been implied in the term "profession".

I think the incentive of a fee-for-service is the only way to get people to work hard, and not what basically is of service for people.

I think the fee-for-service has kept up, around item-by-item of particular tasks to be done—and there are some very idealistic people who operate within such a fee-for-service system, but in my view not because of it. And I see the opportunity for both in health centers.

There are a whole group of physicians—some of them in this room—that find satisfaction of serving, not patient by patient, but working with the community through a board and developing manuals of all things not being done health education, preventible mechanisms, anticipating problems before they happen. Half the problem has been taken care of with return to the community with a maximum effort for remaining there.

And I think the only way we are going to be able to turn around is to return to the commitment for service, rather than a fee-for-service.

Senator KENNEDY. Thank you, very much. It is a pleasure to hear you.

Our next witness is Msgr. Timothy O'Brien. Monsignor O'Brien is director of Catholic Charities for the Archdiocese of San Francisco. He is past president of the Catholic Hospital Association and is now the president-elect of the California Hospital Association.

Monsignor O'Brien, the subcommittee is pleased to receive your testimony.

STATEMENT OF MSGR. TIMOTHY O'BRIEN, DIRECTOR OF CATHOLIC CHARITIES, ARCHDIOCESE OF SAN FRANCISCO

Monsignor O'BRIEN. Senator Kennedy, thank you for the opportunity of being here. It is nice to be the last man. It means everything has been said. I had an old professor who said, "If you can't say it in 3 minutes, the collection drops."

Being in the business I am, I will try to make it brief and to the point.

Senator KENNEDY. If you have some comments, we can include it in the record.

Monsignor O'BRIEN. Let me just try to make four points.

No. 1—about the crisis—yes, there is no question that the basic problem in our present health delivery system, as far as I am concerned, is fragmentation. I believe our country has the best trained doctors, nurses, and other health professionals. We have the finest in health facilities. But, unfortunately, too often, we do not play as a team.

As health professions we have preferred to play "king of the mountain." I think we should be playing "tug of war," which really means pulling together and being mutually accountable for our efforts.

The goal of a national health system must be to mold the world's finest health professionals and best health facilities into an effective health delivery system.

I want to make it very clear that I believe we need a radical reorganization of the Nation's health resources if we are to build a team.

The second point I would like to make is that today, we in the hospital field profess, as our basic belief, that health care is an inherent right of each individual and of all the people in the United States. We see that four corollaries flow from this basic belief:

That health care must be so organized and located that they are readily accessible to all.

That health services be available without regard to race, creed, color, sex, age, or to any person's ability to pay.

That the purpose of health services is to enhance the dignity of the individual served and to promote better community life for all men.

And that it is the function of Government to assure that all this occurs.

The third point that I would like to make is that a reorganized health system must bring under one organizational entity at the local level the various providers of health care. These providers must be able to give to their community that assurance that all reasonably needed levels of health care are available to the community served.

These local organizational entities should be under the regulatory power of a State commission. This commission should issue certificates of need to avoid duplication. It should approve the rates to be charged to all purchasers of the service. It is imperative that the regulatory power of the system be separate from the purchaser of the health services.

The fourth point I would like to make is that the building of a team—which is, as I see it, so important in order to carry out our belief—must continue to attract the most competent and most dedicated people in our society.

The new health system must retain the strongest asset of the fragmented system; namely, an ability to attract the highest qualified people into the health professions.

The quality of health care received is based primarily on the profesional competency of the health professional. As we move from the fragmented to the nonfragmented health care, the biggest danger we face is decreasing the quality of care as we increase the availability and the accessibility.

I want to make it clear I believe that a team system fostering professional freedom, financial incentives, private ownership, and dedicated religious service can be created if the creator has this goal in mind.

In conclusion, I would like to make two points. The first is that I do think the health system is trying to move ahead; it is trying—it is difficult.

We are talking for California—the California Hospital Association is trying to put through an act, and we are having trouble doing that—it is an act that would demand disclosure of all the financial information of all hospitals.

A second point I would like to make is that the new nonfragmented system can only come about by evolution and not by revolution. There was a book, "Too Much Too Soon." Too much too soon can be destructive. We all know that applies to alcohol. We know in the Catholic Church that too much too soon can be destructive to renewal of the Christian church.

I think it can also apply to the creating of a health system.

Thank you, very much for the privilege.

Senator KENNEDY. Too much too soon might be bad—but too little too late is also bad.

You have been very good, Monsignor, to be with us and we appreciate very much your taking the time.

(The prepared statement of the California Hospital Association follows:)

STATEMENT OF THE CALIFORNIA HOSPITAL ASSOCIATION

BEFORE THE U. S. SENATE SUBCOMMITTEE ON HEALTH

May 17, 1971, San Francisco

The California Hospital Association appreciates the courtesy of the opportunity to be heard by this important committee. We will return this courtesy by being as brief and clear as possible.

Although the increasing curve of costs may not show it, the hospital leadership in California has been very much concerned with controlling hospital costs for many years. Until recent years, however, efforts have been spotty, uncoordinated, and focused on short-term corrective measures. About three years ago, the California Hospital Association began a program covering two broad fronts having the aim of riding herd on costs. The two fronts can be identified as internal management improvements and external pressures.

It should be noted that this association has no coercive powers. Our tools have been persuasion and reason.

The first frontal attack was formally initiated in 1968 under the leadership of Samuel J. Tibbitts, president of the Lutheran Hospital Society of Southern California, who was then president of the California Hospital Association. This was the management approach.

The external approach was initiated in 1969 with the adoption of a CHA-sponsored Health Facilities Planning measure prohibiting licensure of facilities built or expanded without having participated in voluntary area planning. A companion measure adopted that same year prohibits Medicaid payments to any health facility built or expanded without a favorable final decision by an area health planning agency.

A second aspect of external control measures is before the California Legislature. It is the Hospital Disclosure Act, also sponsored by CHA, which was approved by the California Senate Health and Welfare Committee April 21. The measure would establish a State Hospital Commission empowered to obtain and fully disclose to the public hospital financial information based upon compulsory accounting and financial reporting procedures to be designed by the seven-member commission. Failure to comply with provisions of the proposed law would subject an institution to loss of its license.

These two control approaches represent two legs of a public utility concept. Through planning, entry of new or expanded facilities into the field is based upon the needs of the community. Through disclosure, reliable and valid information regarding costs will be provided so that governmental and private agencies such as insurance firms can make valid comparisons and projections regarding costs.

The third leg of the public utility concept is regulation of rates. We are moving cautiously in this area because of our strong conviction that regulation of rates without valid cost information would be at best hazardous and at worst catastrophic in terms of providing quality health care. We are pleased to note that Maryland's new law establishing a State Hospital Commission shares this concern. The Maryland Commission will function for three years as an information-gathering and disclosure body before it will be authorized to set rates.

This is where we stand now on the external control front in California. Progress has also been made on the internal management front since its 1968 beginnings mentioned earlier. The management program contains one aspect we believe to be especially worthy of note. Included was a built-in means of measuring management improvements on a statewide basis. Following initiation of management improvement programs sponsored by the California Hospital Association, a means of measuring "productivity" was designed, tested and put into effect.

There have been three major aspects to CHA's management improvement program. The first was a series of meetings statewide to familiarize top hospital management with methods and techniques available and to urge their participation in these programs. Most notable of these is the hospital adaptation of industrial engineering

methods developed by the Commission for Administrative Services in Hospitals (CASH), which is headquartered in Los Angeles. This program essentially relates to the measurement of time required for the proper care of patients and establishes standards so that an institution can determine whether it is devoting too much or too little time to a wide variety of functions. The CASH program enjoys an excellent reputation in California and nationally.

A second program explained to hospitals is the Hospital Administrative Services program (HAS) of the American Hospital Association. This service provides hospitals with statistical reports regarding a variety of "indicators" such as figures on lengths of patient stays, costs for various hospital departments and so forth. HAS reports permit the institution to compare its figures with those of other institutions of similar size or of different size throughout the nation. With HAS, hospitals can measure performance compared to others. With CASH, hospitals can measure performance against their own past performances. The CASH program also provides for recommendations for improvements based on accepted industrial engineering methods and studies performed in the hospital by CASH experts.

The initial series of "sales" meetings held statewide resulted in significant increases in the number of hospitals participating in HAS and CASH. At these same meetings, held during 1969, the

second phase of management improvement was previewed. CHA's management goals were explained and a series of seminars for hospital top management was announced. The seminars were held in the fall of 1969 and proved quite successful. As a result, the seminars concerned with "Management by Objectives" were expanded to hospital middle management. These were held in the spring of 1970.

Following their completion, the third phase was begun, consisting of a management accreditation program. This program was under development and testing for a year. Initiation is scheduled for June 1 of 1971. It consists of an analysis of hospital records, visits to hospitals by administrative experts which will cover one and one-half days of study and consultation with administrative personnel. Recommendations for improvement will be made and certificates of management accreditation will be awarded to institutions meeting management standards.

This last phase, of course, has not yet had any effect. The first two phases, however, are showing positive results in California based upon productivity measurements designed and analyzed by CASH experts.

The original 1968 goal was to tool up and attain a 5 per cent productivity increase by the end of 1970.

The actual productivity increase as measured by CASH has been three per cent. This is not as high as we had hoped but it is by no means a failure. This is a significant increase in productivity per patient stay. This increase has saved the citizens of the State of California approximately $36 million over the two-year period that measurements have been taken. The rate now is $28 million annually. There has been a decrease in the average length of stay per hospital patient from 7.3 days in 1968 to 6.9 days in 1970. This is a 5.5% improvement, which is in large measure attributable to peer review, a responsibility of hospital medical staff physicians, and hospital administration.

This adds significance to the fact that productivity per employee and per patient stay has increased by the aforementioned three per cent. Normally you would expect a greater utilization of employee hours per patient day as patients stayed in the hospital for shorter periods and the patient population turned over faster.

While we did not reach our full five per cent goal, we are pleased with this performance. It proves something can be done. It substantiates the value of our program to improve management of hospitals. This not only provides the savings indicated earlier, but should make our future programs that much more saleable and that much more effective.

We have educated others, and we have also been educated.

The California Hospital Association recognizes that hospital costs are high. When our management programs began in 1968 the average cost per patient day as measured by CASH was $74 per day (73.90). In 1970, this reached $94 per day (93.96). The national average for 1968 was $59 and for 1970 was $75.

The Association also recognizes that there is no hope for any significant reduction in hospital costs given the state of our economy and the continual improvement in hospital and medical technology. We can only hope to contain the cost rise at some acceptable percentage as long as this is consistent with hospital care. This does not mean that we are pessimistic about the total health care bill, however.

The solution, we believe, lies in preventing hospitalization through improved means of delivering health care so that disease and injury is prevented or made treatable outside the hospital setting to the extent possible. In the long run, maintaining health is far less expensive and more productive than restoring it. This becomes even more obvious if costs such as time lost from work, from the family and from productive activities of all kinds are considered as part of the cost of hospitalization. It must also be recognized that as hospitals are able to perform at more advanced levels of care, costs will rise inevitably, if these costs are measured only from the standpoint of their economic cost. We must also look at the benefit to the community and to the nation which arises from having productive citizens restored to full activity.

We also urge everyone concerned with the future of this nation and with health care to be wary of overstressing dollars to the detriment of human values. Human values, we submit, are in the final analysis infinitely more important than dollars.

Senator KENNEDY. Miss Cecelia Lannon, legal aid—from Marin County.

STATEMENT OF MISS CECELIA LANNON, LEGAL AID, MARIN COUNTY, CALIF.

Miss LANNON. I would like to tell you, very briefly, about a particular view of the medical program here in California that is not just related to the failure of medical service, but the absolute denial of medical service to the most needy poor persons in our Nation. This has been made possible by linking medical service to welfare eligibility for the majority of poor persons.

The particular persons that I want to tell you about are minors—an unpopular group politically in California in terms of receiving public service. These minors are emancipated. That means they can contract for medical service without their parents being involved, without parental consent, and without financial responsibility.

These minors are women. These women minors are pregnant. Their medical need is prenatal care. In some cases an abortion is absolutely essential. With these minors, what medical experience has shown—unless this particular age group gets the necessary prenatal care the chance of giving birth to a dead baby or a stillborn, goes up. Also, the chance of her suffering toxicity from that pregnancy, impairing her health, goes up unless she gets prenatal care in the first trimester.

In the case of a minor who needs to work, it is just that crucial, because unless the minor can get an abortion—and that means a person who is neither physically or emotionally capable of giving birth and raising the child—she is forced to have the child.

The situation in California is this: If these pregnant girls were wealthy or even from middle-class families, they have recourse—they could get this medical care. This would be no problem. With a minor, poor in the sense she must go to the welfare department; and despite the fact that California law specifically excludes her parents from involvement in her medical problems, despite that fact, that policy, California does not give this minor medical care even though she qualifies, until after the welfare department has checked with the parents of the minor or has involved them in her medical care. The result of this—if the minor doesn't get parental consent, and the investigation takes a long time to do—the minor doesn't get the care.

In some cases it results in simply not being able to involve the parents in the medical care—and she has a right not to, under California law. The result of that is disastrous to the girl who doesn't get the care, and has to give birth, or sometimes self-aborts.

This policy has resulted in litigation. Our office is struggling to try to change that policy. There is no basis in California law for this policy and there is no basis in Federal law, but it is the policy in the State of California. And it is also impossible for these minors simply because in order to get that care you have to be eligible for welfare and being eligible for medical care depends on welfare; it is subject to political manipulation—and also, unfortunately, by personal abuse by some welfare workers.

It is our position that these minors are absolutely in need of medical care. It is essential to their health, to their future. It is also essential to curbing the welfare cycle because these girls, if they can't get the aid they need, they are going to have a second and third child and are going to end up on welfare.

The crisis is political; it is not a financial one—it is the result of political manipulation and total lack of recognition of the problem. In order to remedy this, the only way I can see would be a separate type of medical service from welfare, have separate agencies, have no type eligible determinations they require now for welfare. That is the only way the poor are going to get adequate medical care.

Senator KENNEDY. Very good comment.

If we had the time, you could go through a lot of these other kinds of instances like we heard—Miss Lannon you could probably do this, working for a legal service.

We had some comments at other hearings. They have an extraordinary access to the kind of cases we have heard this morning. This has been their experience, as well, generally where you have these consumers that are, as you identified, a very poor group in our society—but for others, as well—that are deficient in terms of health needs and health care.

Miss LANNON. Do you mean in terms of the poor?

Senator KENNEDY. Yes.

Miss LANNON. I didn't get the first part of your question.

Senator KENNEDY. The kind of cases we have had this morning; and we have heard from the legal service people—you could give us a whole stack or list of people.

What we are trying to find out is whether the seven people are exceptions or whether you are rubbing shoulders with these kinds of people day to day in your legal service.

Miss LANNON. In our county we have had a lot of experience with the young people, because there are a lot of young people in this area—but the abuses this group suffers because they are denied medical care the older people suffer because the delivery of medical services is denied.

Middle-age people can't get glasses. They can't go in for surgery. Sometimes, if they have to have medical care that isn't emergency medical care, under the medical program as it is set up now in California, surgery can be delayed up to 90 days—if the particular medical consultant decides that he wants to delay it.

They are just unlimited—the number of people that can testify as to their own personal disasters, poor persons who can do this.

Senator KENNEDY. Thank you, very much. That is another reason why the CRLA should be funded.

[Applause.]

Senator KENNEDY. Percy Steele, chairman of the board of directors, Westside Community Health Center.

STATEMENT OF PERCY STEELE, CHAIRMAN, BOARD OF DIRECTORS, WESTSIDE COMMUNITY CENTER

Mr. STEELE. Thank you, Senator.

In consideration of the time factor, I will just be very brief rather than to repeat other concerns that have been expressed already this morning.

Westside has had a tremendous insight into the overall problem related to comprehensive health planning, based on 3 years of experience in the welfare area field of the community which is largely a ghetto area.

One of the things in reading S. 3 we wanted to point out—we would like to see this health oriented rather than illness oriented because of the ramifications. And we feel that psychiatric patients should have equal freedom and access to the kind of services described in this legislative proposal.

One of the secrets of an adequate health planning and health delivery service, based on my own experience, is that there must be an opportunity for built-in participation for the residents of all levels; that is, youths, adults—not only planning for health delivery services, but carrying them out.

The training aspect is one we give 100 percent support to because we do not have enough professionals and we do not have enough paraprofessionals in medical delivery of services—and we hope there is a strong effort to move toward this.

Senator KENNEDY. Thank you, very much.

Charlotte Offhouse. You have a statement here. We will put this in the record.

STATEMENT OF MISS CHARLOTTE OFFHOUSE, NURSE SPECIALIST IN COMPREHENSIVE CARE OF STROKE PATIENTS

Miss OFFHOUSE. I know it is hard to include everyone in the series, but we haven't heard from nursing and it is a critical area.

I am in the clinical nursing specialty—and from the testimony I have heard today I can verify it is true in many, many comunity agencies around the bay area.

I see these things in the hospital and out of the hospital.

I think in my testimony I went into detail and covered a lot of things other people said.

In our present system of medicare, we have two levels of inpatient care which, again, is a very costly aspect. We have acute and subacute care; and probably the most important is the subacute aspect of care, because at the present time all of the subacute care is at a costly rate, at the acute care rate—and we really haven't provided facilities to take care of the subacute. I won't got into all of the definitions because they are lengthy.

But I think in our health industry we have to look at the role of the nurse.

In the State of California—and I had trouble deciding my priorities because I should be up in Sacramento defending our nursing services because there are hearings on what is called skilled nursing care and that means sticking needles and tubes into people. And I would very much like to see some of the new roles for nursing manpower directly reflected in any proposed health security system such as nurse practitioners, nurses in primary care roles, clinical nurse specialists, and so forth.

Certainly with the management of subacute and chronic disease coming to the fore, a recognized, responsible role for nursing should play an important and dynamic part. A current study in the bay area indicates no shortage of nurses but demonstrates misappropriation of services in many facilities—utilization of health manpower should be scrutinized, reassessed, and clearly outlined in any new system that may emerge.

A recent article in the San Francisco Chronicle told of an empty bed crisis in San Francisco's hospitals—"a crisis so severe that many institutions here are in deep financial trouble * * * almost all major San Francisco hospitals are in the midst of an intensive building program right now or have just completed them"—perhaps a sign that we are not meeting community needs.

Ironic as it may seem, that same paper told a story of a hospital in a neighboring town which is soliciting funds to build 131 acute care beds—another indication of a lack of sensitivity to community needs.

For this reason alone, it is costly not to define levels of care and place limits on length of stay within the bounds of levels of need.

Our present system is not defined by patient care needs. This has produced so-called abuses which are usually an attempt to provide some kind of care to patients even though it may not fall within the bounds of the system.

We speak of controls and incentives, but where are they? The cost of health care will continue to increase because consumers will be relegated the responsibility of paying for these unnecessary and unusable facilities which are being built.

Our communities—as we saw here today—are telling us loudly and clearly what their needs are, yet several groups of health professionals who have attempted to meet these needs have been denied funding or denied payment after services were rendered.

The present system does not permit us to meet these pressing community problems—we need ess concrete and mortar and more patient services outside of the institutional setting.

In order to best utilize existing structures it would seem appropriate to immediately engage in regional surveys of present resources and convert facilities to fit within the proposed framework of levels of care.

It should be clear by now that superimposing new concepts onto old frameworks is impractical and unworkable.

If we are to embark upon a health security plan for all, let us listen to the needs of our people and meet them.

Senator KENNEDY. Thank you, very much.

(The prepared statement of Miss Offhouse follows:)

TESTIMONY FOR THE HONORABLE EDWARD M. KENNEDY

ON

HEALTH SECURITY FOR AMERICA

MONDAY, MAY 17, 1971 SAN FRANCISCO, CALIFORNIA

I am Charlotte Offhouse and am presently employed as a Nurse Specialist in the Comprehensive Care of the Stroke Patient. In the past I have been a direct provider of health care to patients. My present work takes me into many community agencies on a consulting basis.

At the onset, I would like to commend you and your staff for your efforts to establish a comprehensive national health insurance program for all our people. I read with great interest your bill to create a Health Security Program. I concur that it is critical to eliminate eligibility clauses if we believe health to be a right for all and not a privilege for a few. After studying your proposal, I would like to discuss with you the urgency to change our present system of health care delivery to meet community needs if we are, in fact, going to provide health care services for all. It seems reasonable that to meet community needs, we must first look at what those needs are. This can be done by defining levels of care and then to think of alternative methods of providing services which will embrace the entire community. Certainly one of the alternatives would be coordinated groups of health professionals giving primary family care. A major emphasis should be on ambulatory, out-patient care including minor surgery not requiring overnight stay in hospital. We should provide for organized out-patient programs to meet specific community needs such as alcoholism, drug addiction, venereal disease, terminal cancer, medical diseases

such as heart disease, cancer and stroke, mental health problems, family planning, maternal and child health care, environmental health problems and home care programs all geared to work with patients outside of an institutional setting when possible. There should only be enough "back-up" beds for in-patient treatment as absolutely necessary. In-patient care can be defined as follows:

Acute care:	crisis intervention, unstable conditions, acute exacerbations of existing conditions in need of intensive care
Sub-acute care:	immediate post crisis intervention, stablizing conditions in need of intensive rehabilitation
Interim care:	stablized conditions in need of supportive care
Long-term care:	chronic conditions in need of supervision or activities of daily living

If we think in terms of separating patients according to patient care needs and not by diagnosis, we could hope to have each staff especially trained in certain activities which would pertain to that particular level of care. For example: staff in an acute unit would be prepared for admissions on a 24-hour basis. They would be equipped to start intravenous feedings, draw blood, take and interpret electrocardiograms and make critical observations. There might be 24-hour physician coverage if necessary. All staff should be involved in rehabilitative measures but the staff in a sub-acute unit would be specifically trained in teaching patients to transfer safely, offering psycho-social therapeutics and other such rehabilitative measures.

I have attempted to outline the levels in a progressive order from acutely ill to well patients. A patient should be able to enter the progression at any point that is

deemed necessary by his care needs. It would be a rare instance that one patient would need care from all of the units but the following sequence might occur:

> A woman aged 28, undergoing a prematiral examination, is diagnosed as having metastatic cancer. After being informed of her status she becomes suicidal and rejects her family and friends. Under the proposed system, her physician would enter her into the sub-acute level of in-patient care for intensive rehabilitation: psycho-social therapy, recreation therapy and diet therapy to help her overcome her fears and better understand her disease process. This therapy would also provide support for her fiance' and family. When her condition stablizes she could return home and receive drug therapy as an out-patient. When she evidences further metastesis and if acute care is indicated, she could be admitted to an acute care unit for radical surgery. Such surgery could precipitate a deep depression. As soon as physically possible after surgery, she would be transferred to the sub-acute unit for continued psycho-social therapy and post-operative care. At this point her condition may become terminal. She can be successfully discharged to a home care program which has been coordinated with her in-patient care. The home care program will provide the necessary support and services throughout her final stages of life.

Perhaps the most critical area in this scheme is the sub-acute level of care. In today's system of care the acute facility has been the seat of all health care delivery. The Medicare Law has defined two levels of in-patient care -- acute and

extended care. This program philosophically encompasses existing hospitals and nursing homes but in reality new terminology was coined for traditional health care services. Extended care has been delegated to the nursing homes and convalescent hospitals which have been certified as Extended Care Facilities. By and large, these facilities are neither staffed nor equipped to properly handle sub-acute care. Thus sub-acute patients are remaining in acute beds which creates a costly program. Usually, by the time a patient is transferred to an extended care facility he is well into or already passed the sub-acute phase of illness. Then, because care needs do not fit into the system, confusion results from trying to justify the need for further in-patient care. Modern medical advances have greatly reduced acute illness in this country. If we are to embark upon a new system of delivery, I think it imperative that we identify and give credence to the management of sub-acute illness. This can be done by analyzing patient needs.

Under our present insurance systems we have the term "covered care." This has hidden meaning, is ill-defined and often leaves patients with unanticipated health bills because benefits are denied after the fact as "non-covered care." Hopefully, if we institute a system of clearly defined levels of care "covered care" could be specifically differentiated from "non-covered care." I have seen interpretations of the Medicare laws vary from time to time and place to place. A patient in one facility is covered when a similar patient in another facility is denied as the result of undefined guidelines.

Some attention must be paid to who will provide which services and at which level. Acute care takes place in present-day units such as intensive care units, coronary care units, stroke intensive care units, etc. Most sub-acute care is given on

general medical and surgical units in acute hospitals. If an extended care facility were specially staffed and equipped, sub-acute care could be provided out of the hospital setting at a lower cost but the cost for this care should be higher than the present rate of reimbursement for nursing home extended care beds. Interim care and long term care could be provided in present-day nursing homes at lower costs than the first two levels of care. Such deliniation eliminates the false concepts that nursing homes can provide extended care or that acute hospitals should continue to offer sub-acute services while being reimbursed at acute rates. If there were more definitive separation in levels of care, both hospitals and nursing homes could specialize in their own area of expertise. I am aware that these ideas are non-traditional and will be resented or misunderstood by most people in today's health care industry.

One of the most unfortunate problems I have seen evolve from the Medicare program which I would like to see reversed is the role of nursing. In no way does the definition of covered care reflect what nursing really is. The only nursing care which is recognized is called "skilled nursing care" and that basically reflects sticking needles and tubes into people. We in nursing are aware of various and often conflicting public opinions of what nursing is. Some of this confusion is generated from within the profession itself. The recently published Lysaught Report[1] which is the report of the National Commission for the Study of Nursing and Nursing Education has made great strides in defining nursing roles in present-day health care. I recommend this report to anyone concerned with national health and would very much like to see some of the new roles for nursing manpower directly reflected in any proposed health security system such as nurse practitioners, nurses in primary care

[1] Lysaught, Jerome P., An Abstract for Action, McGraw-Hill Book Company, New York, 1970.

roles, clinical nurse specialists, etc.. Certainly with the management of sub-acute and chronic disease coming to the fore, a recognized, responsible role for nursing should play an important and dynamic part. A current study in the Bay Area indicates no shortage of nurses but deminstrates misappropriation of services in many facilities; utilization of health manpower should be scrutinized, reassessed, and clearly outlined in any new system that may emerge.

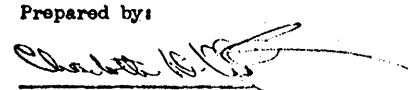
A recent article in the San Francisco Chronicle told of an empty bed crisis in San Francisco's hospitals--"a crisis so severe that many institutions here are in deep financial trouble...almost all major San Francisco hospitals are in the midst of an intensive building program right now or have just completed them"[1] -- perhaps a sign that we are not meeting community needs. Ironic as it may seem that same paper told a story of a hospital in a neighboring town which is soliciting funds to build 131 acute care beds -- another indication of a lack of sensitivity to community needs. For this reason alone it is costly not to define levels of care and place limits on lengths of stay within the bounds of levels of need. Our present system is not defined by patient care needs. This has produced so called "abuses" which are usually an attempt to provide some kind of care to patients even though it may not fall within the bounds of the system. We speak of controls and incentives but where are they? The cost of health care will continue to increase because consumers will be relegated the responsibility of paying for these unnecessary and unusable facilities. Our communities are telling us loudly and clearly what their needs are yet several groups of health professionals who have attempted to meet these needs have been denied funding or denied payment after services were rendered. The present system does not allow for accommodation to these pressing community problems: we need less concrete and mortar and more patient services outside of the institutional setting. In order to best

[1] San Francisco Chronicle, Monday, May 10, 1971, Page 1.

utilize existing structures it would seem appropriate to immediately engage in regional surveys of present resources and convert facilities to fit within the proposed framework of levels of care. It should seem clear by now that superimposing new concepts onto old frameworks is impractical and unworkable.

If we are to embark upon a Health Security plan for all let us listen to the needs of our people and meet them.

Prepared by:



CHARLOTTE D. OFFHOUSE
Nurse Specialist

FINAL

REPORT OF THE CALIFORNIA TASK FORCE ON DENTAL CARE IN NATIONAL HEALTH INSURANCE PROPOSALS

February 6, 1971

REPORT OF THE CALIFORNIA TASK FORCE ON DENTAL CARE IN NATIONAL HEALTH INSURANCE PROPOSALS

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REPORT OF THE CALIFORNIA TASK FORCE ON

DENTAL CARE IN NATIONAL HEALTH INSURANCE PROPOSALS

INTRODUCTION

The California Task Force on Dental Care in National Health Insurance proposals was charged to develop suitable dental health planning recommendations for consideration by legislators, health professionals, and consumers concerned with current legislative activity in the field of national health insurance. Members were requested to review current health planning at state and national levels, the present systems of dental care delivery, utilization of dental manpower, education and also some of the logistic factors directly related to dental health program planning.

This summation of task force deliberations addresses the issue from a background of information developed to insure an understanding of a basic practical philosophy which it is believed must be the foundation for sound national health planning. It also describes direct program elements with recommendations designed to reflect a sound and necessary position for dentistry in NHI planing.

COMPOSITION OF TASK FORCE

Members of the California Task Force were selected for their interest and expertise in various facets of health care, from a cross section of ethnic and income groups, representing consumers,

insurance carriers, labor, industry, government and dentistry.

HEALTH CARE AS AN ESSENTIAL

Past history shows that whether the origin of any given health program is private or governmental, there are seldom adequate sources of funds to provide total health care for all. This has led to severe competition of priorities by those who design health programs. The designers are not always legislators or government officials. They may be recipients of care motivated by desires related to their own needs, with subsequent communication to some collective agent, representatives in government, or an insurance company.

Establishment of Priorities

In the race to establish the priorities of health care and by virtue or limitation, it became necessary to define what was to constitute the "basic essentials" of health, the base from which all additional health care programs would pyramid as superstructure. The base has been defined under federal law (Title XIX) and is the mandate to be used by states in considering the availability of federal funds in existing programs. To date, as outlined in Medicaid (Title XIX) Guidelines, the federal government has not included dentistry as a "basic essential" service.

Presently, oral health care is defined as an elective service by legislators and administrative officials. Program designers have frequently expressed the hope that sufficient funds would be available to provide some oral health care services at the onset of proposed health programs and that at some later date, such provisions would be expanded to include comprehensive oral

health care services. This expectation is seldom realized; in fact, the reverse is true.

In California, for instance, government sponsored dental care has repeatedly been one of the first services to be reduced or omitted when budget deficits occurred. This has been demonstrated as recently as December, 1970 with Medi-Cal cutbacks. At one time, only a legal technicality prevented total elimination of all dental care under the California Medicaid program. Other "elective" services have suffered the same dilemma.

Oral Health as an Essential Service

A dichotomy apparent to many in the dental profession is that in medicine there are electives which are included with "essentials"; in dentistry "essentials" are included with "electives". An understanding of the dichotomy should make it apparent that it is impossible to virtually eliminate all oral health care as a non-essential in regard to basic health care, or to avoid its vital essentiality in consideration of total health care. Conversations in depth with governmental administrators have demonstrated their understanding and agreement with this premise.

Right to Oral Health Care

Therefore, for the benefit of the people who are demanding that their right to adequate health care be honored, it is critically important that they be entitled to a proper definition of essential health care. That defintion is faulty without the inclusion of oral health care. There is no more logic to arbitrarily ruling out the treatment of disease of one part of the human anatomy, i.e., the oral cavity, than there is in deciding to treat deseases of the right arm while ignoring the left.

The long standing principle that dental care is an essential component of total health care must be strongly reinforced. Dental care must be on a parity with other essential health care services in all public and private health programs. The dental components of such programs should include diagnosis and prevention, education and motivation, and treatment and maintenance.

Dental Components of Health Programs

NEED FOR DENTAL SERVICES

There are many reasons underlying the generally accepted fact that the dental needs of our population are not being met. These include manpower shortage and maldistribution, economic barriers, and lack of educational acceptance and motivation.

Incentives to attract dentists to areas of greatest need should be provided in order to help correct the problem of maldistribution. One method would be to establish government or privately-sponsored scholarship grants and incentive loans for dental students, tied to emphasis on location in designated need areas upon graduation. Designation of areas of need and numbers of dentists required should be made by the regional comprehensive health planning agencies. Substantial government loans should also be made to finance office development including remodeling, equipment and initial supplies to those who are willing to practice in designated need areas.

Maldistribution of Dental Manpower

Incentive loans should be interest free until graduation from dental school and should be forgiven on a graduated scale with

Incentive Loans

increasing increments for each year spent in practice in a designated need area. If a dentist secures both an educational loan and office development loan, both loans could be considered under the forgiveness concept.

Auxiliary Manpower Needs

Manpower needs are not limited to dentists alone, but apply to dental auxiliaries as well. The dental profession recognizes its obligation to initiate and direct programs under its control which will:

1. Increase the number of auxiliaries employed by dentists.
2. Effect better utilization of present auxiliaries under existing laws.
3. Review and revise dental practice acts where necessary to encourage involvement in expanded duties for auxiliary members of the dental health team.

EDUCATION OF DENTAL HEALTH PROFESSIONALS

Dental Manpower Shortage

Dental schools in the United States, while expanding enrollment in existing facilities and adding to the number of teaching institutions, are not keeping pace with current population growth. Future projections do not show improvement in the ratio of dentists to population. Recent figures released by the United States Public Health Service show an estimated current shortage of 17,800 dentists by 1980. California licenses at least one third of needed dental manpower from dentists trained outside the state. This is also true of other populous states, with a resultant serious, net manpower loss to those states which are unable to retain health professionals who have been trained in their state.

Emphasizing educational needs, the Carnegie Commission's report on Higher Education and the Nation's Health, released in October 1970, suggests a 20 percent increase in dental school enrollment by 1980 with greatly expanded educational facilities. It also suggests the adoption of uniform tuition fees for health professions schools in the range of $1,000 per year, per student. State subsidy grants to private health professions schools in order to avoid bankruptcy, coupled with increased federal subsidy, is recognized as a pressing need. The Task Force is in agreement with these concepts.

Findings of Carnegie Commission

At present the health professions do not show proportional representation of recognized minority groups. Incentive programs consisting of financial assistance should be encouraged by the health professions to motivate minority individuals to enter the health professions.

Minority Students

Education in the health professions has always been costly, but in recent years expenses have soared. Dental Education is now the most expensive career to pursue from the standpoint of doctoral expense, since it involves equipment and supply expenses as well as the costs of tuition and living. Unfortunately, government sponsored scholarship funds have been decreasing in recent years rather than increasing and the debt profile of students in dental schools across the nation is reaching critical proportions.

Cost of Dental Education

Recent action by the American Dental Association House of Delegates has approved guidelines for more flexible curriculum development and operation in dental schools than was previously allowed. This should allow action by educators to improve educational opportunities related to increase in and better utilization of all types of dental manpower. While recognizing the need for manpower, this Task Force also strongly recommends that

American Dental Association Guidelines

research in health professions institutions, especially related to prevention, should be strongly urged and funded at appropriate levels.

It seems certain that the principle of prevention, strongly implanted in students during the educational process and reinforced by research activity of health professions scholars, is the only certain way that reduction of dental needs will be met in a way which may make it possible to meet the demand for services in the foreseeable future. Without this approach, ramified throughout the profession, remedial rehabilitative care will continue to overburden our health manpower pool and unnecessarily drain private and governmental fiscal resources.

Preventive Measures

PREVENTION

The philosophy of prevention as a priority must be incorporated at the inception of national health insurance coverage, if the objective of massive reduction of dental disease is ever to be met. Preventive measures in a national health program must be effective in preventing oral disease practical for incorporation on a large scale and combined with incentives to encourage use of preventive measures.

Since water fluoridation is the most effective preventive dental measure presently available, a national health insurance program must encourage its use. Incentives should be provided for those consumers in states or areas which require fluoridation and for patients of specified ages who take a prescribed course of preventive topical fluoride treatments.

Water Fluoridation

It is recognized that comprehensive dental care should be available to all persons. However, studies have shown that a given amount of money will provide care for more young patients than older patients. Money spent on the care of the young can be, in effect, returned to the program by eliminating the need for expensive procedures at a later age. Sound dental health planning and sound fiscal planning both encourage and emphasize care for the young recipients. The dental profession believes that primary emphasis of preventive dental care should apply to preschoolers through age 18.

Preventive Care for the Young

Evidence points to the fact that there is a need for innovation in dental health education, both in the dental office and other settings adapted to meet the specific needs of particular target populations.

Educational material presented to the patient should include information as to where and under what conditions dental care is available and how such care will be paid for. Information should be provided on specific preventive techniques such as topical fluoride applications, plaque control, carries prevention, nutrition and diet, oral care during pregnancy, home care for the periodontal patient, the orthodontic patient, etc.

Educational Material

Clearly, the dental office provides an ideal opportunity for the dentist to educate and motivate the patient on a one-to-one basis. It is recognized that at present health education in the dental office is sporadic and that the dentist's time may be better utilized in providing care that only he is qualified to perform.

Patient Education in the Dental Office

Therefore, emphasis should be given to innovative approaches which improve the "one-to-one" educational approach in the dental office by utilizing auxiliaries and audiovisual methods and materials to effect productive patient education.

Dental Health Education in the Schools

Established school dental health programs are also very important. They must be continued and improved. Any dental health school program must be preventive oriented. Present school dental health education, like much of the dental office education, is sporadic, with some schools providing relatively good preventive programs and others virtually no programs. The minimum content of a school program should include an audiovisual presentation on dental health concepts and an annual dental examination of the school children by a dentist or dental hygienist with a report to the children's parents. Effective follow-up must be used to ascertain that children receive needed care.

Community Health Aides

The use of community health aides to provide follow-up and to educate patients has proven to be quite effective, especially in low income areas. Use of community health aides in an OEO center has raised the recall utilization rate for dental service from 22% to 87%. Funds should be provided to train community aides for use in connection with health insurance programs where necessary.

As noted earlier, factors directly related to detailed planning of a health program were studied in addition to consideration of essentiality of care, need for services, manpower needs and preventive measures. The following recommendations relate to program

details of eligibility, organization and administration, delivery systems, quality and cost control, and cost and program design.

PRIORITY

This Task Force strongly believes that there is an immediate and imperative need for clear reordering of the nation's priorities; that it is now time for this nation to adopt as national policy, the right of dignified access to total health care for all its residents, unobstructed by racial, ethnic or economic barriers.

ELIGIBILITY

In developing and implementing a national health program, fundamental consideration must be given to providing dental care coverage, including preventive and remedial dental services, for all residents of the United States.

ORGANIZATION AND ADMINISTRATION

National Health Insurance Program Board

A National Health Insurance Program Board should be established which will be responsible for public accountability of the total NHI program. The Board should have significant dental representation; furthermore, it would seem logical that the Board be responsible to the Secretary of Health, Education and Welfare Department (HEW).

National Dental Advisory Committee

A National Dental Advisory Committee should also be formed, composed of members of the dental profession and of the public at large, in order to insure both professional and consumer orientation of program development. The Dental Advisory Committee

would be responsible for recommending scope of benefits, standards for dentist participation, quality control and policy guidelines regarding actual delivery of dental services.

The National Health Planning Board, with the assistance of the Advisory Committee, should work to assure efficient administration and effective coordination of the program by using existing private health agencies for fiscal administration. These agencies should compete for administrative contracts.

Regional, State and Local Representation

The National Health Insurance Program Board and the Dental Advisory Committee should be represented also at the regional, state and local levels. Such a system would assure a greater response to the needs of the public and the providers of care.

In consideration of the organization and administration of a dental care program under a national health insurance program, the following recommendations are emphasized:

1. The fee concept adopted for reimbursing the provider of services must be on a parity with all health disciplines included in the program.

Fee Parity

2. The program should be established on a fee-for-service basis reflecting usual, customary and reasonable charges, adopting the concept of establishing individual fee profiles. The unique advantage of the usual, customary and reasonable concept over other methods of reimbursement is that it will insure wide professional acceptance of a

Fee-for-Service Concept

national health insurance program and will thus allow eligible patients to have a meaningful choice of practitioners when seeking dental care. Additionally, the program should encourage exploration of other fee systems.

3. The administration of the plan should provide a mechanism for clearly determining the scope of benefits and the eligibility of the recipients. If a recipient is to make direct payment for partial or selected services, predetermination of total financial responsibility should be clearly outlined. *Scope of Benefits*

4. Maximum care should be exercised in the overall organization and administration system so that it does not work to the disadvantage of dentists in lower income areas nor place a stigma on any recipient.

It is recommended that existing fiscal intermediaries, on a competitive contractual basis, establish processing centers to perform all administrative phases of dental forms processing. These centers should be established in locations conducive to maximum efficiency. Personnel should be professionally oriented to assure competence in administering the provisions of the national health insurance program. The processing centers should perform the following functions: *Processing Centers*

1. Provide dentists with dental treatment planning forms; receive and organize dental statements from dentists who render covered services to eligible patients. *Functions of Processing Centers*

2. Determine if treatment is within the scope of benefits and regulations established by the National Health Insurance Board.

3. Select cases for review by regional dental consultants, including but not limited to the following:

Regional Dental Consultants

   a. Those which present irregular treatment patterns
   b. Those involving patient complaints regarding satisfaction of services.
   c. Those randomly selected for post screening, in sufficient quantity, to assure that a high grade of service has been performed.

   Problems related to review which cannot be resolved by regional consultants should be referred to the appropriate counselling or review committees of the state dental association.

4. Prepare checks for payments to dentists.

5. Serve as distribution center for communication with dentists concerning program developments and changes under the health program.

6. Aid in liaison and coordination with the dental profession at the local level.

DELIVERY SYSTEM

Free Choice of Delivery Systems

Since there are a variety of systems which may fit specific needs, no one delivery system should be penalized at the expense of another. In a national health insurance program, the recipient should have the right to

unrestricted choice of available delivery systems. At the same time, recognition should be made of the right of the dentist, for professional reasons, to choose the patients he will treat.

Comparative Studies

It is recognized that a national health insurance program may be implemented before full comparative studies of different methods of delivery can be completed and evaluated. However, such studies should be undertaken as soon as possible in order to obtain valid supportive data relating to positive and negative points of various delivery systems. Studies should measure efficiency on the basis of:

1. Increased productivity
2. Quality of service
3. Patient utilization
4. Acceptance of the system by the public and the dental profession
5. Cost of operation.

QUALITY AND COST CONTROL

Quality and cost control should provide mechanisms for controls within a system of national health insurance to insure that the best possible care is being delivered under the limitations of funding and that care being provided meets standards of reasonable cost. Cost must be considered reasonable by both the financing agency and the provider if the level of quality is to remain sound.

Under any health delivery system, cost would be considered the dollar outlay expended by the funding agency to achieve a unit of treatment. This would include individual payment of the provider and also associated administrative costs. If a unit value system is used, it would be translated into the cost per unit required to deliver the care to the patient-recipient.

Definition of Cost

Although the cost of a program necessarily includes expense for organization and administration, these costs could outweigh the cost of the treatment provided if they are not properly controlled. For this reason, the competitive system in the administration of public or private programs is vitally important.

Control of Costs

To attain optimal cost control, long range consideration must be given to the type of treatment provided. Preventive and early treatment, especially for children, must be emphasized as a most effective cost control measure which will avoid costly treatment in the future, resulting in greater savings and maximum utilization of the funds available. For example, it has been demonstrated that the cost of one partial denture for a recipient who has been missing teeth for many years would provide care for six children in a fluoridated area and three children in a non-fluoridated area for one year.

Prevention and Early Treatment of Children

Regular maintenance of oral health care as a concomitant effective method of cost control must also be encouraged with financial incentive to the provider where possible.

In considering quality control in a program of health care, attention must be given to the exact definition of what is

Definition of Quality Control

being considered. Quality may be defined as a class, kind or grade of treatment; the term itself does not denote excellence, i.e., quality may be excellent, good, fair, acceptable, poor or unacceptable.

Evaluation and Control of Quality

To be effective, quality standards of dental care must be controlled by the dental profession, with guidelines set by the profession itself. Evaluation of quality should be provided through peer review, using random sampling techniques for selection of consumer and provider participants, in addition to review initiated through complaint. The possible problem of lack of interest in participation, especially by the satisfied consumer, would be avoided by clearly stipulating that both provider and consumer be required, as program participants, to accept random sampling evaluations if selected.

PEER REVIEW: AN ESSENTIAL FACTOR OF QUALITY AND COST CONTROL

White House Report

A challenge was issued to dentists and physicians in the July, 1969 "White House Report on Health Care Needs", which declared: "We will ask and challenge the physicians, dentists and other practitioners of the nation through their national Societies and through the County Associations to establish procedures to review the utilization by their members...and to discipline those who are involved in abuses."

Peer Review Procedures

In November of 1967, the National Committee on Health Manpower recommended that professional societies, health insurance organizations and government extend the development and effective use of a variety of peer procedures in maintaining high quality health care. The Task Force believes these procedures should incorporate the following principles:

1. Peer review should be performed at the local level with professional societies acting as sponsors and supervisors. Consumers of health care should also be represented on peer review committees.

2. Assurance must be provided that evaluation groups perform their tasks in an impartial and effective manner.

3. Emphasis must be placed on assuring high quality performance and on discovering and preventing unsatisfactory performance.

Quality Evaluation Procedures

A peer review committee should have responsibility for quality evaluation, determining utilization and evaluation of cost/unit patterns to assure the highest level of care possible at reasonable cost to a program. When a peer committee determines that care provided by an individual is below the acceptable level it must have the authority and wisdom to properly discipline that individual. Such discipline should, if necessary, extend to exclusion of the provider from the program. In addition, the committee should encourage better standards of care by requiring further training or post graduate study if necessary.

A bipartite peer review system with consumer representation that is included in any dental insurance program is invaluable in demonstrating to the public that the dental profession will not white-wash abuses and that those few men who violate their professional trust will be disciplined by their peers.

The Task Force recognizes the conflict between optimum desirable services and available funds. In this regard, the Task Force recommends that the concept of patient copayment should be utilized, where necessary, as a device to (a)broaden the scope of services and (b)to control program utilization and cost. However, the Task Force recommends that the copayment concept should be avoided in the case of (a)emergency care for all participants and (b)with respect to preventive care for children. Copayment should also be held to a minimum with respect to other children's services through age 18.

As stated, the Task Force emphasizes the need for comprehensive care for all residents of the U.S.; it also recognizes that certain areas of dental care may remain outside the scope of the initial national health insurance program because of fund limitations. This fact may require that program designers know what specific services can be obtained according to the amount of money available. The Task Force therefore recommends six plans which delineate services relative to scope of benefits and cost. The proposed level of benefits is summarized as follows:

PLAN I: COMPREHENSIVE: This Plan provides for:

a) Preventive & Diagnostic

b) Basic
--Operative
--Oral Surgery
--Periodontics
--Endodontics

c) Prosthodontics

d) Orthodontics

PLAN II: Includes the same benefits as Plan I except for (d) Orthodontics.

PLAN III: Includes the same benefits as Plan I except for (c) Prosthodontics and (d) Orthodontics.

PLAN IV: EMERGENCY ONLY

Provides for elimination of pain and acute infection.

PLAN V: CHILDREN'S PROGRAM TO AGE 18 - This Plan provides for:

a) Preventive & Diagnostic (including space maintainers)

b) Operative (amalgam, silicate and plastic restorations)--stainless steel crowns and crowns for fractured anteriors.

c) Endodontics

d) Oral Surgery

PLAN VI: Combines Plan IV for adults and Plan V for children.

The estimated cost of each plan can be expressed in units with Plan I being designated as a base of 100.

Plan I = 100

Plan II = 90 to 95 percent of Plan I

Plan III = 64 to 69 percent of Plan I

Plan IV = 5 to 7 percent of Plan I

Plan V = 22 to 26 percent of Plan I

Plan VI = 28 to 32 percent of Plan I

If Plan I for optimum care cannot be funded immediately under NHI, the Task Force urges that funding be attained within five years from the initiation of a national health insurance program.

With respect to those services not included in the initial national program, the Task Force recommends that existing private plans continue to provide dental care coverage at a level which in no way reduces the amount of coverage provided prior to the advent of the national program. Further, any savings realized by existing programs through benefits provided under NHI should be utilized to improve the overall level of care in conjunction with the national program.

The Task Force recognizes that present national health insurance proposals contain recommendations for several methods of financing, which generally include the following:

1. Employee contribution through social security taxes.
2. Employer contribution through payroll tax.
3. Government subsidy from general revenues.
4. Tax credit.
5. A combination of the above.

Irrespective of the method of financing a national health insurance program, comprehensive dental care must receive the same priority as other essential health services.

Senator KENNEDY. We are going to have to recess the hearing—but before we do, if there are others who would like to comment we ask them to send us their comments and we will include them in the record. We will keep the record open for 10 days.

And also, if you want to write to me in care of the Health Subcommittee of the Senate—we value that.

Again, I want to thank the school administration for their kindness, and to thank all of you—you have been enormously attentive and interested and I think it has been a very worthwhile and valuable hearing—and in terms of the total record to the Senate—I am sure it is going to give all of us in Congress a much better insight into the problems, in human terms, that are affecting so many people.

I want to thank all of you for your attention and your kindness in being with us today.

(The material referred to follows:)

STATEMENT OF CALIFORNIA BLUE SHIELD

SUBMITTED TO THE

SENATE SUBCOMMITTEE ON HEALTH CARE

OF THE

COMMITTEE ON LABOR AND PUBLIC WELFARE

Thomas C. Paton, President
California Blue Shield
May 17, 1971

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Although a previously scheduled meeting prevents my attending this hearing, California Blue Shield welcomes the opportunity to submit this statement for the committee's consideration.

California Blue Shield began in 1939, the nation's first statewide nonprofit medical care plan. During the succeeding thirty two years we have matured into an organization that now serves 5,422,000 Californians (about 28% of the state population) through our regular Blue Shield programs and the three government programs where we act as intermediary or carrier -- Medicaid (called Medi-Cal in California); Medicare; and the Civilian Health and Medical Program of the Uniformed Services, popularly termed CHAMPUS.

During 1970 a total of 43 million claims were paid for benefits provided to beneficiaries by physicians and allied health care professionals participating in these four programs. The total value of the benefits received was $680 million. The overwhelming majority of physicians in private practice in this state are Physician Members of California Blue Shield. As of now, such membership totals over 19,000 physicians, who have entered into agreements with Blue Shield to provide service benefits to subscribers. Throughout the state we employ 3,000 persons in the administration of these claims for medical care benefits.

Attached to this statement are pages showing the operating highlights for the Medi-Cal and Medicare programs in the years 1967 through 1970. In

this statement I would like to direct the Committee's attention to

(1) the Utilization and Peer Review programs now operating for all our programs, including Medicare and Medi-Cal,

(2) our network of local and regional operations, and

(3) our concerns about utilization of services.

Utilization and Peer Review

California Blue Shield -- in cooperation with the California Medical Association, its component local medical societies, the Foundations for Medical Care and other associations whose members provide services within Blue Shield administered programs -- has developed a comprehensive system for utilization review. The purpose of this review system is to measure the quality of care and the frequency of use. The emphasis is corrective and educational -- not punitive. The system seeks to control cost and quality with equity for the patient, the provider, and the purchaser.

From a system where medical advisors reviewed problem claims and cases individually, with the advisor exercising his best judgment to determine unnecessary services, it has evolved into a sophisticated program where primary utilization auditing is done by computer. First, area "norms" for physician performance are established through computer stored data. Against these norms the individual performance of each member of the group can be compared. Computer generated reports of providers whose pattern of practice differs from the norms are printed out for medical review. Any other related data about the physician is

collected and the "case" is forwarded for review by a Blue Shield medical advisor in the provider's specialty. This is the first level of peer review.

Where the medical advisor finds unacceptable practice he may handle the matter himself, working with the provider. Failing resolution of the problems, he will refer the case to the local county peer review committee serving the provider's county. This is the second level of peer review.

The review committee reviews the "case" and makes a determination -- upholding Blue Shield's findings or not. Additionally, in cases that appear to involve fraud, the matter is referred to the proper authorities. This is the third level of peer review.

As a final level of peer review, in the event either party continues to disagree with the decision, provision is made for appeal to the California Medical Association or, in the case of a non-physician provider, his allied health field association.

More detailed information about this sytem is included in the exhibits.

In 1970 estimated reductions in physicians' billed charges resulting from medical advisor performance totalled $12,567,000. In addition, estimated reductions resulting from committee and Utilization Audit Review staff performance amounted to $520,000. This review activity, together with the application of our Profile System and the application of program percentiles, produced estimated reductions in physicians' billed charges totalling $66 million in 1970. The detail of these

estimated reductions is set forth in Exhibit III.

Regional Operations

Through a series of contracts and subcontracts with 17 county Foundations for Medical Care and Medical Societies claims in 31 of California's 58 counties are reviewed locally before being transmitted to the central office for payment and record maintenance. (Sample subcontracts are included as exhibits.) This localized claims review provides for on the spot resolution of incorrect or incomplete claims, it provides local examination of claims for both charge and utilization patterns, and it facilitates local peer review.

Local peer review, pioneered under this system as an integral claims processing function, now is achieving national recognition as an essential ingredient in utilization and quality control. It is important that this local review is accomplished while the significant advantages of a statewide information bank and payment procedure are retained.

Our most recent local claims processing operation began in April 1970 in Compton, the southeast area of Los Angeles County. Because of the high welfare population -- Los Angeles County produces about 40% of the total statewide volume of Medi-Cal claims -- the Compton office was set up to process claims for physicians' services rendered to Medi-Cal patients in the area. Medical review of the claims is performed by Medical Advisors recruited from the communities served. As an example of the smoothing out of claims processing that can be accomplished through localization, when the office was first set up, 4% of all claims required review. Now only 1% require review. During the first four months of 1971, claims processed through this office are averaging 55,000 per month.

Regional claim processing and review has progressed steadily in California in recent years. This approach will be expanded to new geographical areas and provider groups whenever local capabilities mature to the point where significant advantages will accrue to both the programs and the people being served by these programs.

Utilization Concerns

For the information and record of the Committee, I have submitted several exhibits which illustrate some of the administrative and professional practices in utilization control. Included are a description of computerized Peer Group Norms and a sample subcontract between Blue Shield and Foundations for Medical Care.

Our experience in administering health care programs has verified that abuse or misuse is centered in a relatively small number of providers of health care services. The medical profession in California has been most willing to discipline and educate physicians who misuse or abuse the programs.

Our emphasis in utilization thus far has been almost exclusively aimed at over utilization. The reductions that are being made in billed charges -- $66 million during 1970 -- clearly demonstrate the conservation of the tax dollars and the private dollars paid for health care. Our next proper concern in utilization is that of under utilization of services. Here we are talking about needed services not being supplied for one reason or another. We are already experiencing the squeeze on state and federal budgets that require cut-backs in

Medi-Cal and greater patient participation in the cost of Medicare benefits. We can anticipate that introduction of Health Maintenance Organizations and the spread of capitation payment programs may sharpen the concern over the potential for under utilization because of the incentives to reduce services in order to stay within the capitation payments.

Clearly, an effort in the direction of under utilization will not be based upon the conservation of dollars. However, as new systems are developed, there must continue to be concern for both the dollars involved and the quality of services, and for both over utilization and under utilization.

Exhibit I (a)

MEDI-CAL HIGHLIGHTS

1967 - 1970

	1967	1968	1969	1970
Eligibles [a]	1,407,739	1,541,391	1,774,336	2,174,486 [b]
Claims Received	19,903,000	21,551,000	28,761,000	34,573,000
Claims Processed	19,975,000	20,762,000	29,648,000	34,446,000
Benefits Paid	$225,858,000	$228,443,000	$313,450,000	$389,946,000
Average Benefit per Eligible by Provider Type:				
Physician	$ 92.65	$ 81.99	$ 94.01	$ 93.87
Other Medical	16.17	15.42	21.08	20.87
Dental	21.41	20.13	23.26	25.69
Drug	30.18	30.70	38.34	38.95
Total Benefit per Eligible	$160.41	$148.24	$176.69	$179.37
Operating Expense Average per Claim Processed	$.45	$.50	$.50	$.56
Operating Expense as a Percent of Total Program Costs	3.9%	4.4%	4.5%	4.7%
Average Daily Claims Processed	--	--	--	139,338 [c]

[a] Monthly Average
[b] Preliminary
[c] Based upon September-November 1970

Source: California Department of Health Care Services Reports
California Blue Shield

Prepared by:
Corporate Planning and Research
California Blue Shield
May, 1971

Exhibit I (b)

MEDICARE HIGHLIGHTS

1967 - 1970

	1967	1968	1969	1970
Eligibles [a]	1,048,500	1,110,500	1,140,250	942,200 [b]
Claims Received	3,669,000	4,265,000	4,800,000	4,890,000
Claims Processed	3,410,000	4,160,000	4,877,000	4,976,000
Benefits Paid	$115,085,000	$129,747,000	$148,268,000	$137,898,000
Average Benefit per Eligible	$109.76	$116.84	$130.03	$146.36
Operating Expense Average per Claim Processed	$2.11	$2.39	$3.32	$3.19
Operating Expense as Percent of Total Program Cost	5.9%	7.1%	9.8%	10.3%
Average Daily Claims Processed	--	--	--	18,153 [c]

[a] Annual Average
[b] Estimated
[c] Based upon September-November 1970

Source: Social Security Administrative Reports
California Blue Shield

Prepared by:
Corporate Planning & Research
California Blue Shield
May, 1971

Exhibit II (a)

THE
CALIFORNIA BLUE SHIELD
UTILIZATION REVIEW PLAN
FOR
GOVERNMENT PROGRAMS

Prepared by:
Provider Review Division
California Blue Shield
Rev. 1 September 1969

ADDENDUM
September 1, 1970

The Utilization Review and Control Program, explained in some detail in the following pages, remains essentially as reported, with the following changes and update of performance data:

1. The early computer casefinding system referred to in the original document has been completely replaced by the new Peer Group Norm Comparison technique -- also described in detail in the original document. Peer Group Norm Comparison provides a 100% audit of all providers and each procedure performed, furnishing an exception listing of all providers exceeding any one norm.

2. California Blue Shield currently employs 170 Medical and Allied Health Field Advisors.

3. California Medicine and Paramedical Associations provide 117 local peer review committees consisting of more than 1,600 private practitioners who donate in excess of 100,000 man hours per year to the review of utilization cases arising out of the three governmental programs administered by Blue Shield.

Updated Performance Data

1969 Title XVIII (Medicare) Performance.

18,642 Individual claims reviewed by Advisors.
290 Major Utilization cases closed.
$488,065 Program Savings from review activity.
2 Special Studies (including audit and review of all claims submitted by 65 providers who earned $25,000 or more in the Medicare Program during 1968).

1969 Title XIX (Medi-Cal) Performance.

326,584 Individual claims reviewed by Advisors.
830 Major Utilization cases closed.
$11,363,983 Program Savings from review activities.

California Blue Shield formalized its Utilization Review activities in February of 1967 with the creation of the Provider Review Division. Since that time, through July 1970, it has recorded the following performance.

Total individual claims reviewed	1,597,692
Total cases closed	7,302
Total Divisional savings	$28,831,131
Total suspension from Medi-Cal recommended	38
Total (Action by Director, DHCS)	9
Total revocation of licenses (Action by Bd. of Medical Examiners)	6
Total criminal investigations	15
Total continuous "corrective reviews" by Medical Advisors(ordered by Peer Review Committees)	190

AN OVERVIEW

The California Blue Shield program of utilization control has many facets --- some are integral parts of the Provider Review Division, while many others are inherent in the good business practices of the Corporation.

Claims review starts in the Blue Shield mailroom and is continuous throughout the claims handling process. At California Blue Shield, formal utilization audit and review is performed by a corporate division (the Provider Review Division) headed by a Vice President, and employing 89 full-time staff. In addition to the "in-house" operation, California Blue Shield, in partnership with California medicine, has developed the most effective professional review mechanism in the United States:

1. Medical Advisors - California Blue Shield employs more than 160 medical advisors to review unusual and questioned cases. All medical advisors must be actively engaged in the private practice of medicine and have had experience in review procedures through prior service on a county medical society or hospital review committee. (See Appendix I, 1969-70, Medical Advisors).

2. County and District Review Committees - In addition to the advisor system employed by California Blue Shield, county and district review committees provide "peer" review of questioned medical practice and recommend appropriate corrective action, both to the plan and to their appointing societies. (See Appendix II, 1969-70, Peer Review Committees).

   Professional peer review is the key to effective utilization control. Case finding is a function well within the capability of most carriers; the collection of facts and records demonstrating a misuse, and their presentation to the proper committee, is a time-consuming, manual operation but also within the capability of most carriers organized to perform such a function. The all important ingredient is the existence of a review committee that will examine the evidence and render a valid medical opinion in the light of community practice and custom.

3. Society and Foundation Review Organizations - Currently, 12 societies and foundations review claims on behalf of California Blue Shield. In these organizations all Medi-Cal and foundation sponsored claims are examined and processed for payment. Included in this process is a "built-in" utilization review mechanism. This review procedure is being extended to include Medicare (Title 18) claims in selected counties.

California's Provider Review Division serves as a clearing house and control center for all the "misutilization" information generated within Blue Shield, as well as information from outside sources (individual physicians, review committees, State agencies, groups, subscribers, recipients, paramedical associations, etc.)

Systematic review of provider-vendors is performed by the Division. Cases involving matters of medical practice necessitating medical evaluation and opinion are submitted to advisors and or county review committees. Cases involving fraud or other criminal acts are submitted to the proper legal authority in the form of criminal complaint or information. Cases involving misuse and abuse are presented to county medical societies for appropriate corrective action.

Deterrent Effect - In the "control" of any human behavior, the most productive approach is to deter unacceptable behavior.

California Blue Shield employs this approach in its Utilization Control Program. Awareness on the part of providers of medical and paramedical care and recipients of Blue Shield benefits, that a comprehensive "control" program exists, supported by a very sophisticated electronic surveillance system, generates a self-discipline among providers and beneficiaries and promotes a conscious effort to operate within the established rules of the program.

Utilization Audit and Review, as employed by California Blue Shield, is a highly specialized activity combining the latest Electronic Data Processing equipment, direct microfilm printouts of magnetic tape information, professional scanning and evaluation of provider files, with tried and proven methods of fact-finding and investigation. The key to its success is the system of professional review committees that provide an acceptable mechanism for case disposition.

Functionally, Utilization Audit and Review can be divided into 5 distinct steps:

1) Case-finding, including computer profiles and summaries, prepayment reviews, routine field audits, and complaints and information from all sources.

2) The gathering together and summarizing of all the records "in the house" pertaining to each case.

3) Field investigation and case preparation, including the review of hospital and office records, patient interviews, and the collection of facts "out of the house".

4) Case presentation and disposition.

5) The keeping of records and the preparation of reports.

Each of the five steps are essential to a successful program of utilization control.

THE PEER REVIEW MECHANISM

When Blue Shield has reason to believe that the Title XIX - Medi-Cal Program, or any other health care program administered by it, has been misused and abused by a provider, the professional review committee of jurisdiction is asked to examine claims, reports, records and the profile of the provider to determine whether, in their collective opinion, an abuse or misuse has in fact occurred.

The committee's investigation includes adequate provision for the provider to appear before the committee, to hear the charges made against him, to examine the evidence, and to present evidence and/or to make a statement.

In the event the committee finds that the provider's practices constitute a misuse and abuse of Blue Shield administered health care programs, the review committee is asked to:

1. Provide Blue Shield with a written statement to the effect that in their opinion the claims, records and reports reviewed by them clearly indicate that the provider has misused and abused the health care program administered by Blue Shield, and

2. Recommend a suitable disposition of the case. Such dispositions may take the form of the following:

   a. Recovery of monies improperly paid.

   b. Deletion of services and reduction of fees billed.

   c. Establishing a prepayment review as a corrective or educational device, either by the committee or by a committee designated advisor.

   d. Recommend prior authorization by the county Medi-Cal consultant for the type of service being abused.

   e. Recommend suspension from further participation in the Title XIX Program.

THE APPELLATE REVIEW MECHANISM

The California Medical Association, the California Pharmaceutical Association, the California Podiatry Association, and the California Optometric Association have each established a state level committee of appeals that, acting on behalf of its Association, provides a professional appellate review body in relation to questions, grievances or appeals from patients, physicians, county or district review committees, and Blue Shield regarding the delivery of health care services under the provisions of P. L. 89-97 and Medi-Cal.

GUIDELINES FOR REVIEW COMMITTEES

These guidelines are intended to be applicable in any case where a review committee may adopt a recommendation to CPS Blue Shield dealing with a provider's future participation in the Medi-Cal program, the reduction or deletion of fees billed, or with the payment of claims which a provider may submit in the future.

These guidelines should be regarded as applicable as soon as it appears to the committee or to the Blue Shield utilization field representative that the committee is considering a matter which may warrant recommendations affecting the provider's continued participation or the payment of present or future claims. The guidelines are not intended to be applicable in routine referrals which involve questions of reasonable fees in specific instances, as distinguished from an apparent pattern of misconduct, or in instances wherein the committee is asked to consider practice patterns involving an apparent irregularity which, if demonstrated, is usually correctible without consideration of action affecting future participation.

Compliance with the guidelines is legally essential prior to committee action which either directly or conditionally affects future or continued participation by the provider, which provides for a patter of reductions in fees billed by the provider, or the establishment of prior authorization requirements.

1. Referral to Committee:

Referral to the Committee shall be in writing, and shall include a summarization of the nature of the matter to be considered, and a history of any previous efforts to resolve the issues presented.

At the time of referral, Blue Shield shall advise the committee whether or not the matter appears to be so serious as to require compliance with the guidelines. In any case where Blue Shield has not stated that the guidelines are applicable, the chairman may nonetheless invoke the guidelines and he shall do so in any case as soon as it appears that the Committee may wish to consider participation by or payment to the provider in the future.

2. Notice of Hearing

The provider shall be given written notice of any meeting at which the committee will receive evidence on the matter submitted. This notice shall be given by Blue Shield (with knowledge of the chairman) no less than ten (10) days prior to such hearing. The notice shall state the nature of the matter under submission. If particular cases are to be discussed, the provider shall be furnished the patients' names. If the matter under submission involves a pattern of conduct or if it is impractical to list specific cases, the provider shall be given information sufficient to enable him to identify the period involved and the nature of any procedures in question.

3. Attendance by the Provider:

The provider shall be entitled to attend any committee meeting while evidence regarding him is received.

The provider shall have the right to see any documentary material received by the committee. The provider shall be accorded adequate opportunity to present evidence on his own behalf, or to rebut any evidence offered against him, or to offer any explanation to the committee. The provider shall have the right to be accompanied by counsel, but counsel shall not be entitled to participate in any hearing unless the chairman or a majority of the committee determines that his participation would be of assistance to the committee. These hearings shall be informal and the rules of courtroom evidence do not apply.

4. Written Record:

A written record shall be prepared in any case where the committee recommends action limiting or denying future or continued participation in the Medi-Cal program, including recommendations for imposition of requirements for prior authorization. In such cases, the record shall:

a) Indicate the date of any hearings and the persons in attendance.

b) Contain or summarize all testimony.

c) Include all documentary evidence received.

d) Describe any other evidence received.

e) Contain the findings and recommendations of the committee, indicating the vote on each finding and recommendation.

f) Include copies of notices to the provider.

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5. Findings:

In such cases, the committee shall make specific findings on those issues which support any recommendation made. Causes for suspension are enumerated in Medi Cal Regulations, Section 51455(b), (copy attached as Appendix III), and the findings must state which provision or provisions thereof have been violated by the provider. Insofar as is practical, reference should be made to specific testimony or other evidence supporting each finding.

6. The committee shall make a written recommendation as to action to be taken. In any case where the recommendation would impose conditions on future payments, prior authorization, or participation, the committee shall indicate how the recommendations should be implemented.

7. Notice of Decision:

The provider shall be mailed a copy of the committee's findings and recommendations upon issuance, and he shall be advised in writing as to appeal, including his right to hearing before the provider' State Association Appeals Committee, regardless of the provider's membership status with that Association.

8. Rehearing:

The chairman or a majority of the committee may grant a rehearing when it appears that the provider offers substantial new evidence which he could not reasonably have offered at the meeting, or when it appears that the committee has acted in error.

9. Report to the Department of Health Care Services:

It will be the responsibility of Blue Shield to forward the record of the review committee (or, if appealed, the Appeal Committee), including the committee's findings and recommendations, to the Department of Health Care Services. The Department of Health Care Services will initiate appropriate action, with appropriate notification to the provider. The chairman of the committee or a member thereof will be given opportunity to be present and participate in any administrative hearings conducted by the Department of Health Care Services.

CASE-FINDING

The first step in an effective control program is the development and implementation of a "case-finding" program that will identify "suspects" for investigation and review.

At California Blue Shield the volume of claims handled (150,000 daily) and the number of providers (78,000) dictate that misuse, abuse and fraud "case finding" be computerized and an effective EDP System be employed to record utilization patterns.

Blue Shield has developed a computerized standard utilization "data base", identical in all the programs it administers --- its own standard programs, Federal Employees, CHAMPUS, Title XIX and Medicare.

The "base" takes the form of a calendar quarter of services, by county, within the county --- by provider, and within the provider --- by patient. The data is recorded on microfilm through a machine conversion from magnetic tape. Each microfilm represents the entire practice pattern of the provider for the recorded quarter within one program; and because identical formats are used in all programs, the entire practice of the provider (handled by Blue Shield) can be merged and visually displayed via microfilm viewing machines.

The quarterly microfilm provides California Blue Shield with an evergrowing library of "practice patterns" of each provider. It includes provider name, address, license number, primary specialty, secondary specialty, patient's name, identifying numbers, diagnosis, procedure or treatment, date of service, amount paid, document number and check number.

Since the inception of this quarterly microfilm program, late in 1966, Blue Shield has conducted "case-finding" by running against this array of utilization data, a large number of "indicators" or selected procedures (chosen by Medical Advisors) for their "abuse potential" (a list of the procedures and ratios used, to date, are included in Appendix IV). Each indicator run against the data base produces a printout (on machine record paper) of the overall pattern of behavior of all providers and identifies a pre-selected number with the highest ratios for further investigation.

The "indicator" system of casefinding, although adequate during the initial phase of Blue Shield's utilization review program, has two major shortcomings -- (1) it requires the selection of procedures or combinations of procedures to be tested, and (2) it imposes a 6 to 9 months delay in data accumulation before the indicators can be run against the quarter-of-service data base.

On or before December 1, 1969, California Blue Shield will place in operation an entirely new and improved method of computer casefinding based upon the construction of Practice Pattern Norms for a peer group of physicians or suppliers. "Peer group" in this instance is defined to be the physicians of a comparable specialty within a locality. Specialty need only be defined as the area in which a doctor directs his efforts as opposed to requiring board certification. Locality should provide a relevant structure for practicing policies and group urban, suburban and rural practices.

A detailed outline of the new system is described below:

Ratio Analysis Practice pattern norms are developed for each peer group based upon ratio analysis of physician groups. Each physician is subjected to the computation of two ratios for each procedure.

1. Occurrence per Hundred Patients.

   Computed as:

   $$\frac{\text{Number of Times Procedure Performed}}{\text{Number of Patients Seen}} \times 100$$

This ratio indicates the frequency of performance of a procedure on a given patient and may indicate overutilization.

For example: Let us assume that Doctor A is a general physician operating in a large urban area. He has seen 175 Medi-Cal patients in the time period under examination and has billed for 350 routine office visits. When we compute his occurrence per hundred patients ratio we arrive at:

$$\frac{350}{175} \times 100 = 200.0$$

Doctor B, on the other hand, (who is in Doctor A's peer group) has seen only 20 Medi Cal patients and has performed 70 routine office visits. His occurrence per hundred patients ratio is:

$$\frac{70}{20} \times 100 = 350.0$$

In reviewing the above example, it becomes apparent that comparison can be made, regardless of volume, to derive a norm for a procedure within a peer group.

By developing this norm by peer group, we remove distortion based upon the physician's practice specialty. For example, assume Doctor C is a General Surgeon who performs most of his work in a hospital. He has seen 20 Medi-Cal patients, but has performed only 2 routine office visits. His occurrence per hundred patient ratio computes to:

$$\frac{2}{20} \times 100 = 10.00$$

If this ratio were compared to the General Practice Ratios computed above the surgeon's practice would seem to be very much different when, in reality, he is practicing at about the norm for all surgeons in his locality.

Abnormalities or deviations from the norm within a peer group could indicate that a physician was performing a given procedure on an inordinate number of patients and should be a candidate for case investigation.

2. Occurrences per 100 Services.

Computed as:

$$\frac{\text{Count of Procedure}}{\text{Total Number of Services}} \times 100$$

This ratio provides the Division with a measure of utilization based upon services performed. This ratio, when compared to norms within a peer group, may determine if a procedure has been performed an inordinate number of times regardless of patient count.

For example: Let us assume that Doctor X, Urologist, operating in an urban environment, has billed for 3 diagnostic cystoscopies and 25 cystoscopies with ureteral catheterization. He has performed 75 services in all for the time period in question.

Computations of the occurrence per hundred services ratio would show:

$\frac{3}{75} \times 100 = 4.0$ (diagnostic)

$\frac{25}{75} \times 100 = 33.3$ (ureteral catheterization)

Assuming that a peer group norm would essentially show the reverse of this practicing pattern, with most of the charges being for the diagnostic procedure, it becomes apparent that a comparison to the norm will isolate this individual for further investigation.

Peer Group Practice Pattern Norms

Once the ratio analysis is done for each provider, certain frequencies can be established for each procedure within a peer group. For example, using the occurrence per hundred patients ratio, let us assume that the following ratios exist within a peer group for extended office visits:

	Occurrence/Hundred Patients
Doctor A	75
Doctor B	75
Doctor C	90
Doctor D	85
Doctor E	125
Doctor F	35
Doctor G	50
Doctor H	50
Doctor I	50
Doctor J	50

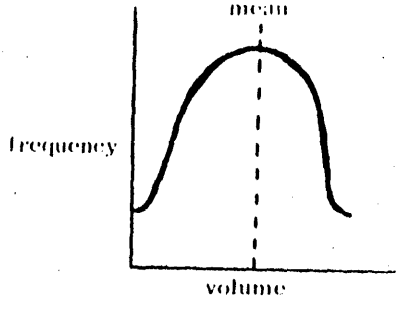
If frequency groupings are established for this procedure within the peer group we find:

No.	Amt.	No.	Amt.	No.	Amt.	No.	Amt.	No.	Amt.	No.	Amt.
1	35	4	50	2	75	1	85	1	90	1	125

The average of this distribution is 68.5.

Obviously, using the average of this grouping as the norm does not provide the desired result of pinpointing those physicians with the most abnormal pattern. Some measure of deviation from the mean must be established as a norm to allow for flexibility in isolating only those providers who grossly deviate from the norm.

In looking at a normal distribution we find that a curve is generated in a bell shape:

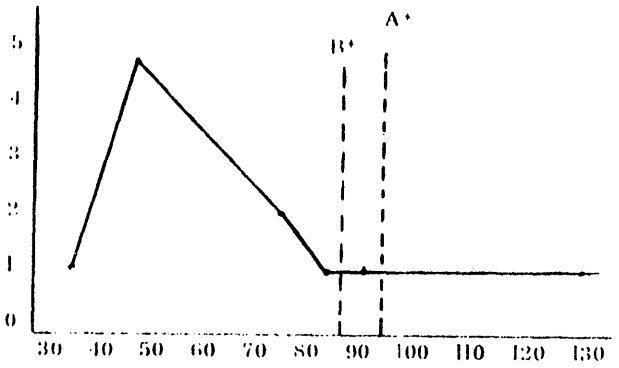


In reality, however, most curves plotted for any distribution will be of a different shape (i.e. skewed left or right), hence it is difficult to place a 'norm' on the curve and state that any provider who exceeds the 'norm' for that procedure is a possible offender. In some cases the grouping may be so tight that there are no real 'offenders'.

In order to establish 'norms' that vary with the type of curve being examined, Blue Shield has chosen standard deviation as the basis for measurement. Standard deviation alone, however, provides some of the same problems the average (or mean) concept present. In using a standard deviation from the mean it may be that groupings will produce many offenders or, conversely, no offenders. Other factors entering into this problem include the division workload and the capability and availability of trained staff. For these reasons, it was felt that a flexible number of standard deviations from the mean should be used to determine the norm.

Returning to our example, we can plot the curve indicated below:

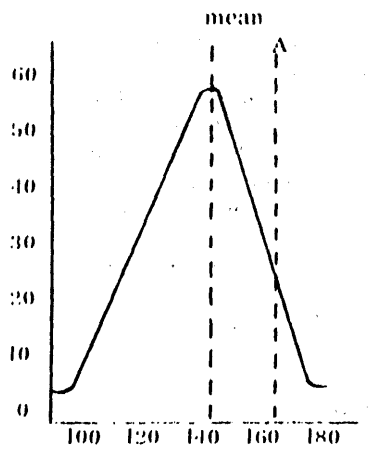
A Mean + 1 Standard Deviation
A Mean + .75 Standard Deviation



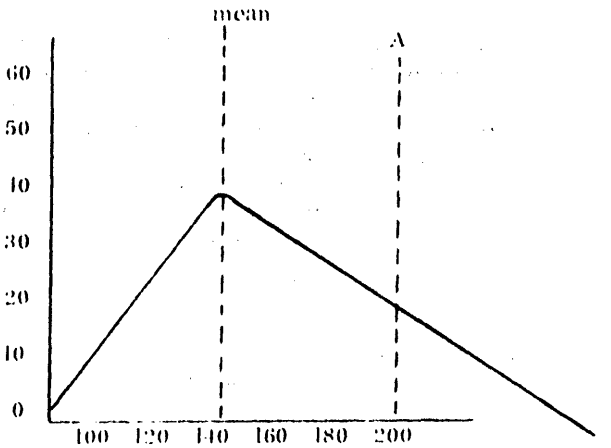
Computing a standard deviation we find it to be 25.5. If a factor of 1.0 is applied to the standard deviation and added to the average, 94 becomes the norm and Doctor E (at an occurrence per hundred patients of 125) becomes a candidate for investigation.

Assuming that the workload and staffing level of the Provider Review Division is such that more physicians may be investigated, it is a relatively simple matter to drop the factor to .75 and again apply it to the standard deviation and add the result to the mean. Note on the graph that this produces 2 doctors for investigation. The same technique can be used to produce any number of provider candidates for review depending upon the depth of analysis to be performed and the staff capability of the Division.

Because standard deviation is computed based upon each curve's spread, its variability will allow case investigations based upon each procedure. For example, Curve A below shows a tight grouping around the mean, whereas Curve B shows a much looser grouping.



Curve A
Procedure 1.
Mean 140
S.D. 20



Curve B
Procedure 2
Mean 140
S.D. 60

Using a factor of 1.0 we arrive at point A for the norm on each curve. Note that offenders of the more tightly grouped Curve A are pointed out as readily as those over the Curve B norm.

The Use of Patterns

Within a peer group most providers will perform approximately the same procedures and, over a period of time, approximately the same number. Providers who do not conform to these patterns should be reviewed for possible overutilization of the Program.

This is not to say that all overutilizers will offend the norms nor that all norm offenders will be overutilizers. It means simply that by comparing a provider's practicing pattern to that of his peers certain abnormal practicing trends may be detected and specified for further investigation and advisor and committee review if warranted.

Procedure Weighting

After isolating exceptions for each procedure on the curve, weighting factors are applied to the providers who are flagged. These weighting factors are applied to the providers who are flagged. These weighting factors are supplied by the Provider Review Division for all procedures with a high probability of misutilization. The total weighting factor is accumulated for a provider and those providers with the highest total weight are subjected to case investigation and review.

In addition to the primary reports described above, this E.D.P. system will produce the following secondary reports:

(1) Monthly Patient Profile exception listings printing out all recipients with services from four or more different providers during the data period --- each provider to be listed.

(2) Monthly reports of year-to-date total payments, by provider, arranged in descending order.

(3) Monthly reports of year-to-date total payments, by provider, arranged in provider number order.

(4) Selected parameters upon request.

(5) A full 6 months payment history of pre-selected providers, on demand.

(6) A review of selected providers on demand (by provider number) regardless of their practice pattern.

(7) Identifying "no match" providers resulting in "invalid claim" and "no payment". (These exception lists will be investigated and the Master Provider File updated if required).

In addition to computerized casefinding --- both the current quarterly parameter system and the new "patterns" system --- California Blue Shield employs a system of "modified pre-payment review" by Medical Advisors as a casefinding tool. This system, limited to 100 Medi Cal providers at any one time, provides for the review of one entire month's claims of a given provider by medical advisors.

The procedure is operated in the following manner:

1. Any advisor has the prerogative of nominating a provider as a candidate for pre-payment review.

2. When one of the 100 review positions becomes available, Medical Review Administration Department (the staff support unit of the Advisor Department) notifies the provider-candidate of the scheduled review and asks him to bundle his claims for one month and mail them to a special address.

3. Upon receipt, the claims are delivered to the reviewing advisor.

4. After review, the advisor takes one of three actions:

(a) Finding no misuse or abuse, the claims are entered into the payment system and the provider is released from review.

(b) Finding minor discrepancies, the advisor conducts an educational program with the provider, adjusting claim as indicated, and when satisfied that the situation has been corrected, releases the provider from review.

(c) When the advisor review discloses gross misuse and abuse worthy of peer review by committee, the claims are forwarded to the Utilization Review Department for further investigation, preparation, and presentation to the appropriate Peer Review Group.

In addition to the modified pre-payment review outlined above, the Utilization Audit and Review Department conducts a rotating random selection audit of 50 drug stores each month. Each pharmacy is asked to forward one month's claims to the UAR Department for review by the Department's pharmacy reviewer.

Other sources of cases include complaints and information from many individual sources as well as special requests from HEW, DHCS, and the State Legislature.

CASE DEVELOPMENT AND REVIEW

Case-finding is the beginning of the review process. The second step is conducting a proper investigation of the facts and preparing a case for presentation to Review Committee (see attached copy of model case - Appendix V). Next is presentation to a Review Committee (described in detail, above), and case disposition. Local peer review has been the accepted method of evaluation and correction in California for several years, and in our opinion, the only way to approach utilization control. The Blue Shield system is not punitive, but rather intended to be corrective and educational. The mechanism used most often by

committees is that of "corrective review". This is a technique of placing the errant provider in review by a Medical Advisor until his reporting practices become acceptable.

The last step in the process is record keeping; we have found it necessary to carefully document our program and its results so that when we appear before legislative committees, etc. we are able to demonstrate our performance and that of organized medicine in California. Our performance for 1968 is as follows: During the year, Blue Shield handled 554 Committee cases containing 21,600 claims resulting in recoveries, reductions, and deletions of $319,000. The UAR Advisor in his reviews (not committee action) handled 188 cases, 10,000 claims, saving $118,000. Division Staff handled 943 cases involving $66,000. The total recovery by UAR (including Peer Review Committees, Division Advisors and Staff) since beginning of the department in February 1967, exceeds $1 million.

During the same time period (since February 1967), the Medical Advisor Department has effected savings (through reduction of fees and deletion of services) of $9,700,000. A two year Division total of $10,871,000.

Exhibit II (b)

In the Forefront.

Utilization and Peer Review

Medicine's Privilege and Responsibility

RALPH W. SCHAFFARZICK, M.D. AND HARRY J. PARKE, *San Francisco*

Peer review affords a privilege for medicine to participate in the shaping of its future. As a corollary, however, medicine must accept the responsibility of stewardship which attends this privilege. Physicians must be willing to participate even more actively in peer review.

Properly, utilization review of professional medical services can be performed only by physicians. They may be assisted by informed lay personnel and by computer-derived data. In no instances, however, should judgment of medical necessity be rendered by computer alone.

Although an important function of peer review is the control of health care costs, even more important is the evaluation of the quality of care provided the consumers—our patients.

"Due process" must be an integral feature of peer review. Any provider must be given the opportunity to discuss his pattern of practice with his peers, and an appellate mechanism must be available.

Prospective, rather than retrospective review is preferable, although both approaches are necessary.

ALTHOUGH PEER REVIEW has been a recognized mechanism in California medicine for many years, many states still have only rudimentary forms of peer review—or none at all. This observation was made apparent during a conference sponsored by the Council on Medical Services of the American Medical Association in November, 1969. The enactment of Public Law 89-97 (The "Medicare" Law) in 1965 provided stimulus for increasing the involvement of physicians in controlling utilization and costs of health care services. This stimulus continues to be a potent one. In August 1969, the Chief Medical Officer of the Bureau of Health Insurance (BHI) of the Social Security Administration convened an ad hoc committee of medical representatives from several states to assist in the development of national guidelines concerning utilization. At the meeting the director of the BHI, who had just completed testimony before the Senate Finance Committee, made the discouraging statement that, according to the temper of the Senate Finance Committee, "the period of accommodation is over," and that in its view medicine had been given an opportunity to exercise self-control and had been found wanting. The inference was that unless some more effective self-control could be exercised, it would be necessary for the Social Security Administration to formulate restrictive

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regulations. Since that time, the Senate Finance Committee and other governmental agencies, both at the federal and state level, have been seeking ways to contain the rapidly escalating cost of health care. Subsequently in May 1970 Representative Wilbur Mills (D-Ark.), chairman of the House Ways and Means Committee, responded to a question raised by Representative Jerry Pettis (R-Calif.) by stating that the task of reviewing physicians' fees and services ". . . will have to be by his peers. It has to be a doctor who is a peer of a doctor."[1]

If physicians are to preserve their franchise, it becomes imperative that they be increasingly involved in peer review. If the concept of "usual, customary or reasonable" is to prevail over that of fixed fee schedules and prescribed limitations of professional services, physicians must acknowledge the *responsibility* which attends the *privilege* and be willing to participate aggressively in peer review. Otherwise there is considerable danger that this responsibility and privilege will be abdicated to governmental agencies.

The primary aim of peer review and utilization audit is directed at the quality of health care being provided and at cost control. Cost control is often the more stressed, but quality is equally important. This observation cannot be emphasized strongly enough; for, in the last analysis, all of our efforts should be directed toward the benefit of our patients, and the ultimate beneficiary of peer review is the consumer, or patient.

There are various levels of peer review. The first of these, of course, is the physician's own action when rendering medical care or prescribing services in or out of the hospital setting. The second level of peer review is performed by a variety of hospital committees such as tissue, medical record and utilization committees. The third level of review may occur at the county medical society in mediation committees. In California, in addition, decisions of a county medical society committee which have been disputed by a provider, a patient or a carrier may be heard by a California Medical Association appeals committee. In instances of Medi-Cal (Title XIX) disputes, further appeal may be made to the Department of Health Care Services. Finally, as a last resort, a case may be submitted to the civil courts. This provision of *due process* is of paramount importance for the protection of all parties concerned. Additional peer review may be provided in certain group practice situations, in foundations for medical care and by such specialty organizations as the California Society for Internal Medicine and its component member societies.

California Blue Shield and Peer Review

With implementation in California of Title XIX of the Medicare Act in March 1966, and Title XVIII in June 1966, California Blue Shield contracted to serve as a carrier for these massive programs. Since that time, a comprehensive and effective technique for utilization review has evolved as a joint venture of California Blue Shield, the California Medical Association, its component societies, the foundations for medical care, and the other associations that provide services within Blue Shield administered programs. This has developed, over the past four years, into a venture employing the full-time services of a Blue Shield staff of 91 persons, the part-time services of 168 medical and allied health advisors, and 117 local review committees, consisting of 1,600 private practicing providers of care, who devote collectively more than 100,000 man hours annually to reviewing the utilization practices of their colleagues at an overall cost of $2 million a year.

The purpose of the system is to measure quality of care and frequency of use against community norms in both Blue Shield's standard business and in the government sponsored programs administered by Blue Shield. Its main purpose is corrective and educational, not punitive. Its goal is cost and quality control with equity for provider, patient and the purchasers of health care. The California system is today's best hope for quality care at reasonable costs. Peer review is the keystone of the system.

Primary utilization auditing is accomplished by computer. First, "peer group norms" are established, and the individual performance of each member of the group is compared with the group norm. Providers whose pattern of practice differs by more than a predetermined amount are identified, and a list of their performance is printed out of the computer along with the group norms. Each "peer group" contains all the providers of a specialty practicing in one locality

for example, all general practitioners in San Francisco County or all neurosurgeons in Northern California. The size of the locality is constructed to provide a sufficient number of the same specialty from similar socio-economic areas to provide a valid peer group. The "time frame" used is the most current three months. The data used are all payments made during that time frame regardless of the date of service. The "peer group norm" established for each procedure used by the group is the mathematical mean occurrence (or frequency of use) of that procedure expressed in occurrences per 100 patients, plus a pre-selected number or fraction of standard deviations. The number of times each provider in the group performs a given procedure per 100 of his patients is tested against the peer group norm (mean plus standard deviations), and providers whose frequency of use exceeds the norm are listed and the complete detail of their practice is printed out for review.

All raw data printed out of the computer are reviewed and tested for validity by a group of non-physician analysts who verify such items as correctness of specialty classification and accuracy of input data. The analysis unit recovers all the provider's claims that were included in the computer "peer group norm comparison run" from claims storage. The analysis unit constructs graphic charts for each procedure in which the provider has exceeded his group norm, demonstrating the distribution of frequency per 100 patients of the group and the magnitude of the provider's deviation from the norm of the group.

After validation by the analysis unit, the claims, charts, graphs and the computer printout are turned over to the Utilization Audit Department for development as a utilization case. The development of the "case" includes collection of all available data about the provider's practice and billing patterns: hospital and office records, operative reports, past claims history, current billing practices, total amount billed, total amount paid, number of patients, ratio of services per patient, and other such items. All the data are then collated and arranged in logical order, all services provided one patient in date order, all patients in the same family grouped together. This array of data is then reviewed by trained utilization personnel, and a summary of the "pattern" is prepared and forwarded, along with a complete set of claims and other data, to a medical advisor of the provider's specialty for his review and recommendation.

This advisor review constitutes the "first level" of peer review. If the provider being reviewed practices in either the San Francisco Bay Area or in the Los Angeles Area, this "first level review" is performed by a Central Advisor—one who works at the Blue Shield office in either San Francisco or Los Angeles. If the provider practices in an area other than Los Angeles or San Francisco, the case is reviewed by an Area Advisor in his locality. The reviewing advisor makes a determination of "acceptable" or "unacceptable" practice—based upon community standards of quality and use. If he finds the documentation represents a medically acceptable practice, the case is closed without further review. If his finding is an "unacceptable practice," he may proceed in one of two fashions—handle the matter himself, or refer the case to the local peer review committee serving the provider's component society area. In the vast majority of cases, and almost always with "first unacceptables," the review advisor attempts to resolve the matter privately with the provider through a series of "educational interviews" and an ongoing "corrective review" of all the provider's claims which for a time are submitted directly to the advisor rather than through the normal claims processing system.

During the interviews and ensuing corrective review, an attempt is made to improve the provider's general quality of care and utilization practice to a level that meets the community standards. Medically unnecessary services are deleted from the provider's claims, and recovery of money paid for unnecessary services documented in the original case is instituted. The provider usually remains in "corrective review" for several months. When the reviewing advisor is satisfied that the provider's practice consistently meets community standards, the "corrective review" process is discontinued, and the provider again submits his claims directly into the normal claims processing system.

In the case of the recidivist—the provider with a tendency repeatedly to relapse into his previous mode of behavior—or in the case of the obvious misuser or abuser who clearly, with intent, grossly overuses or practices at a completely unacceptable level of quality, the reviewing advisor, rather than electing to handle the case, will di-

rect that it be prepared for presentation to the provider's local peer review committee—the "second level" of peer review. This committee is appointed by the local county medical societies.

Cases going to peer review committees are usually of a more serious nature than those routinely handled by advisors. Preparation of the case, including staff summaries and advisor comments, is of a formal nature. Adequate notice (usually 15 days) is given to the provider. He is invited to attend the committee review session and is advised of his right to be accompanied by legal counsel. A complete copy of the "case" with all supporting documentation is provided via registered mail, and he is invited to bring any records, reports, claims or other documentation of fact he would like the committee to consider in reviewing the matter. Although review committee proceedings are somewhat formal, and every effort is made to protect the rights of the provider and afford him "due process," the hearing is medical, not quasi-legal. The determination to be made is whether the provider's practice is medically acceptable as measured by prevailing community standards of utilization and quality of care.

As in the review by a medical advisor (the first level) the committee is asked to make a determination of "acceptable" or "unacceptable" practice. In the event the finding is "unacceptable," the committee is asked to recommend to Blue Shield a proper disposition of the case as well as take any society action the case warrants. Recommended dispositions usually take one or more of the following forms:

1. Recovery of funds paid for improperly billed services.
2. Deletion of unnecessary services items from claims.
3. Continuous "corrective review," either by a Medical Advisor or by the committee.
4. In Medi-Cal cases (the California Medicaid Program—Title XIX), request that the Director of the State program suspend the provider from further participation in the program.
5. In Medi-Cal cases, request that a program restriction be imposed by the Director requiring prior-to-service authorization by a county consultant for certain procedures.

In addition to the above recommendations, committees may, and in certain cases should, recommend to their appointing society that the matter be reviewed by the society's ethics or professional standards committee, other society disciplinary or education committees, or that the society referring the case to the licensing board of the State for its attention.

Matters of fraud and other violations of criminal law should be (and in California are) referred to the proper authorities. Review committees are no more competent to evaluate or deal with these matters than courts and law enforcement agencies are competent to evaluate medical practice in relation to standards of quality, utilization and costs.

The "final level" of peer review is the provision of an appellate mechanism. The California Medical Association and several of the allied health field associations in California have each established a state level committee of appeals which, acting on behalf of its association, provides a professional appellate body to review the findings and recommendations of local review committees. The services of the state-level appellate body are available to patient, provider, local committee and Blue Shield regarding questions arising from the delivery of, and submission of claims for, services provided under Titles XVIII and XIX of P.L. 89-97, CHAMPUS, and standard health benefit contracts.

Professional peer review is the key to effective utilization review and the control of misuse and abuse of health care benefits. Computer auditing of utilization patterns is a function well within the capability of many carriers. The collection of facts and records surrounding a case of possible misuse, and preparing and presenting them to "peer review," are time-consuming and expensive manual operations, but they are also within the capability of most carriers. The all-important ingredient is the existence of the peer review mechanism that will examine the facts and render a valid medical opinion in the light of community standards, custom and practice. Peer review in California is made possible by the tireless dedication of 1,768 providers of health care and the commitment of organized medicine and the allied health care associations of the State to review utilization and control misuses and cost of health care.

In recent months, representatives of the Department of Health Care Services, California Blue Shield and Blue Cross have conferred to develop

a system of coordinated utilization review between the carriers for physicians' and hospital services. While it is well recognized that the total costs for physicians' services make up a relatively small portion of the budget for health care, and that the great majority of expense stems from institutional care, it is still the physician who orders hospitalization and the treatment provided therein. It is, therefore, natural that physician and institutional services should be considered in a coordinated program of audit and review. Sophisticated computer techniques will be applied in the same fashion as they are in the EDS program for California Blue Shield, with appropriate adaptation to hospital services. Again it should be emphasized, however, that this technique will be used primarily for case-finding and any apparent departures from the norm must be studied by medical advisors and, where necessary, referred to medical society committees.

With the development of innovative forms of health care delivery such as pre-paid, group practice, stimulated by pending congressional legislation, the necessity for developing new techniques of utilization review has become apparent. Anticipated problems include utilization audit of "in panel" and "out-of-panel" services. In the case of capitation programs, it is possible there may be a tendency toward under-utilization rather than the opposite.

Hospital Utilization and Peer Review

In 1965, the California Medical Association published "Guidelines for Utilization Review."[1] This is an excellent reference concerning the subject. As an example of implementation of these "Guidelines," in 1965 the Utilization Committee of the St. Francis Memorial Hospital in San Francisco reorganized its modus operandi. It was decided that rather than retrospective audit, daily prospective evaluation of the current patient census was more appropriate. The Utilization Committee is organized with a central nucleus of members, augmented by a rotating group of physicians serving as "monitor." Each nursing station in the hospital is assigned a physician monitor. In conference with the head nurse, at daily intervals, the monitor reviews the census with the following points in mind:

1. Was hospital admission indicated? Was the medical condition one which really required hospital services or could the case have been managed on an out-patient basis?
2. Were appropriate diagnostic procedures instituted in an efficient and orderly fashion to expedite confirmation of diagnosis? Were excessive, unnecessary tests ordered or others omitted?
3. Was consultation solicited when indicated and was such consultation rendered promptly?
4. Was treatment ordered appropriately?
5. Was the patient approaching a point in time where dismissal from the hospital properly should be anticipated and was the attending physician making preparations for this dismissal?
6. Was the Social Service Department consulted sufficiently in advance of dismissal to make arrangements for transfer to a long-term facility or to home with suitable home health care services?
7. Is there *under*-utilization? Should, for example, the patient with arrhythmia be placed in the cardiac care unit rather than a ward bed?

If the physician monitor discovers possible over- or under utilization, he may attach a questionnaire to the chart, requesting information from the attending physician, or he may discuss the case with the attending physician on a doctor-to-doctor level.

The committee meets at intervals of two weeks to discuss problem cases, to document re-certification of patients on government programs, and to provide due process for physicians who may wish to discuss their cases with the committee. In addition to the doctor members, the committee includes the directors of Nursing and Social Service, a member of the hospital administration, and a full-time secretary. These members are all involved in the team effort.

The concept of daily, prospective review of the current hospital census provides several dividends. First, of course, is the reduction in costs of hospitalization by optimizing duration of stay and prompt initiation of relevant diagnostic tests and therapeutic programs. Second, and even more important, the quality of care may be enhanced, the patient deriving benefit from more efficient and effective treatment. Third, educational experience is provided for the members of the staff,

Exhibit III

GOVERNMENT PROGRAMS

ESTIMATED REDUCTIONS IN PHYSICIANS' BILLED CHARGES

1970

Prepared by:

Corporate Planning & Research Division
March 1971

ESTIMATED REDUCTIONS FROM PHYSICIANS' BILLED CHARGES GOVERNMENT PROGRAMS, 1970

During 1970, the claims review operations of California Blue Shield and the Foundations resulted in reductions of $66,211,000 from the amounts billed by physicians* in the three government programs. These reductions amounted to 12.1 percent of the total amounts billed.

Of the total reductions of $66,211,000; nearly 20 percent, or $13,087,000 is accounted for by the operation of MRAD and UAR and 80 percent or $53,124,000 by the routine claims review of California Blue Shield and all claims review activities of the Foundations.

Total reductions from billed charges for each of the government programs separately for the year 1970 are given in Table 1. Reductions in each quarter of the year for all programs combined are presented in Table 2 and for the individual programs in Table 3, 4 and 5.

MRAD and UAR reductions are shown in Table 6 and Table 7 gives the percentage distribution of the reductions by source of reduction.

* In the case of the Medi-Cal program, it appears that the figures related to all "medical" vendors and not to physicians alone.

TABLE 1

ESTIMATED TOTAL REDUCTIONS FROM PHYSICIANS' BILLED CHARGES
GOVERNMENT PROGRAMS
1970
(000 omitted)

Program	Amount Billed	Amount Allowed*	Reduction Amount	Reduction Percent
Medi-Cal[a/]	$289,303	$249,439	$39,864 **	13.8
Medicare	222,080	199,206	22,874	10.3
CHAMPUS	35,808	32,335	3,473	9.7
Total	$547,191	$480,980	$66,211	12.1

a/ The amounts for Medi-Cal appear to include "medical" vendors other than Physicians.

* Before deductions for deductibles, coinsurance, etc., except for Medi-Cal as noted below.

** Includes deductions for deductibles and coinsurance for Group II Medi-Cal beneficiaries -- approximately 8% of all Medi-Cal beneficiaries.

TABLE 2

ESTIMATED TOTAL REDUCTIONS FROM PHYSICIANS' BILLED CHARGES
GOVERNMENT PROGRAMS COMBINED
1970
(000 omitted)

Quarter	Amount Billed	Amount Allowed	Reduction Amount	Reduction Percent
First Quarter	$138,733	$121,413	$17,320	12.5
Second Quarter	130,720	116,906	13,814	10.6
Third Quarter	134,540	118,167	16,373	12.2
Fourth Quarter	143,198	124,494	18,704	13.1
Total	$547,191	$480,980	$66,211	12.1

TABLE 3

MEDI-CAL
ESTIMATED REDUCTIONS FROM PHYSICIANS' BILLED CHARGES
1970
(000 omitted)

Quarter	Billed*	Paid*	Reduction** Amount	Reduction** Percent
First	$ 61,542	$ 54,152	$ 7,390	12.0
Second	71,457	62,474	8,983	12.6
Third	73,126	62,600	10,526	14.4
Fourth	83,178	70,213	12,965	15.6
Total a/	$289,303	$249,439	$39,864	13.8

a/ The totals given in the source for these figures appear to include vendors other than physicians such as optometrists, podiatrists, chiropractors, home health agencies, x-ray, laboratory and other vendors classified as "medical".

* Assumes paid amount on overlap claims is equivalent to billed amount.

** Note: These reductions include certain deductions for deductibles and coinsurance for Group II Medi-Cal beneficiaries. In the first quarter of 1970 such beneficiaries represented 8 percent of all Medi-Cal eligibles.

Source: Quarterly Billed vs. Paid Input Report

TABLE 4

MEDICARE
ESTIMATED REDUCTIONS FROM PHYSICIANS' BILLED CHARGES
1970
(000 omitted)

Quarter	Billed	Allowed	Reduction* Amount	Reduction* Percent
First	$ 70,616	$ 61,325	$ 9,291	13.2
Second	52,362	48,249	4,113	7.9
Third	49,170	44,618	4,552	9.3
Fourth	49,932	45,014	4,918	9.8
Total	$222,080	$199,206	$22,874	10.3

* Reductions before deductions for deductibles and coinsurance

Source: Quarterly Billed vs. Paid Input Report

TABLE 5

CHAMPUS
ESTIMATED REDUCTIONS FROM PHYSICIANS' BILLED CHARGES
1970
(000 omitted)

Quarter	Billed	Allowed	Reduction*	
			Amount	Percent
First (est.)	$ 6,575	$ 5,936	$ 639	9.7
Second	6,901	6,183	718	10.4
Third	12,244	10,949	1,295	10.6
Fourth	10,088	9,267	821	8.1
Total	$35,808	$32,335	$3,473	9.7

* Before deductions for deductibles and coinsurance

First Quarter -- Estimated on basis of amount paid during this quarter.

Source: Second, third and fourth quarters -- Billed vs. Paid Input Reports

TABLE 6

REDUCTIONS RESULTING FROM OPERATIONS OF
MEDICAL ADVISORS AND UTILIZATION AND AUDIT REVIEW
GOVERNMENT PROGRAMS
1970
(000 omitted)

Program	Medical Advisors*	Utilization and Audit Review	Total
Medi-Cal	$11,209	$380	$11,589
Medicare	1,115	80	1,195
CHAMPUS	243	60	303
Total	$12,567	$520	$13,087

* Includes reductions to profile limitations

Source: Provider Review Annual Report

TABLE 7

DISTRIBUTION OF REDUCTIONS FROM PHYSICIANS' BILLED CHARGES
GOVERNMENT PROGRAMS
1970
(000 omitted)

	Total Reduction		MRAD and Utilization Audit Review		California Blue Shield Routine Claims Review and Foundation Claims Review	
	Amount	Percent	Amount	Percent	Amount	Percent
Medi-Cal	$39,864	100.0	$11,589	29.1	$28,275	70.9
Medicare	22,874	100.0	1,195	5.2	21,679	94.8
CHAMPUS	3,473	100.0	303	8.7	3,170	91.3
Total	$66,211	100.0	$13,087	19.8	$53,124	80.2

Source: Derived from Tables 1 and 2.

Exhibit IV

AGREEMENT

THIS AGREEMENT, made and entered into this 15th day of May 1970, at County of [redacted], State of California, by and between California Physicians' Service, dba California Blue Shield, hereinafter called the Contractor and the Foundation for Medical Care of [redacted] County hereinafter called the Foundation provides:

A. Recitals

1. The State of California, hereinafter known as the State, pursuant to the Agreement, hereinafter known as the Contract, entered into on the 19th day of February, 1966, with Contractor, has agreed that the Contractor shall perform enumerated duties which it is qualified to perform with respect to the California Medical Assistance Program, hereinafter known as Medi-Cal.

2. The Contractor with the prior written consent of the Director of the Department of Health Care Services has the authority to subcontract to, or agree with, other qualified organizations to perform a part of the services to be provided by it under its Contract with the State.

3. The Foundation is experienced in processing bills, invoices and statements, hereinafter known as claims, and in reviewing same to determine the reasonableness of charges and in reviewing the quality of medical care rendered and the degree of utilization.

4. Services to be rendered by Foundation may include the following, as hereinafter provided:

   a. Receive and organize claims from providers who have rendered covered services to eligible persons, known hereinafter as Beneficiaries.

   b. Determine whether claims received are in compliance with applicable Medi-Cal regulations and rulings and with such administrative guidelines, medical policy and fee directives as may be provided the Foundation by the Contractor.

   c. Determine under applicable administrative regulations whether prior authorization is required for care given and, if needed, whether such authorization was obtained. If it was not obtained, the Foundation agrees to notify the provider and to enclose appropriate instructions when returning such claims to such provider.

d. Install and implement appropriate procedures:

1. To reject all claims not payable under applicable laws, regulations, and medical policy guidelines and

2. To notify the provider submitting the claims of their rejection and the reasons therefor.

e. Approve claims for payment pursuant to the applicable laws, regulations and guidelines and forward same to the Contractor for further processing and payment as warranted.

f. Furnish to the Contractor and the State of California Department of Health Care Services on written request such timely necessary information and reports as may be requested in writing.

g. Maintain such records and afford such access thereto as the Contractor and the State of California Department of Health Care Services, by written request, finds necessary to assure the correctness and verification of the information and reports which may be required of the Contractor pursuant to the Medical Care Law.

h. In conjunction with the Contractor, provide liaison and coordination with providers, with groups and organizations representing such providers and with other interested groups, committees and similar bodies.

i. In conjunction with the Contractor, assist providers in the development of procedures relating to utilization practices.

j. Assist in the application of safeguards, through the use of review and evaluation mechanisms acceptable to the Contractor and the State of California Department of Health Care Services, against unnecessary utilization of the provisions for care and services by providers, Beneficiaries and others, and recommend to the Contractor and the State of California Department of Health Care Services such action as appears warranted in cases of unnecessary utilization.

k. Assist in the application of safeguards related to fraud or abuse by providers, Beneficiaries and others, which shall include written notification to the Contractor and the State of California Department of Health Care Services on suspected fraud or abuse situations.

l. Develop and revise as necessary, manuals or procedural delineations governing the Foundation's operations hereunder.

m. In conjunction with the Contractor, implement procedures enabling providers to utilize other sources of payment.

n. Carry Workmen's Compensation and liability insurance, as an independent contractor, in such coverage and amounts as the law may require or otherwise as the Contractor may require and report such coverage and amounts to the Contractor.

5. The specific services which Foundation shall provide shall be described in such addenda to this Agreement as shall be executed from time to time by the parties hereto. By such addenda, or any addendum, the scope of Foundation's duties hereunder may from time to time be increased or reduced, as the efficient administration of the Contract may require.

B. Terms and Conditions

NOW, THEREFORE, the parties do agree as follows:

1. Foundation agrees to provide any or all of the particular services described in paragraph A(4) of this Agreement, as required by any addendum to this Agreement executed by the parties, and to be bound by this Agreement and the terms and conditions of the Contract, which by this reference is made a part hereof and is incorporated herein.

2. The Contractor agrees the Foundation shall be reimbursed for administrative costs incurred in the performance of duties and the provisions of services pursuant to this Agreement, upon the basis provided in the Contract. It is the intent of the parties that such reimbursement conform to the no-profit, no-loss principle set forth in Section 88 of the Contract.

3. Effective Date and Renewal

This Agreement shall be effective on May 15, 1970 and shall remain in effect on a month to month basis. Should the Contract between the State and the Contractor be terminated, the Agreement between the Contractor and the Foundation will not be extended beyond the date of Contract termination.

Either the Contractor or the Foundation may terminate this Agreement by notifying the other party in writing at least thirty (30) days prior to termination that the Agreement shall be terminated upon a specified date, which must be the last day of a month. Any termination of the Agreement for whatever cause shall be subject to the Liquidation conditions set forth in Section 4 below.

4. Liquidation

a. Following termination of this Agreement, it shall cease to apply to services rendered by providers to eligible

persons subsequent to the termination date, but shall remain in effect and binding on the Foundation for purposes of processing claims for services rendered to eligible persons prior to the termination date and for such other duties related thereto as the Foundation has agreed to provide under this Agreement.

b. The Foundation shall be compensated for such services provided and duties performed during the liquidation period in the same manner provided for services rendered and duties performed prior to the termination date.

5. Compliance with Regulations

All services under this Agreement shall be performed in accordance with the applicable law, regulations and administrative directives in effect at the time of performance. The Contractor shall keep the Foundation informed regarding law, regulations or directives, or any changes thereto. The Contractor will provide the Foundation with current information regarding providers whose services under the Medical Care Law have been lawfully terminated, suspended or restricted.

6. Books and Records

The Foundation shall maintain books, records, documents and other evidence pertaining to administrative costs and expenses

incurred under this Agreement to the extent and in such detail as shall properly reflect all costs, direct and apportioned, and other costs and expenses of whatever nature for which reimbursement is claimed under the provisions of this Agreement. The Foundation's accounting procedures and practices shall conform to generally acceptable accounting practices and the costs properly applicable to this Agreement shall be readily ascertainable therefrom. The Foundation shall submit its statements of costs and other expenses to the Contractor on a monthly basis no later than the 15th day of the month subsequent to the month for which such accounting is submitted and shall be in such order and form as the Contractor may specify. The Contractor shall reimburse the Foundation for its administrative charges no later than the end of the month in which they are submitted.

The Foundation agrees to make all cost and expense records available to the Contractor, the State and the United States at its offices at all reasonable times for inspection, audit or reproduction by any representative authorized by the Contractor, State or the United States.

7. Assignability

This Agreement is not assignable by the Foundation either in whole or in part.

8. Amendments

This Agreement may be amended by written agreement duly executed by the Contractor and the Foundation. It is mutually understood and agreed that no alteration or variation in the terms of this Agreement shall be valid and binding upon the parties hereto unless made in writing and signed by them.

9. Communications

The parties to this Agreement will each appoint an individual having primary responsibility for the communications essential for the effectiveness of their mutual performance.

10. Fair Employment Practices

The Foundation agrees to be bound by and to comply with:

a. Standard Form 3, Fair Employment Practices Addendum, a copy of which is attached to, and by this reference made a part of this Agreement, and

b. Regulations and requirements in the field of Non-discrimination in Employment imposed by the Government of the United States upon persons or corporations performing the functions undertaken by the Foundation under this Agreement.

IN WITNESS WHEREOF, This Agreement has been executed, in quadruplicate, by and on behalf of the parties hereto.

DATED: 3-27-70

FOUNDATION FOR MEDICAL CARE OF [redacted] COUNTY

By [redacted]

Executive Secretary
Title

DATED: April 16, 1970

CALIFORNIA PHYSICIANS' SERVICE

By Charles W. Stewart
Charles W. Stewart
Vice President - Operations
Title

APPROVED:

DATED: May 14, 1970

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

By Earl W. Brian
Earl W. Brian, M.D.
Director
Title

ADDENDUM #1 TO

AGREEMENT BETWEEN

CALIFORNIA PHYSICIANS' SERVICE (CONTRACTOR)

AND

FOUNDATION FOR MEDICAL CARE OF [redacted] COUNTY

This Addendum shall supplement the Agreement dated May 15, 1970 1970, between said Contractor and said Foundation pursuant to the terms thereof.

Effective May 15, 1970 the Foundation in accordance with the terms of the Agreement shall:

a. Process from receipt through keytaping all claims relating to care of Medi-Cal beneficiaries provided by physicians practicing in [redacted] Counties, State of California, except that such claims shall not include those relating to care of Medi-Cal beneficiaries who are also entitled to benefits under the Medicare Program (Title XVIII, the Social Security Act of 1965.)

b. Identify in claims processed any potential or actual third party liability case and forward to the Contractor for his disposition such case data related thereto as the Contractor may require.

c. Process claims for payment so as not to exceed the maximum fees allowable under the Medi-Cal payment system in effect for the county at the time services are rendered.

3. Effective May 15, 1970 the Contractor, in accordance with the terms of the Agreement, shall:

a. Receive key tape claims data from the Foundation and process such data so as to effect the payment of the physicians involved.

b. Receive and process for payment the Medi-Cal portion of any claim submitted by a physician practicing in [redacted] Counties for services to a beneficiary entitled to the benefits of both the Medi-Cal and Medicare Programs.

c. Provide the Foundation with microfilm paid claims history on a timely basis as follows:

1. In provider sequence, data on claims processed by the Foundation.

2. In beneficiary sequence, data on claims processed for [redacted] Counties beneficiaries regardless of the place of service.

3. In provider sequence, data on claims processed for beneficiaries of both Medicare and Medi-Cal receiving services from physicians practicing in [redacted] Counties.

d. Forward to the Foundation for processing:

1. Any Medi-Cal claims for services provided by affected physicians sent directly to the Contractor.

2. Any claims for services provided by these physicians which relate to beneficiaries of both Medi-Cal and Medicare and which are rejected by Medicare as a non-benefit.

e. Handle all matters pertaining to third party liability cases, potential or actual, based upon information to be provided by the Foundation as required by the Contractor.

f. Conduct reviews and claim audits on an ongoing basis to insure adequate quality control.

4. The Foundation shall continue to provide all other services as required by said Agreement and any prior Addendum not heretofore modified or revoked.

5. To the extent that this Addendum makes provision for services which relate to the processing of individual claims, it shall be applicable only as to the claims received on or after the effective date specified herein.

DATED: 3-27-70 DATED: April 16, 1970

FOUNDATION FOR MEDICAL CARE

OF [redacted] COUNTY CALIFORNIA PHYSICIANS' SERVICE

By [redacted] By Charles W. Stewart

Executive Secretary Charles W. Stewart

Vice President - Operations

Title Title

APPROVED:

DATED May 14, 1970

STATE OF CALIFORNIA

DEPARTMENT OF HEALTH CARE SERVICES

BY Earl A. Brian

DIRECTOR

ADDENDUM #2 TO

AGREEMENT BETWEEN

CALIFORNIA PHYSICIANS' SERVICE (CONTRACTOR)

AND

FOUNDATION FOR MEDICAL CARE OF [redacted] COUNTY

1. This Addendum shall supplement the Agreement dated May 15, 1970 1970, between said Contractor and said Foundation pursuant to the terms thereof.

2. Effective July 1, 1970 the Foundation in accordance with the terms of the Agreement shall:

   a. Process from receipt through keytaping all claims relating to care of Medi-Cal beneficiaries provided by dentists practicing in [redacted] Counties, State of California, except that such claims shall not include those relating to care of Medi-Cal beneficiaries who are also entitled to benefits under the Medicare Program (Title XVIII, the Social Security Act of 1965.)

   b. Identify in claims processed any potential or actual third party liability case and forward to the Contractor for his disposition such case data related thereto as the Contractor may require.

   c. Process claims for payment so as not to exceed the maximum fees allowable under the Medi-Cal payment system in effect for the county at the time services are rendered.

3. Effective July 1, 1970 the Contractor, in accordance with the terms of the Agreement, shall:

a. Receive key tape claims data from the Foundation and process such data so as to effect the payment of the dentists involved.

b. Receive and process for payment the Medi-Cal portion of any claim submitted by a dentist practicing in [redacted] Counties for services to a beneficiary entitled to the benefits of both the Medi-Cal and Medicare Programs.

c. Provide the Foundation with microfilm paid claims history on a timely basis as follows:

1. In provider sequence, data on claims processed by the Foundation.

2. In beneficiary sequence, data on claims processed for [redacted] Counties beneficiaries regardless of the place of service.

3. In provider sequence, data on claims processed for beneficiaries of both Medicare and Medi-Cal receiving services from physicians practicing in [redacted] Counties.

d. Forward to the Foundation for processing:

1. Any Medi-Cal claims for services provided by affected dentists sent directly to the Contractor.

2. Any claims for services provided by these dentists which relate to beneficiaries of both Medi-Cal and Medicare and which are rejected by Medicare as a non-benefit.

e. Handle all matters pertaining to third party liability cases, potential or actual, based upon information to be provided by the Foundation as required by the Contractor.

f. Conduct reviews and claim audits on an ongoing basis to insure adequate quality control.

4. The Foundation shall continue to provide all other services as required by said Agreement and any prior Addendum not heretofore modified or revoked.

5. To the extent that this Addendum makes provision for services which relate to the processing of individual claims, it shall be applicable only as to the claims received on or after the effective date specified herein.

DATED: 3-27-70

FOUNDATION FOR MEDICAL CARE OF [redacted] COUNTY

By [redacted]

Executive Secretary

Title

DATED: April 16, 1970

CALIFORNIA PHYSICIANS' SERVICE

By Charles W. Stewart

Charles W. Stewart
Vice President - Operations

Title

APPROVED:

DATED May 14, 1970

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

BY Earl M. Brown

DIRECTOR

FAIR EMPLOYMENT PRACTICES ADDENDUM

1. In the performance of this contract, the Contractor will not discriminate against any employee or applicant for employment because of race, color, religion, ancestry, or national origin. The Contractor will take affirmative action to ensure that applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, ancestry, or national origin. Such action shall include, but not be limited to, the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; lay off or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. The Contractor shall post in conspicuous places, available to employees and applicants for employment, notices to be provided by the State setting forth the provisions of this Fair Employment Practices section.

2. The Contractor will permit access to his records of employment, employment advertisements, application forms, and other pertinent data and records by the State Fair Employment Practice Commission, or any other agency of the State of California designated by the awarding authority, for the purposes of investigation to ascertain compliance with the Fair Employment Practices section of this contract.

3. Remedies for Willful Violation:

(a) The State may determine a willful violation of the Fair Employment Practices provision to have occurred upon receipt of a final judgment having that effect from a court in an action to which Contractor was a party, or upon receipt of a written notice from the Fair Employment Practices Commission that it has investigated and determined that the Contractor has violated the Fair Employment Practices Act and has issued an order, under Labor Code Section 1426, which has become final, or obtained an injunction under Labor Code Section 1429.

(b) For willful violation of this Fair Employment Practices provision, the State shall have the right to terminate this contract either in whole or in part, and any loss or damage sustained by the State in securing the goods or services hereunder shall be borne and paid for by the Contractor and by his surety under the performance bond, if any, and the State may deduct from any moneys due or that thereafter may become due to the Contractor, the difference between the price named in the contract and the actual cost thereof to the State.

SCHEDULE OF ALLOWABLE ADMINISTRATIVE COSTS

The following schedule of administrative expenses shall be chargeable at actual rates paid in accordance with the Contractor's usual scale of compensation and actual costs. In cases where it is necessary to prorate costs, reasonable estimates shall be acceptable.

For the purpose of this contract, administrative costs shall fall in two categories -- Direct Charges and Apportioned Charges.

Direct Charges shall be those costs which are incurred and chargeable to the program as set forth in Schedule I.

Apportioned Charges shall be those costs that are incurred and chargeable to the program on a prorated basis as set forth in Schedule II.

SCHEDULE I

ADMINISTRATIVE EXPENSE CONTRACT
DIRECT CHARGES

CLASSIFICATION	EXPLANATION
Salaries (including salaries paid in form of Annual Service Recognition):	Based on actual rates applicable to the program and consistent with Contractor's other activities.
Overtime:	Overtime necessary to the program consistent with Contractor's other activities.
Accrued Employee Benefits and Other Payroll Expenses:	(A) Workmen's Compensation - prevailing rates for salaries charged. (B) FICA (Social Security) - prevailing rate for salaries charged. (C) SUI and FUI - prevailing rates for salaries charged. (D) Pension costs - Prorate of pension plan contribution computed as follows: The ratio of salaries charged above as it relates to the total of all salaries charged for all programs. The resulting percentage to be applied to program salaries to arrive at the pension costs chargeable to the program. (E) Payment of employees' cost of group and other benefits consistent with Contractor's other activities. (F) Sick and vacation charges as used. (G) Other related payroll expenses.

CLASSIFICATION	EXPLANATION
Forms & Printed Matter:	Charges to be based upon actual cost of items purchased specifically for the program. Withdrawals from general stock to be charged on an actual basis, to include freight charges when applicable.
Office Supplies:	Same as above
Other Materials & Supplies:	Same as above
Travel & Related Expenses:	Cost of travel within the State and to contiguous areas where care under the program is rendered, and related expenses of personnel engaged with program activities. Such costs to be on an actual basis for personnel engaged in the program.
Telephone & Telegraph:	Charges for installation or disconnection of phone units. Charges as necessary for phone usage to be as follows: (A) Direct Lines - 100% to the program (B) Trunk Lines - Prorate share of total cost of main trunk line based on weighted average of (1) phone units per department to total trunk line units, (2) weighted by experience on long distance phone usage.
Postage, Mailing Expense and Shipping Cost:	Postage to be charged for actual cost for outgoing mail as reflected by meter readings and shipping costs.
Maintenance & Service Contracts:	Actual charges for maintenance and repairs for equipment used in connection with program.
Utilities:	Prorated based on square footage or actual cost.

CLASSIFICATION	EXPLANATION
Conference, Meetings & Sundry Expense:	Expenses incurred for conferences and meetings within the State, and to include sundry expenses incidental thereto.
Freight:	Charged when applicable to the program.
Other General Expense:	(A) Expenses applicable to the program not covered in other expense classifications. (B) Rentals and other expenses borne by the Contractor which are incurred by him to obtain an overall fiscal benefit for the program; subject to prior written consent of the State.
Equipment Rental other than EDP or ADP:	Rental of equipment necessary.
Use of Space:	Based on direct rental expense or pro-rata based on square footage. To include amortization of any unexpired term lease or of penalty costs connected therewith, with the express proviso that all leases in excess of one year must be approved in writing by the State.
Professional Fees:	Legal, auditing, and other professional services required by the program.
Furniture & Equipment:	(A) Furniture and equipment as and when purchased by the Contractor, such furniture and equipment to be of the same general quality as Contractor's general furniture and equipment. NOTE: Items of a cost of less than $50.00 need not be carried into physical inventory records.

CLASSIFICATION	EXPLANATION
	(D) Purchase of items of a cost in excess of $5,000.00 must be approved in writing by the State prior to purchase.
	(C) Items of furniture and equipment owned by Contractor and not purchased under (A), above, to be charged at a reasonable rental. When necessary, such charges will be prorated on the basis of usage.
Taxes:	Taxes for which Contractor is liable and which are applicable under the program.
Insurance:	Insurance coverage applicable to the program, consistent with Contractor's other activities.
Other Fixed Expense:	Other items or services expended for and chargeable to the program but not easily identified in another classification.

SCHEDULE II

ADMINISTRATIVE EXPENSE CONTRACT
APPORTIONED CHARGES

CLASSIFICATION	EXPLANATION
Management Personnel Expense:	Prorated in a manner consistent with Contractor's general practice.
Internal Audit:	Based on time devoted.
Personnel Management:	Charge to be based upon ratio of number of personnel in the program to total personnel.
Switchboard & Telephone Pools:	Charge to be based upon ratio of number of phone units in program to total units or ratio of phone call volume.
Professional Relations:	Charge to be based upon ratio of field calls made or time expended for the program to total field calls made or time expended for all programs.
General Accounting:	Same as Management Personnel Expense.
Electronic Data Processing & Electronic Machine Accounting:	Charges to be based upon ratio of the programs job cost to total job cost. Resulting percentage applied to actual EDP and EMA costs to arrive at charge.
Mail Processing:	Charge to be based on outgoing meter readings in dollars as it relates to meter readings in dollars for all programs.
Purchasing:	Same as Management Personnel Expense or based on periodic time studies.
Building Maintenance:	Charge to be based upon ratio of square feet utilized for program to total. In cases of direct rental of space, charges will be based on actual expense incurred.
General Operations:	Expenses not covered by other classifications.

May 24, 1971

The hearing held in San Francisco failed to examine medical care in its full perspective. Undoubtedly, the statistics which compared medical conditions in the United States with other countries elucidated the medical crisis in the U.S. The crisis is best borne out by the variability of health care in this country. The infant mortality rate is almost twice as high for nonwhites as whites. Furthermore, although the infant mortality rate for whites has been declining, the rate for nonwhites has not changed appreciably during the past decade. In two counties in Mississippi more than ten percent of all infants die during the first year of life!

Moreover, the hearing exemplified present medical conditions, but failed to provide inquisitions. Why do doctors repeatedly ignore the importance of good nutrition during pregnancy? Research completed as early as the 1930's by Strauss and Rees linked metabolic toxemia of late pregnancy to malnutrition. More important, the incidence of congenital anomalies increases in the offspring of women who were malnourished during gestation.

Due to an appalling combination of ignorance and indifference, many obstetricians in poverty-stricken areas have not been able to communicate with their patients. Impersonalization and condescending attitudes supersede rapport. Hundreds of doctors indiscriminately prescribe

diuretics and amphetamines, while recommending low calorie-low salt diets to obese pregnant women. Under such circumstances, the occurence of abruptio placentae, coma, and convulsions increases markedly. There is no medical evidence to document the popular myth that women should not gain more than twenty-five to twenty-eight pounds during pregnancy! Instead, doctors should recommend diets high in protein and calcium, considering weight gain of secondary importance regardless of the severity of the obesity. Iatrogenic diseases can be abolished only when the medical profession strives to enhance health rather than to maximize profits.

Many of those occupying our jails and reformatories are victims of malnutrition and inadequate medical care. Born with mental disorders and physical abnormalities, many of them, their lives already victimized by racism, are forced into "deviant" roles as a consequence of the reverberating effects of discrimination. How can politicians and people in the medical profession regulate the lives of people in poverty-stricken areas, the life style of which they know nothing? Doctors with condescending attitudes who prescribe ineffective drugs to their patients for financial reward are the criminals!

With widespread utilization of proper medical treatment, many present barriers to fulfillment in life would be shattered. Hormone imbalance, epilepsy, and cerebral palsy would no longer be diseases of the protein deficient poor.

Racial attitudes would soon be left without foundation. Having adequate medical care for all could eventually establish a precedent for abolishing discriminatory behaviour.

Naturally, the present administration, which has never displayed compassion for the poor, would discount the above reasoning as unfounded and revolutionary. However, examining the crisis under their frame of reference (i.e., financially), one draws similar conclusions. Providing adequate medical care for everyone can be viewed as an investment. Less protection would be required and the staggering totals of property destruction would decline since the compulsion underlying crime are diminished.

Hopefully the members of the Subcommittee not only heard the testimony of people such as Mrs. Henderson, who represents tens of thousands of women in this country, but listened attentively and will remain attuned to ameliorating the present system of medical care. Passage of this bill would be a step forward towards insuring that the government ceases to protect the medical profession and commences to protect the people.

Jay Hodin

Jay Hodin

2307 Virginia
Berkeley, California

Testimony before the Senate Subcommittee on Health
San Francisco, Calif. May 17, 1971
by the
San Francisco Bay Area Chapter, Medical Committee for Human Rights

The Medical Committee for Human Rights wishes to alert the people of the United States to the collapse of the American health care system. This collapse is clearly evident from the testimony of the health consumers who spoke here this morning. And the tragic experiences of these consumers can be multiplied a million-fold throughout doctors' offices, clinics and hospitals of the country.

The problems which have lead to this health care collapse were mentioned this morning. 1) Fragmentation: patients are shunted from one specialist to another (both in mainstream medical practice and within prepaid group practices like Kaiser) with no doctor willing to take responsibility for the health of the whole person. 2) Economic discrimination against the sick and the poor: the sick cannot get insurance, and thus cannot pay their health care bills; the poor cannot find care even if it is paid for. Because the poor are frequently black and brown, we call this racism in health care. 3) Discrimination against women: women receive the majority of medical care, yet the number of woman doctors is tiny. And male doctors often treat women as neurotic objects, handling their pregnancies, deliveries, and gynecological problems in a routine, disinterested--rather than in a personal, humanistic--manner. In addition, the burdens and complications of contraception have been placed upon women rather than shared with men. 4) Mystification: the medical profession refuses to explain to patients what is happening to themselves and to their bodies. 5) Uneven quality: numerous examples of poor care were given this morning. These examples will continue until health care is demystified and people are allowed to enter, in an educated way, into the medical decisions which deeply affect their lives.

These and other features of the health care system reveal the need for a total restructuring of American health care. What is the fundamental principle of such a

restructuring? That people be given power over their own lives in the area of health. Only in this way will the multibillion dollar institutions of health care begin to serve those who use these institutions.

Because control of health care institutions should be transferred to the consumer of health care, the Bay Area Chapter of the Medical Committee for Human Rights cannot support any of the existing national health insurance proposals. None of these proposals actually shifts power from those who presently control the health care system to the consumer. Of all the bills, the Health Security Act leaves open a remote possibility for consumer control of hospitals and health centers. However, this uncertain possibility is not enough. In the battle for control of health care institutions, medical societies, large corporations and medical schools will almost always beat out groups of consumers. Thus, health care legislation should state unequivocally that any money collected by a national financing mechanism be paid only to community-worker controlled institutions. (We say "community-worker control" because all the people who work in health centers and hospitals should work cooperatively with those who use these institutions in formulating policy.)

What are the implications of this principle that ordinary people should gain power over their own lives in the area of health? First, it means that service--rather than profit--must be the governing force in the provision of health care. Profit-making should be abolished from health care. This means that doctors should not be paid by the fee-for-service method. Also, the huge industries with vast control over the health care system--particularly the drug industry--must take on public, non-profit ownership. And private insurance companies have no place in the health care system; their function can be handled by a public system of taxation.

Secondly, ordinary people will never have power over their own lives if a small group of wealthy people, with unlimited money, can buy hospitals and health centers, can buy politicians through huge campaign contributions, and can buy people's minds through media advertising. Thus wealth must be redistributed--from rich toward poor--by truly progressive taxation in which the rich pay their share.

In order to begin the work required to place these principles into practice, the Medical Committee for Human Rights, at its national convention in April, 1971, decided to develop its own national health proposal. We wish here to state the general features of this proposal:

1. Health care will be free for everybody, and comprehensive (including educational, preventive, diagnostic, therapeutic and rehabilitative elements of physical and mental health).

2. Health care will be financed by a national tax on total income or wealth which, unlike any existing tax, makes the rich pay their share.

3. Profit will be eliminated from the health care system; this means an end to fee-for-service payments, profit-making drug companies and other health related industries, and insurance companies.

4. A sufficient number of health workers will be trained at public expense to meet the needs of all people in every area of the country.

5. All health care institutions will be run by policy-making bodies democratically elected by those who use or potentially use the institution, and by those who work in the institution.

6. Health care institutions within factories and other places of work will be controlled by those employed in that place of work.

7. Health worker schools will insure that each category of health worker has representation from minority groups, women and poor classes in proportion to their numbers in the general population. In order to reverse the present over-representation among doctors of white middle class males, applicants from minorities, women, and lower economic classes will be given preferential admission until present imbalances are eliminated.

8. Health worker education will be flexible such that workers, utilizing courses and on-the-job training, can move from one job to another.

9. Community-worker bodies will also be involved in policy formation in the areas of environmental and industrial health.

Senator KENNEDY. The subcommittee stands in recess.
(Whereupon, at 11:30 a.m., the subcommittee recessed.)

HEALTH CARE CRISIS IN AMERICA, 1971

TUESDAY, MAY 18, 1971

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Los Angeles, Calif.

The Subcommittee on Health met at 12:55 p.m., in the Los Angeles County-USC Medical Center, Los Angeles, Calif., Senator Edward M. Kennedy (chairman of the subcommittee) presiding.

Present: Senator Kennedy (presiding).

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

Senator KENNEDY. The subcommittee will come to order. I want to express my very warm appreciation to all of those here at the hospital who have been kind enough to help the staff arrange this hearing. We are very much in your debt.

I also want to welcome all of you for joining us here today. Over the period of the last 11 weeks, the Senate Health Subcommittee has been holding extensive hearings on the health care crisis in this Nation. We heard for some 8 weeks from various professional witnesses representing the American Medical Association, the hospital associations, Blue Cross and Blue Shield, plus many other different groups. After we concluded that part of the hearings, we traveled into New York City to consider the health crisis in a major urban area. After that, we traveled into Westchester County and Nassau County, two affluent counties, to consider the quality of health care in those areas.

Next, we traveled to West Virginia, which is the second most rural State in the Nation, to consider the health crisis in rural America. We traveled into Ohio and into Chicago, and then into Iowa, again to get some feel for the nature of the health crisis in a rural State.

We went to Nashville, Tenn., and to Denver, which have two of the great medical complexes in the Nation. Finally, we have been to San Francisco, now Los Angeles, and we return to Washington this evening.

During that period of time we have tried to visit with different groups. We have also had sessions such as this, which will be open to some of the consumers who are touched by the health delivery system. We have also tried to meet with the deans of medical schools; we have tried to meet with residents and interns where we have had an opportunity to do so; we have met with representatives of the insurance companies. We met with other providers of health care. We have gone to neighborhood health centers.

Last night we visited the Mexican-American Pediatrics Center in East Los Angeles. Earlier today we visited the Watts Neighborhood Health Center, the Martin Luther King Center, and the Los Angeles County Hospital Outpatient Clinic. Later, having seen the facility here, we will go over to UCLA to talk to them about the contrasts which exist in facilities. We have tried over this period of time to get as broad an impression as we possibly can. We don't think that from our visit here alone we are going to understand completely the health needs of the people in southern California. But we are going to try to put them in some perspective, based upon our hearings and studies and try as a result to have an impact on future health legislation.

I think you can observe just so much in the hearing rooms in Washington. You can have public hearings there, and you can listen to expert witnesses; but I have found since we have done the field hearings that our most dramatic comments have been from the consumers themselves. That is who we are here to listen to today.

We have some charts which are to some extent self-explanatory. On this one you will see what it will cost in 1973 under the present health system. Those costs, which are out-of-pocket, private health insurance, public, and others such as Veterans', DOD programs, and so forth, are diagrammed here. The costs of the administration's program and the Health Security Act are diagramed here. We estimate the cost of the Health Security Act at $68 billion. HEW values it at $77 billion. I think our figures are more accurate. Figures at $68 billion, you see, the result is that the American people are going to be spending $100 billion per year on health care by 1974, according to HEW. But the real question is how it will be spent. We are not here today to have hearings on national health insurance; but as the sponsor of the Health Security Act, I am interested in it.

In the next chart, you see a very brief summary of the various components of the health crisis in this country, which includes cost, manpower, quality, the delivery system, and too few consumers involved in decisionmaking.

You get an indication from this next chart of what has been happening to costs. You see the extraordinary increase in terms of hospital charges as compared to construction costs, and the comparison of doctor's fees to construction costs. The increase in hospital charges has been rising at the rate of three times the consumer price index; doctors' fees have doubled the rate of increase of the consumer price index over recent years. You see a comparison of the hospital day costs per patient day in Los Angeles in 1960—$44. In 1970, it was $142. In the next chart we find the ratio of doctors to population in Los Angeles. This reflects an enormous maldistribution of doctors in this community.

This exists not only in the urban communities, but just as dramatically in rural America, perhaps ever more so.

In this chart the principal aspects of S. 3 are shown. In this one, Los Angeles and different counties are diagrammed with respect to maternal mortality rates. You can get some kind of a view of the areas we are interested in from these charts.

We will have seven witnesses who are consumers; they will tell their stories. Then we will hear from professional witnesses. We will try to

have 15 or 20 minutes at the end of the hearings for those in the audience who would like to make some comment on the health care crisis. For any of those who will have been unable to make some presentation, we hope you will write to me in care of the Senate Health Subcommittee, and we will include those comments in the record. We will keep the record open for a period of some days.

I would like to indicate at the outside that the professional witnesses will be a panel representing organized labor, and Alex Gerber, who is a physician. We were to have heard from the Los Angeles County Medical Association, but they are going to be unable to be with us this afternoon. This, of course, is a disappointment to us. They have been following us quite closely, though, over a period of time. Even though they have expressed some reservation because they couldn't make all of their statements in the time allotted to them, I might indicate that the AMA generally hasn't missed out on our various hearings. When we were in Denver just a couple of days ago, they circulated this briefing paper. Representatives from the Colorado Medical Society, the Denver Medical Society, the surrounding county medical societies, and dental societies, representing the AHA and the CHA, were present at a briefing session held on April 30, 1971. In addition, the AMA had three staff people, a gentleman from Chicago who has been traveling throughout the country attending the hearings and taping them, and two AMA field representatives, one from Columbus and one from Denver, at the briefing session. The field representatives have been coming to hearings in their own regions, so there is great continuity among the AMA staff.

We know that the AMA is here in the room. Wherever they might be, we want to extend a warm welcome to them, and if the doctors wonder where their increased dues are going, they are going toward sending four or five people around the country covering the hearings. In any event, we welcome them here. We are delighted that their representatives are with us.

Our first witness will be Mr. Sumner Cotton. Mr. Cotton, we appreciate your being here.

STATEMENT OF SUMNER COTTON, ATTORNEY

Mr. COTTON. I kind of come here on a triparte mission, in a sense, because I am concerned, No. 1, as an attorney; I am concerned, No. 2, about what is going on, being in the insurance business, but not actively engaged in the insurance business. And, thirdly, perhaps a subjective portion, if you will, or perhaps an emotional one, if you will, is the particular medical event which is perhaps the primary reason that I am here.

In any event, just briefly to detail a personal experience, as I say, I will try to be as objective, yet not trying to be totally objective, I think, is the event which occurred——

Senator KENNEDY. You work for an insurance company, is that right?

Mr. COTTON. I no longer do. I have been in the insurance business about 12 years. So, I know the insurance industry quite well. At another time on another occasion we could go into some problems which I see there in the area of private insurance.

But, basically, to the medical experience that occurred in 1970, just last year, my wife felt ill in 1968. She was in and out of the hospital, five or six times, and had diagnostic studies done. At that time I did have group insurance, so it was marvelous. But they could find nothing specifically wrong with her. She kept complaining of some discomfort, some illness, but they couldn't come up with any particular diagnosis. All diagnosticians please take note.

Anyway, she obviously had several claims which were submitted to the private insurance carrier, the group carrier, 1969 went by relatively well. In June of 1970, while she was visiting back East, she was stricken with an aneurysm in the interior lobe section of the brain.

When I left employment in the insurance industry as an insurance executive I tried to convert the group coverage to some meaningful private coverage, and despite having known a number of good underwriters, it was impossible for me to obtain any meaningful coverage for her. The basis for that was that she had lodged claims five or six times in the preceding year. They said to me—now, this is the personal kind of conversation I had with these gentlemen—"Wait a couple of years, old friend, and if she has had no further claims and she is in good health, why, we will get her some health insurance."

Well, that's great, except before that period when she came down with the aneurysm and at that point was not only uninsurable, she was not insured. There was no insurance available on the street, with Blue Cross, or what-have-you. No one. Obviously, the financial burden that that event posed was quite substantial.

Senator KENNEDY. As I understand it, you did have some insurance and even worked for an insurance company for 10 to 12 years. When you took another job you lost your health insurance.

Is that correct?

Mr. COTTON. Well, the group insurance. You can convert a portion of it, but you can't convert the meaningful portion of it.

Senator KENNEDY. But you feel it was virtually worthless. Is that right?

Mr. COTTON. Well, they were generous, obviously: a little 10, $15-a day plan, with minimal miscellaneous and minimal everything else.

Senator KENNEDY. But your wife was sick during this time. You were trying to get some other insurance. You were unable to do so.

Mr. COTTON. Well, she was sick and she wasn't. They couldn't pinpoint what was wrong with her.

Senator KENNEDY. But they couldn't pinpoint what was really wrong with her. Is that right?

Mr. COTTON. Insurance companies don't like to buy claims.

Senator KENNEDY. Why not?

Mr. COTTON. It hurts their profit.

Senator KENNEDY. So she was hospitalized and you got a bill. Is that right?

Mr. COTTON. Right. A substantial one. Right.

Senator KENNEDY. How much was the bill?

Mr. COTTON. Oh, the total bill was in excess of $13,000.

Senator KENNEDY. $13,000? And how much of that $13,000 was covered by any insurance that you had?

Mr. COTTON. Zero.

Senator KENNEDY. You have got that bill now?
Mr. COTTON. Not with me; no.
Senator KENNEDY. Do you owe $13,000?
Mr. COTTON. I owe a very good portion of the $13,000, yes.
Senator KENNEDY. Are you trying to pay that off now?
Mr. COTTON. Attempting to.
Senator KENNEDY. How long do you think it will take to pay that off?
Mr. COTTON. Oh, good Lord. I suppose if I were lucky, maybe in a year; maybe two years.
Senator KENNEDY. Have you received any letters about the bill?
Mr. COTTON. I have gotten one communication from—this hospital was in your neck of the woods—Massachusetts General, and they sent a nice little note saying, "Okay, fellow, pay up or else we will take legal action." Unfortunately, I think, they get people in a rather strange position, because they make you sign almost a confession of judgment.
Senator KENNEDY. They what?
Mr. COTTON. They have you sign a form which amounts almost to a confession of judgment. They can go into court in Boston, for instance, take judgment without giving you any due notice if you sign that document.
Senator KENNEDY. When do they usually ask you to sign that?
Mr. COTTON. Oh, right at the time.
Senator KENNEDY. You mean when you go in?
Did they ask you to sign it?
Mr. COTTON. Oh, yes.
Senator KENNEDY. You mean when you brought your wife in for treatment they asked you to sign this?
Mr. COTTON. Right.
Senator KENNEDY. What is the effect of that document?
Mr. COTTON. The document, of course, makes you liable, which is, the case whether you sign the document or not. It makes no difference. What they attempt to do is instill a kind of fright. Being an attorney, I said, "Forget about that. Let's read this thing."
Senator KENNEDY. You are an attorney?
Mr. COTTON. Yes. So, I just revised the document before I put my name to it.
Senator KENNEDY. You are going to try and pay that bill off? Is that right?
Mr. COTTON. I have no choice.
Senator KENNEDY. What do you think of a health system that provides not only the pain, hardship and suffering which you have experienced, and which your wife has experienced, but also the financial indebtedness?
Mr. COTTON. Well, unfortunately, I just want to refer basically in terms of the health system, I think it is kind of a triumvirate. We have a problem, No. 1, with the soaring hospital costs that you have outlined here which is obviously true. The second and third problems relate to the private insurance industry. The third problem is relative to the people who they employ to market these products. There is a great deal of misrepresentation. There is a great deal of half-

truths, if you will. And "X" buys a policy and "X" thinks he has "Y" and he doesn't have "Y" at all. He has something less, in most cases.

It is unfortunate that the industry itself, and I say this having been in the industry, hasn't really taken up the cudgel, taken up the challenge and really gone forward to the degree that they could. The industry is not known for its progressive nature, either in marketing products or in terms of management techniques.

Senator KENNEDY. They do pretty well in profits, don't they?

Mr. COTTON. Well, you have to distinguish between those companies which are stock companies and those which are not stock companies. The stock companies have stockholders and have profits. The nonstock companies are responsible to themselves. It is almost a self-indulgent, self-sustaining kind of management.

Senator KENNEDY. Are you on the verge of bankruptcy?

Mr. COTTON. Oh, I suppose if I were pushed into a corner right now, I would have no choice.

Senator KENNEDY. Thanks very much.

Mr. COTTON. Right.

Senator KENNEDY. Mr. Harry Sternberg.

STATEMENT OF HARRY STERNBERG, RESIDENT OF LOS ANGELES

Mr. HARRY STERNBERG. I am here, Senator Kennedy, because I recently underwent open heart surgery. When I got my bill I was so outraged at the ridiculousness of the cost that I decided to contact the hospital, which was Cedars of Lebanon, and tell them I was not going to pay the bill until they justified every item that they have.

I have a computer runout here of 14 pages, which is really unimportant, because the important thing is that they have charges in there that were never incurred by me.

For example, they have a pharmaceutical bill for $1,113.

Senator KENNEDY. How long were you in the hospital?

Mr. STERNBERG. I was in the hospital for 19 days, 2 days prior to my operation, and I was in ICU for 9 days and, very candidly, was not aware of what was going on during those 9 days. But for 8 days I was given 80 pills, which I am now buying at an average of about 5 cents a pill, which means that in 9 days I was given approximately $120 worth of drugs for 9 consecutive days. And I defy them to justify a charge like that.

Then they threw a laboratory charge of $2,382 at me. An inhalation therapy charge of $1,614. A charge called equipment nonortho for $200. And when I inquired I was told that I had a heating pad that I used for 3 hours, and for that incurred a charge of $200.

Now, I was operated on on January 12——

Senator KENNEDY. Is that on the bill now?

Mr. STERNBERG. I am sorry?

Senator KENNEDY. Is that heating pad on the bill?

Mr. STERNBERG. It is not called a heating pad. They call it equipment nonortho.

I think perhaps they call it that to confuse the public. When I checked with the hospitals I was advised that that charge was for the

heating pad that I used. I think it had some platinum running through it, or something. But I really am in no position right now to state that.

They also showed 36 I.V. units of charges incurred at the rate of from a dollar and a half to $3 each. And when I inquired, I was told it was either for a new needle or a new tube. When I asked my personal doctor if they change a needle or a tube whenever they change a bottle, he said, "Most unlikely."

They charged for 16 X-rays and 16 portable X-rays. Well, as I stated before, during the time I was in ICU I was not aware of what was going on. But I know that for the 10 days that I was not in ICU, I was given 8 X-rays for which I went down to the X-ray room to have them taken.

Then the other thing that threw me was that when I got this little bill, which is, incidentally, the bill that anybody gets, and this computer runout bill is something that only one who inquires will receive, but when I got the original bill from the hospital it showed that the total that I owed them was $10,209 for the 19 days. Now, they automatically deduct the 80 percent that Blue Cross would pay. But, included in the bill was a little statement which stated that the 80 percent that they showed that Blue Cross would pay was an approximate amount.

Senator KENNEDY. Well, has Blue Cross paid that?

Mr. STERNBERG. I have here the two notifications from Blue Cross which amounted to exactly the same amount that the hospital deducted. The point that I am trying to make is——

Senator KENNEDY. So, Blue Cross went right ahead and paid them without question?

Mr. STERNBERG. Yes, without any question at all.

Senator KENNEDY. Who pays the premiums on those Blue Cross policies?

Mr. STERNBERG. I do, as an individual.

Senator KENNEDY. A lot of other people, too.

Mr. STERNBERG. Oh, yes. Yes, of course. But I thought you were referring to my particular——

Senator KENNEDY. They paid whatever the hospital asked?

Mr. STERNBERG. Well, in my particular case they did. And this was the second time that I was in the hospital within a 2-month period, because prior to the open heart surgery they do what is called a heart catheterization to determine whether open heart surgery is necessary. And I was there for 2 days and incurred a bill of, $1,600. Again they automatically deducted the 80 percent that Blue Cross was supposed to pay, and Blue Cross picked it up without any questions.

And then in that bill they had items that I did not incur. For example, again they charged for portable X-rays, when I took two X-rays that I went down to the X-ray room myself to take.

Senator KENNEDY. Why do you think Blue Cross just pays these bills without question?

Mr. STERNBERG. Well, very simply because based upon an article in Business Week, the majority of the board of directors of Blue Cross consists of either doctors or members of the boards of other hospitals. So, why should they complain about the fact that Blue Cross approves

all of these bills, because Blue Cross just turns around and passes the cost on to the public.

I just received notification from Blue Cross that my next billing——

Senator KENNEDY. I was just going to ask how much the premiums have gone up for Blue Cross coverage.

Mr. STERNBERG. Well, my next billing will be an increase of 35 percent over my last billing. And within the last 2 years my Blue Cross premiums have increased 200 percent. I have an individual policy.

Senator KENNEDY. 200 percent?

Mr. STERNBERG. Yes. And that is without this last 35-percent increase.

Senator KENNEDY. You have given us an example of where the consumer is just left right out in the cold.

Mr. STERNBERG. Yes. There is no doubt about it.

Senator KENNEDY. Because eventually, if Blue Cross pays that kind of bill, it is going to mean increased premiums for both yourself and other people as well.

Mr. STERNBERG. Well, they have to get it someplace.

Senator KENNEDY. And you are going to be required to pay that.

Mr. STERNBERG. Yes. But don't you think it represents a conflict of interest where the providers of medicine rather than the payers of medicine are a majority of the board of Blue Cross?

Senator KENNEDY. Well, I do.

Mr. STERNBERG. Certainly I would say that this would be one of the most important spots to begin with.

When I received this bill, I called the Los Angeles Medical Council because it was just such an outrageous item. I called to ask if a hospital could arbitrarily charge whatever they wanted to, and they advised me that all hospitals are required to publicly note an itemized list of all the charegs that they pass on to their patients. And when I mentioned this to Cedars of Lebanon, nobody there knew anything about it. If that is so, then they cannot charge more than the hospitals in the immediate area.

But the point that I am trying to make is—

Senator KENNEDY. Well, what do you think was sent to Blue Cross? Don't they get that fully itemized bill?

Mr. STERNBERG. No.

Senator KENNEDY. They just get the summation?

Mr. STERNBERG. They just get the summation, yes. They just get this. That's all they are interested in.

Senator KENNEDY. Then let's see your bill. That's the summation, and that's the bill?

Mr. STERNBERG. This is the bill. It is a 14-page computer runout. And, of course, I guess the only justification for this is that every time a patient gets anything, or has anything done to them, an individual ticket is made out for it and these individual tickets, I guess, eventually are run through the computer and you get this computer runout.

Senator KENNEDY. Now, when you were in the hospital were you required to pay something before they let you out?

Mr. STERNBERG. Oh, yes. They wouldn't let me out unless I gave them five—well, they wanted the 20 percent that was due between the difference that Blue Cross paid and that I owed. I told them I wanted to review the bill before I paid them anything. They said, that wasn't

possible. So they accepted a minimum payment of $500 before they allowed me to leave the hospital.

Senator KENNEDY. You mean you couldn't leave without paying?

Mr. STERNBERG. No. They wouldn't let me out. You know, in order to get out of the hospital you have got to have a pass and have somebody take you out, particularly when you are in the condition that I was in after a serious operation.

The reason that I asked for this computer runout was that after I had the heart catheterization done it seemed to me that there were some charges added on to it that were uncalled for. After I paid the bill I asked for a detailed bill and, sure enough, there were some items there that I did not incur. And when I realized that, it was then, prior to my being let out of the hospital after surgery, that I decided that the first thing I was going to do before paying the bill was to determine whether I incurred all of the charges.

Senator KENNEDY. Have you been over all the items on that bill?

Mr. STERNBERG. Yes. I sent your office a copy of this along with a letter. I realize that you have a couple of other things to do other than go through something like this.

Senator KENNEDY. Would you hold that bill up for us?

Mr. STERNBERG. I think there are 14 pages. Itemizing every conceivable item under the sun.

Just to read the first page very quickly, these are each individual items: "M330, M330," which means the room.

"Telephone, telephone. Lab, lab, lab, lab, lab, lab, lab, lab, lab, lab, lab, electrocardiogram, X-ray chest, pharmacy, pharmacy, pharmacy, pharmacy, pharmacy, pharmacy, pharmacy, room, MICU," which means ICU, "telephone, telephone, operating room, operating room, lab, lab, lab, lab, lab, lab"——

Senator KENNEDY. They spent a lot of time on that.

Mr. STERNBERG. A lot of lab. And all of these figures, as I say, the biggest ones, lab fees total up to $2,382. And the pharmacy bill was $1,113.

All I am trying to emphasize here is that there is no doubt in my mind that so many of these charges are either blown up way out of proportion accidentally on purpose—and I say accidentally on purpose because included in this bill is a charge for 12 pints of blood at $23 a pint. Now, prior to my entering the hospital, my B'nai B'rith group gave the Red Cross 14 pints of blood because that is what they estimated they were going to need for my operation. But the charges are there anyway for the blood, as well as for the administering of the blood. Now, in my particular case the administering of the blood involved nothing but dumping blood into a machine that was taking over the function of my heart, because in this kind of operation they disconnect the heart and the lungs and outside machines do the breathing and the pumping of your blood for you. So they charge you $10 a pint to just dump a pint of blood into a machine that is going to circulate it through your body.

If you are getting the idea that I think that Cedars of Lebanon is a little out of range, you are being very conservative.

Senator KENNEDY. OK; thank you very much, Mr. Sternberg.

Mr. STERNBERG. My pleasure to have been here, and I hope we accomplish something worthwhile for the people of America.

Senator KENNEDY. Thank you very much.

Our next witness is Mrs. Birdell Moore. We will provide an opportunity for the hospitals or doctors who are mentioned in these comments to respond.

Mrs. Moore, we appreciate very much your being here.

STATEMENT OF MRS. BIRDELL MOORE, MULTIPURPOSE HEALTH SERVICE, WATTS, LOS ANGELES

Mrs. BIRDELL MOORE. I am Birdell Moore from the Multipurpose Health Service Center in Watts.

This is the thing I read in the newspaper, and I heard on television from newscasters, that Watts, a little, small culture of Los Angeles City, has the highest poverty in all Los Angeles, rates among the most in the Nation, the highest criminal record, crime records, the most unemployed people, and malnutrition.

Yet millions of dollars have been sent to southern California in the name of Watts.

Everybody, people talk about health. Health serves more than just taking a pill. You have to treat the total person. Comprehensive health care. This includes whatever the person needs, because we know that almost 50 percent of a person's medical ailment, physical ailment, is mental. I had this problem myself. I know. And in coming out to Los Angeles County Hospital before the Multipurpose Health Center was established there, most times I did come to the clinic I didn't make it back home. I was hospitalized because I had asthma or an ulcer attack from the strain of waiting, from the strain of not getting the answers to my questions that I wanted. You see one doctor, they tell you one thing, and then you come back to the hospitpal you want to see that doctor to find out his findings and a stranger walks in that room and asks you what you are doing here.

And if nobody knows what you are doing in a clinic, how can you have confidence in them?

Senator KENNEDY. How long does it take you to get to the County Hospital?

Mrs. MOORE. Well, it took me about an hour and a half. Sometimes it would be longer than that. Depends upon whether you catch a bus. Now, if you get out there in time to catch a bus that was coming, you could get there in about an hour and a half.If you didn't, it would take you 2 or 3 hours.

I was in San Francisco this last weekend and they were describing the President's health plan. I asked many questions about it, and I ended up knowing that there wasn't a damn thing in it for poor people. Nothing. Because I showed my condition with my legs like this, and with me having two heart attacks, chronic asthmatic condition, and I asked the planner what was in their insurance for me, and he told me I was a poor insurance risk.

I said, "Well, now, yet you want the social service money that is for me where I can get my health problems taken care of to use for your planning to serve the people who are able to pay."

Well, what will I do, go out and shoot myself?

These are the things that the poor people is interested in. The continuation of the little health service that they have, improving it, get-

ting moneys that we can hire efficient doctors at the Multipurpose Health Center instead of having so many half, part-time job doctors, and have efficient staff to take care of the patients.

We don't mean just people getting pills, because we know comprehensive health care means more than that, because if a person come in there hungry, the stomach is cramping together, they don't need a pill. They need food. You find a little child with the stomach all swollen up, they don't need so much of pills to go along with it. They need nursing food. It takes social workers, it takes health workers, to go out in these homes and search and find these kind of people, encourage them to come.

You have to pay the staff to do this, because the people are too poor to volunteer. I volunteer my time because I am too damn old to work and too sick to work. So I volunteer my time to try to make myself feel a little bit more like a human being.

And I have this. I would like to give it to you, if I may.

Senator KENNEDY. Fine.

Mrs. MOORE. It is a statement from Birdell Moore and Alma Woods. And these are the problems, Mr. Kennedy, that are facing us in our community, with all the moneys that are coming into southern California and none of it ending up in Watts.

Someone told me yesterday that they give so many million dollars to a new medical school in Watts, and I asked them where it was, that I never did see it, because I know that it isn't in Watts. But yet Watts got that money, so they said. So Watts don't need any more, because we got it all. We haven't got anything. Nothing. You can stand on one end of the streets in Watts, 103d, and count the vacant lots almost to the other end. And people ask what have been done since the riot. Nothing but tore down the buildings. Moved the people out into poor condition, maybe better houses, but nowheres—no markets, no nothing. And welfare people with 12 and 13 children living in a community where there is no market. Well, now, you don't do very much for people.

Senator KENNEDY. Thank you very much. This is an excellent comment about how some of those people in a community such as Watts regard the health system. And I think this is an indictment of the health delivery system. It was pointed out by Mrs. Moore that there are a variety of features to it. But whether it is in terms of manpower, or availability of care, or transportation, or the ability and the quantity of people and facilities, all of these things have to be mentioned.

I want to thank you very much for your comments.

Mr. Gentz. Mr. Dale Gentz.

Mrs. MOORE. Thank you for coming so very much. We are so glad to have you here, Senator Kennedy.

Senator KENNEDY. Mr. Gentz?

STATEMENT OF DALE GENTZ, MEMBER, ADMINISTRATIVE STAFF OF A TEACHING HOSPITAL IN SOUTHERN CALIFORNIA

Mr. DALE GENTZ. Senator, thank you for letting me come. I feel very fortunate after hearing some of the stories that have been told here already. Perhaps I should feel unfortunate, because my problems started with what I would call the credit card.

I have an insurance card, and insurance coverage. That seems to be the magic word when you want to seek medical care. My story is about my wife, Maxine. It began about a year ago last month when she developed a back problem. Low back pain, which apparently is not an uncommon situation among the population. And she sought medical treatment from out local M.D. who put her in the hospital and put her in traction, prescribed therapy,whirlpool therapy, ultrasound therapy, pain medications, muscle relaxants; the whole gamut of conservative therapy. He did X-rays; found nothing.

She did not improve, and they sent her home to continue basically the same things on an outpatient basis. For the next 5 months she lived on pain medications and muscle relaxants, neither of which did any good. He finally became fed up and referred her to an orthopedic specialist. He felt whatever was wrong was out of his hands.

The orthopedic specialist repeated a lot of what was done previously, and this was at a duplicator cost. Again, the magic word was that I had an insurance card, and was allowed to come to a private doctor rather than being sent to the public facilities.

He found very little wrong with her and prescribed an orthopedic corset which he told her to wear as long as she could tolerate it, which was about 1 week. This cost us $102.50.

She continued on with more pain medications and more muscle relaxants for the next 5 months when she was unfortunate enough to fall and reinjure her back even more. She was admitted to the hospital at that time and the doctor who admitted her said, "I am aware of your case and I think it is about time we tried to find out what is the problem."

This was 8, 9 months after she first started going to the doctor. She was seen by another orthopedic specialist, because we were unhappy with what we received from the first one. And the specialist gave her a myelogram and found nothing. He kept her in the hospital for 2 weeks and got nowhere.

She was discharged from the hospital at the end of January and scheduled to see a neurologist for an electromyogram to determine possible nerve involvement.

In the meantime, we have a 2-year-old son, and one point that I have left out, I think, is that she was told to spend most of her time, as much as possible, flat on her back in bed. We don't make a great deal of money, and we can't afford a babysitter. I don't have the time to take off work. So she didn't spend very much time in bed. Her progress was very slow, if any at all.

She saw the neurologist, who didn't do what the specialist requested. Not only did he not do it, but he didn't get the report out to our doctor. About a month went by and she was readmitted to the hospital. The doctor called in another neurologist at a duplicate cost, after never having received the information from the first one. They repeated—they did the test which had not been done the first time and they found what they thought was a herniated lumbar disc. At that time they scheduled her for surgery and sent her home, because surgery couldn't be scheduled for a couple of days.

She came home for 2 days and was readmitted to the hospital and she had surgery. Fortunately for her now, 10 weeks later, she finally

had a good day. She felt very well Sunday. This is the first time in about 14 months.

I think that the comment that was made by her orthopedic doctor the last time she was seen by him, which was about 11 days ago, was particularly ironic because, after fooling around with this problem for 14 months, she was told by the doctor, "If we had found this in time, you would have been all well by now."

During that time she has incurred almost $8,000 worth of medical bills. That, I think, is a part of the problem. I have the good fortune, I guess, of having hospitalization. However, I have the misfortune of making just enough money so that I don't qualify for any kind of assistance for what my insurance doesn't cover.

I now owe about $1,200, and I don't really have any idea how I am going to be able to pay this bill.. The bills are distributed over several different places. One hospital with three bills, a total of about $600, and three doctors, each of whom are demanding immediate payment.

In the past year our total costs which have not been covered by the insurance have been in the neighborhood of $1,700. I am trying to buy a home. I am in danger of losing it because I am not able to make these payments. I do the best I can, but it is not good enough for the people who I owe money to.

I also have other obligations, of course. I am also trying to save money for my son's education when he does get old enough to go to school. It is becoming very difficult for me.

The doctors who have seen her have all tried what, I guess, has been their best. Most of them apparently didn't know what to look for. It has had a great deal of effect on our own marriage. We have had a lot of disputes because we have been told time and time again by the doctor, "It is just something we can't find out. We don't know what is wrong with you. You will have to live with it."

Of course, that is now all changed. But it is very frustrating for someone to become dependent on the pain medications to exist, to not be able to participate in family activities. A 2-year-old who has spent about a third of his life with relatives, trying to identify who his family really is. He may see us 6 or 8 hours in a day; perhaps not that much sometimes. He may not see his mother for weeks at a time when she is in the hospital. It is a great, great problem. We don't know yet how much, if any, pyschological impairment there has been to his development. And we hope not very much.

But, that is basically my story.

Senator KENNEDY. You work in a hospital, do you not?

Mr. GENTZ. Yes, sir; I do. I am on the administrative staff of a major teaching hospital in southern California.

Senator KENNEDY. So you probably have as much familiarity or understanding of how the system functions and works as anyone.

Mr. GENTZ. Yes, sir; I certainly do.

Senator KENNEDY. And still you have had not only the financial hardship of an additional $1,200 in bills, but this gets very much at the whole quality issue.

Mr. GENTZ. Yes, sir; it does.

Senator KENNEDY. You had a policy, and you had some coverage, but you were just a consumer unable to determine or know whether

you were getting good advice and good guidance for a period of some 12 months.

Mr. GENTZ. Yes, sir.

Senator KENNEDY. And if you had been able to receive the best kind of advice in the beginning, you would have saved yourself and your family the pain, suffering, and hardship which you have endured.

Mr. GENTZ. That's correct; yes, sir. It became fairly clear after about 3 months that my wife had a problem which was orthopedic. The doctor who we normally go for treatment is a general practitioner, which means he has had 1 year of training beyond his medical school. It apparently was beyond him to find the problem. I don't wish to condemn him for that. It is just that this is the limitation of his education. There is a place for general practitioners in our community; a very real place.

However, one can't go to an orthopedic specialist unless one is referred by one's private doctor. I think I should relate a small act that may have some bearing on this.

My general practitioner was the assistant on the surgery for my wife. Now, this is not unusual. This is common practice. It is perhaps ironic that my orthopedic surgeon has a partner who is also a specialist in orthopedic surgery, yet the assistant was a general practitioner who, again, has only had 1 year of training beyond medical school.

When I found out that approximately 45 percent of his fee for assisting was not covered by the insurance or by the insurance schedule, I tried to find out why, and I was told that the standard fee for an assistant is 25 percent of the surgeon's fee. And when I asked why, they responded by saying that an assistant must be present because what would happen if your doctor died on the table while he was operating?

It seems to me that happens not very often. But when it happens to you it is most important because it is you or your family. However, it seems to me that what this really amounted to was, if you wanted a qualified doctor to be present, the partner in orthopedic surgery would be the appropriate person. And what I am about to say, I think, is my own opinion. I don't think it represents at all the place where I work because, again, it is a public hospital and things are different there.

We have salaried physicians who don't bill the patients for their treatment. But, what this amounts to is that the doctor has given the general practitioner a sophisticated form of fee splitting, and he is "kicking back" to the doctor a "thank you" for referring him a patient. You have no control over that.

This is not my first experience with the assistant's fees in surgery and involving my wife. And the first time was a similar situation. When I confronted the doctor he said, "You can't prove I wasn't in the operating room."

I saw him at the hospital that day. However, he was fully clothed about 2 minutes after my wife was brought out of surgery, which makes it difficult for me to believe. But, as he said, I can't prove it. And he had to be there to close if the doctor died on the table, which didn't happen.

It is all very frustrating to run into this kind of thing, particularly

when, allegedly, I know the shortcuts. I should know who the people are to contact to get what I want, and I can't.

Senator KENNEDY. Well, I want to thank you very much. This really raises the whole issue of quality and the importance of building quality control into a health system. It is quite apparent in terms of your own experience that quality has broken down. I think it reminds all of us of the importance of quality standards. We can imagine other cases who have had similar kinds of problems. I want to thank you very much for being with us today.

Mr. GENTZ. Thank you, Senator.

Senator KENNEDY. Our next two witnesses will be Mrs. Aurora Rodarte and Mr. Fernando Chavez. We appreciate very much your coming here to be with us.

STATEMENT OF MRS. AURORA RODARTE, RESIDENT

Mrs. AURORA RODARTE. I am Mrs. Rodarte and, well, my complaint is about the general hospital. And I am very nervous.

Senator KENNEDY. Just bring that "mike" up a little closer. That's fine.

Mrs. RODARTE. About 7 months ago my husband had a stroke, seizure, convulsion. I took him to the hospital. Here at the General, for observation and treatment to find out what was wrong with him. Well, they kept him 3 days and the doctor told me that they couldn't find anything wrong with him except a lot of pressure. And he was overworked; to go home. And he gave him a lot of painkillers and about 200 nerve pills, which I took, because I needed them.

And so he told me to bring him back in November for a brain scan.

So then about 20 days later he had another seizure about 5 in the afternoon. I rushed him to the General. The place was empty for once. It was no traffic,—nothing moving. It was really slow. So the doctor comes in and looks at him. And then my husband used to wear glasses, and he asked me if he was blind from one eye, and I told him no.

So, he looked him over, and went out and then I asked the doctor, "Well, what is wrong?"

And he told me he had a seizure.

Well maybe I am ignorant, but not not that ignorant. I knew he had something. So I told him, "Well, aren't you going to keep him?" Because they had his records there.

He says, "No, we are going to give him an injection and you take him home to calm him down."

So my husband couldn't sit because after those seizures he got real weak. So I put him in a wheelchair. Then he started vomiting. The nurse gave him the injection. About half an hour later they took his blood pressure. The doctor disappeared. I was waiting for my brother-in-law to pick me up. He started vomiting. I couldn't get no help. I couldn't get anybody to give me any assistance.

So I just did the best I could, and some doctor toward the reception desk asked me if they had already looked at the patient. I said, "Yes, but he is vomiting a lot. Can't you do something?"

Well, one of them says, "Well, I will give you a prescription to go and get at the pharmacist."

I says, "Well, can't you keep him here? Because I am sure something is wrong with him."

And he says, "Well, if the other doctor says to take him home, take him home."

Well, I took him home. No sooner than I got him home than my husband got another seizure. So after that, I wasn't going to bring him back to the General, since they didn't want to keep him. So that was a problem. I called the rescue squad again and the same ambulance driver went. So I rushed him to the White Memorial then.

I asked them, "How can you treat a patient for something that you don't know what he has?"

Whatever they gave him, he couldn't come out of that second seizure. He tried, and he was groggy. He just couldn't. That blindness in his eyes meant that he was getting paralyzed already on one side. He was supposed to be one of the top neurologists, imagine what the interns could do. That is what made me mad.

I told them that it was just malpractice. I mean, if that's the type of care they are going to give in an emergency, and you know that when something happens in an emergency no doctor will touch you. You have to rush him to an emergency hospital. So they told me, "You have a private doctor."

Yes, but in an emergency, what are emergency hospitals for? That is what I argued about. They did not give me the care free. The insurance covered it. And I wasn't about to pay the balance either, because not for the care they gave him, because in his condition they made sure that he had that insurance. They made him sign papers first. It think it is wrong.

Senator KENNEDY. What happened to your husband?

Mrs. RODARTE. He died.

Senator KENNEDY. After——

Mrs. RODARTE. About 5 hours later.

Senator KENNEDY. Did you get a bill from the hospital?

Mrs. RODARTE. Yes. I gave it back to them. I wasn't about to pay. I didn't sign nothing. My husband signed it. He was dead. I wasn't about to pay, because I don't think in the first place the service they gave him wasn't any service and they were not doing it free. When I put him in the hospital it was for a complete observation, checkup, and everything. If that is the kind of care they are going to give the patient, what do they expect when you are going to come in on a charity case, like I am now, without insurance. Now I have to pay insurance because I don't have any insurance because my husband died.

Senator KENNEDY. You don't have any insurance?

Mrs. RODARTE. No, I don't. I have to get medical insurance. So I wonder what they are going to do; what kind of treatment they are going to give me.

Senator KENNEDY. Thank you. Thank you very much.

STATEMENT OF FERNANDO CHAVEZ, RESIDENT

Mr. FERNANDO CHAVEZ. The reason I made my presentation in Spanish is because another one of our gripes, not only with this institution but other private institutions within East Los Angeles, is a problem with the language barrier. And I would say that 85 percent of the total

working force in this institution cannot understand nor speak Spanish, though about 45 percent of all the patients that enter this hospital, and private hospitals within East Los Angeles, are either Mexican or Mexican-American. Of the 45 percent, 25 percent cannot speak English at all. In this institution itself you have approximately, or a little over 8,000 employees. You have less than 6 percent with Spanish surnames.

Here is a hospital that is situated in a predominantly Mexican American community, right in the middle of the barrio. Within a 5-mile radius of this hospital you have about 85 percent Mexican Americans. We in the past have been the last to receive any type of treatment because it takes them a while to find someone to interpret for the patient. It is getting a little better now. They are moving a little slow, but in 1968 if they didn't have a window washer or a janitor that could speak Spanish, I mean, that patient was just going to stay on the corner, because nobody was going to bother about him.

And you know, the problem still exists. And this is one of the problems that we have fought, we have asked Los Angeles Medical Center here to recruit other interpreters or have people in the ward could understand Spanish, because this is a problem that we have now. It is a problem that we have had in the past. It is a problem that we are going to have a hundred years from now. Not unless you wake up tomorrow morning and you read the papers and it says that Mexico was last seen floating down the Pacific and it is going to attach itself to Australia. But Mexico is there. We are here. We are going to have a problem of immigration. We have the inflow of immigrants coming in here by the thousands every day. These people, whether they are here legally or illegally have the right to medicine. And right now most of our people do not come in for treatment because the fear of immigration, whether they are green card carriers or whether they are here illegally. If they are green card carriers and they have a bill, an outstanding bill with the Bureau of Resources and Collections, and they want to go back to visit Mexico, they cannot reenter. They cannot reenter if they have an outstanding bill. This is one of the problems that we have with immigration.

We know for a fact that in all county facilities, welfare, hospitals, that you have immigration officers floating in and out of the hallways to try to see who is here legally and who is here illegally.

Another problem that we face is the waiting that you have in this institution. We have seen people wait here anywhere from 4 to 8 hours. And a little longer, if you cannot speak the English language.

But the whole problem is not with the facility itself but with the department, or the County of Los Angeles, Bureau of Resources and Collections.

I would like to read you a letter. I will not give the man's name unless you ask for it. We didn't have enough time to contact this gentleman, or he would be here. But the letter reads:

Dear Sir: Unless payment in full in the amount of $2,597.62 reaches this office by May 23d, 1969, or satisfactory arrangements to settle this account are made,, your case will be processed for legal action without further notice to you.

Now, here is a man who takes home less than $90 a week. He has five children and his wife, and he gets a letter like this. Now, you know, this could blow anybody's mind.

Senator KENNEDY. What day did he get it? What date was it mailed?

Mr. CHAVEZ. The letter was sent May 13.

Senator KENNEDY. The letter was sent on May 13 asking for $2,000 in payment by May 23?

Mr. CHAVEZ. Right. Ten days. Maybe 1 or 2 days, by the time he received it.

What happens in cases like this is if these people need further treatment, they will not come back because they are already scared of a legal lawsuit. They don't have the money for an attorney. They don't even have the money to pay for a medical bill. So, if they have to come back for further treatment, they refuse to come back. Half of them are running around in all the communities like I say, in the white, in the black, in the Mexican-American, where their illnesses are never cured totally because of the fear of the Bureau of Resources and Collections.

They have people here in this hopsital that even right after patients get out of surgery, and they don't even know what is happening, come in with statement forms making the patients sign and saying, "Well, why don't you pay $5 a month, because we know this is all you can afford."

Well, you can imagine paying $5 a month for a bill of $2,500. You know, the poor guy is going to be paying it for the rest of his natural life.

And this not only affects the breadwinner, which it was in this case, but he will not even bring his children in to the hospital if they need medical attention, because of the tactics of the Bureau of Resources and Collections.

Senator KENNEDY. OK. Well, I want to thank you very much.

Mrs. RODARTE. Well, thank you.

Senator KENNEDY. Thank you for sharing your experiences and making these comments. Thank you very much.

Mrs. Mapes; Mrs. Eva Mapes.

STATEMENT OF MRS. EVA MAPES, RESIDENT

Mrs. MAPES. I have been coordinating a coalition of consumers.

Senator KENNEDY. You have got some young friends here.

Mrs. MAPES. Yes. These are my troops.

Senator KENNEDY. Do you want to introduce them?

Mrs. MAPES. Yes. That is Larry on the end. He is 9 years old.

Maria is next to him. She is seven.

And the big boy is David. He is 13.

Senator KENNEDY. We are very glad that you are here. Are you missing some school today? Would you rather be in school or be here?

DAVID MAPES. Here.

Mrs. MAPES. I have been coordinating a consumer group that includes doctors and hopsitals, labor unions and social workers. They got together because of the medical cutbacks. And we have been staying together just to try to keep on top of what the Governor has in mind about reforming the medical program.

Senator KENNEDY. Have you figured that out yet?

Mrs. MAPES. No. Daily I have been trying to keep track of the changes. It is a full-time job. And the reason that I became interested

in this is because of my own experiences, and I will tell you what happened to me.

I live alone with my three children, and one of them is an asthmatic child, and nearly every year of his life he must be hospitalized for double lobar pneumonia.

We had been covered by group medical insurance since birth. But my husband left the company that he was with in order to buy his own business, so he had an insurance agent writing up the package deal for all of the insurance that you need when you go into business and the man didn't write for the company that had provided the coverage in the past. So he said, "Well, no problem. I will just write you a new policy."

We didn't really understand that our child had asthma. He had had a cold with a bronchial involvement about a month before, and the doctor had said to me in passing, "Let's treat him as if he had asthma, because maybe he has had too many colds, and if we watch the things that he could be allergic to, he might not have so many colds."

He wrote "acute asthma" in the record, and I didn't know it.

A month later we were in the hospital with him with pneumonia, and I went to a pediatrician who diagnosed him as an asthmatic child. He was in the hospital again about 2 weeks after that, and about halfway through the second hospitalization the insurance company notified us that we were being dropped, the whole family was being dropped because we had tried to defraud them.

Senator KENNEDY. Tried to what?

Mrs. MAPES. Defraud them by denying that he had a preexisting condition.

Senator KENNEDY. The company said that?

Mrs. MAPES. Yes. And we threatened to write to the insurance commissioner, and all those things people do. But, you know, we didn't do too much about it.

And we went back to the doctor and he said, "Yes, they came and photographed his records." And, "Well, I didn't tell you that he had acute asthma, but, you know, that's the way it goes. I can't lie."

So we were left with several hundred dollars, I think close to about $1,000 in debt.

We had been a middle-class family who believes in yearly checkups and trips to the dentist, but from that point on everything just deteriorated. Our economic situation and our level of health care deteriorated. It was, as I said, our first year in business, and we had gone into debt. We had a precarious financial situation. My husband lost the business. We couldn't pay the taxes on our house, so we had become renters, and still are. Of course, there were medical, pharmacy and dental bills for other members of the family.

We started a desensitivation program after that first hospitalization for the asthmatic child and that had to be stopped because we got up to around $400 with the pediatrician and he said, "Well, that's tough, but I have done all I can."

We didn't make appointments for other needs we had because I couldn't afford payment, and that is definitely a condition for getting an appointment in some doctors' offices.

Senator KENNEDY. Now, just to go back a little bit, you were covered by Blue Cross and you would still have been covered if you had been able to continue that policy. Is that correct?

Mrs. MAPES. Yes. Yes.

Senator KENNEDY. But then because you got a new policy, and you were not covered and ran up all of these—your husband changed jobs, and you weren't covered, and you ran up a good amount of medical bills. What was the amount, approximately?

Mrs. MAPES. Oh, I think $1,500.

Senator KENNEDY. $1,500.

Mrs. MAPES. Which has never been paid because since then we had just a general deterioration of our home life, and now it is all mine to take care of. I am not with my husband now. And I think a lot of our problem was psychological, because you sort of lose your dignity when you lose your money, some way or another.

Now, I—well, the first thing I did when I found myself alone was to go to the State, because I really didn't know just where to start.

When I finally got into the system and got a medical card, everything has just been fine. We had complete comprehensive care at the doctor of my choice, and my son has been hospitalized twice and I have been once. We had a broken leg. I think about, probably, $2,000 worth of medical care has been taken care of for this family by the State of California. And I don't know how I could have held a good job that I had and made a stable home that I have and provided the emotional security that I have for the kids if I hadn't had this boost up the ladder. It was a very critical point in our lives.

Senator KENNEDY. We have talked a good deal in the Congress and the Senate about catastrophic costs of illness. Usually, we hear from the consumers about very significant bills. But I am always reminded that a thousand dollars can be just as catastrophic to one person as $5,000 or $10,000 to somebody else. And I think we should be mindful of this in legislation. I think you have pointed out so well, and as we have heard before today, that this is an extraordinary bill. A thousand dollars, $1,500, which is a lot of money, particularly when you have children, at any time. We can just see what your health bill and illness has done to your family and your children. I think this is an indictment of the system as well.

Mrs. MAPES. Last December my security began to erode again. The State instituted many cutbacks in the medical program, and among the things that were cut out were the kinds of drugs that my child needs. He takes very expensive things because he is allergic to all the things that are in the formula. Further, the hospital that I was employed in was destroyed by the earthquake of February 9. A few days ago I was notified by the medical program that I am no longer eligible because I lost my job; because I lost my working mother's allowance.

There are a lot of work expenses, connected expenses, like my car payment, and my babysitting, and transportation to and from work that made my income the right level. And I understand that that structure of medical has been changed anyway, and even if I hadn't lost my job, I still would iave been given a share to pay for medical care that I couldn't have handled.

That means that I have no choice except to go to the county hospital, and it means that every illness, large and small, is a day in the

waiting room with the kids and a day off from the job I hope to have in fairly short order. And I can't see my own physician, the one who has taken such good care of my boy.

Another problem I have is that the county hospital fell down, too, in the earthquake. So I have to come about 25 miles when he is hospitalized, or not be with him at all because I have a job and a family to take care of at home. So I don't know whether or not they have enough acute beds in the valley yet. They have quite a load. I guess they are working on it. I feel angry because I am working to the limits of my capacity to improve my potential so that my kids don't feel like poor kids. Sometimes it seems like a losing battle, because the odds are stacked against people unless they have a large reserve of money or unless they have the right connections. I think most of the billions of dollars spent on the highly sophisticated technological advances are not filtering down to the average people. Unless you can go long distances or unless you have a doctor who puts you in the university hospital, you really don't get to take advantage of space-age medicine. Most people are too busy paying their bills for sore throats and broken arms.

Before we had medical coverage one of the children fell out of bed and broke her collar bone. It only means a harness for 6 weeks, really. There is nothing to do for a broken collar bone. And it costs $150 because of the X-rays. It took me a long time to pay it. I had more than one letter from a collection agency. This is just before I went into Medi-Cal. The insurance policy I had at that time was like two different coverages. So I decided to take my children to the hospital all at one time just for a routine checkup, even when they are not sick, and I would get a bill that I would have trouble paying even when employed. So I only take them when they are sick, and I wait a while to make sure they are really sick. That's a dangerous game to play. I know a lot of mothers who do it, though. I think there are times when my son would have been to the hospital if I had gone in to see the doctor when he had a cold.

Senator KENNEDY. We are putting economics ahead of health.

Mrs. MAPES. Yes. And I know better. I know a lot about peoples' bodies just from reading things, and living. I've known about Government subsidies of big corporations and industries as long as I can remember, and I always thought it was necessary for the purpose of maintaining a healthy economy. But now I am wondering why some people in the Government believe that there is something morally wrong with people who are in financial trouble. They worry about Lockheed, but not the people. It seems to me that Government subsidies to keep people healthy are more important than anything else we are doing. Even if the Government werec oncerned with economics alone, taking care of the health of children and those who can't afford care would be a lot more economical than what is happening now. Thank you.

Senator KENNEDY. Very good. Well, that was a very eloquent comment. It shows that despite all the efforts you have made for your family, the system doesn't allow you to protect yourself.

Just tell me as a matter of interest, have you ever heard from that insurance company again?

Mrs. MAPES. No. I wrote them a letter and they just—they never bothered to answer, that's a fact. I forgot.

Senator KENNEDY. They didn't bother to answer?

Mrs. MAPES. No.

Senator KENNEDY. Is it a local insurance company?

Mrs. MAPES. It is Occidental, I don't mind saying.

Senator KENNEDY. Is that the one with that brand new building up there? You know where the premiums go.

Mrs. MAPES. Yes.

Senator KENNEDY. Thank you very much, Mrs. Mapes. Thank you, children, for coming. We appreciate your presence here very much.

Mrs. Shelene Eckerson.

STATEMENT OF MRS. SHELENE ECKERSON, RESIDENT

Mrs. SHELENE ECKERSON. Senator, I am a member of medicare. And I wanted to call to your attention this afternoon that I believe that the fraud that goes on in this program through doctors billing for service that hasn't been rendered might be in a great way responsible for the medical troubles that medicare is having.

Now, I find that old people are reluctant to report things of this sort. They are afraid of some sort of retribution; that they will lose service of some kind. And they don't like to say anything about it when they are charged for X-rays that they never had, and when their doctor tells them, "Well, I have to charge this much because the Medical Association wants me to and I will be in trouble if I don't."

So I would like to cite just one example of my own experience. My doctor sent in a bill to the insurance company for $270, which was a charge, she said, for surgery and general anesthetic. I was so shocked when I got this I just couldn't understand it. And my minister became interested in it, and he called her and asked her what it was for.

She said she had removed a bunion from my right foot. What had happened, really, was at that visit in her office that day, because my eyesight is poor and I had an ingrown toenail that I couldn't trim very well, I couldn't see well enough to do it, I just asked her if she would trim that. She immediately called her bookkeeper in to make an X-ray of my toe. That was made. And then I was taken into the treatment room where she shot some sort of Novocain, or something of that sort of thing, into the toe. She took her forceps and trimmed the toenail and that was it.

Now, she told the insurance company when they asked about it, because my minister had gone to the insurance company, too, to see what they would do about it, that she had scraped the bone of the great toe of the left foot. This is an example of what can go on in medicare. I don't believe it is an isolated case.

The minister called the Medical Association. They sent out an investigator. He took a statement from me. He examined my feet, both of them, and found no scars at all; that nothing had been done to them.

She had given the insurance company a different story. We don't know what the insurance company is doing about it. We don't know what is going to happen from these investigations.

Senator KENNEDY. Did you ever inquire of the insurance company?

Mrs. ECKERSON. Yes.

Senator KENNEDY. And what did they say to you when you brought this matter to their attention?

Mrs. ECKERSON. That they would investigate it. And then they finally called me. After several weeks they called me and said that she had said that it was a bone scraping. But that I had had a general anesthesia. I hadn't had any anesthesia of any kind except——

Senator KENNEDY. So they want ahead and paid it?

Mrs. ECKERSON. Medicare allowed $240 of it.

Senator KENNEDY. So they paid it; on behalf of medicare?

Mrs. ECKERSON. Medicare. The insurance company paid it, yes.

Senator KENNEDY. The insurance company paid it?

Mrs. ECKERSON. Yes, they paid it.

Senator KENNEDY. The just pass it on?

Mrs. ECKERSON. Yes. That's it.

Senator KENNEDY. The increase in charges that they are just passing back again to the consumer——

Mrs. ECKERSON. Now, this doctor is still practicing, although she has been denied privileges in two or three hospitals there. But she continues to practice. A good many of her patients that I have seen are Mexican, and many of them do not speak English. Of course, many of them are old like I am. Their sight isn't too good and you just don't like to read fine print.

Senator KENNEDY. Thank you very much, Mrs. Eckerson. Thank you very much.

That concludes the consumer part of the witnesses. Now we will go to the panel, and then Dr. Gerber. We are beginning to run into a time difficulty because we have just a little over a half hour remaining. But we will ask the professional witnesses if they will try to help us and summarize their testimony. I hope we will have at least 15 minutes to get some general comments from the audience.

We want to welcome you gentlemen. Mr. Mohn, would you like to proceed? We have here today Mr. Mohn of the Teamsters, Mr. Piercy, of the ILWU, Mr. Arywitz from the federation, and Paul Schrade, from UAW. Gentlemen, we welcome you. You can proceed. I don't know if you prefer any particular order.

STATEMENT OF EINAR MOHN, BROTHERHOOD OF TEAMSTERS

Mr. MOHN. Senator Kennedy, the sad story of America's health is already too familiar to you for me to repeat it. But I think you should know that California's unions have made an unusual effort to deal with health problems and the lessons we learned from that effort have led us to uncompromising support of S. 3, the Health Security Act.

A few years ago several of us in labor began to meet regularly to talk about what we could do to improve health programs and stabilize the costs that were just beginning to run away from us. We believe that we held in our hands some considerable power with the health industry. We represented a little less than 2 million members and their families. We were spending in excess of $750 million annually in negotiated health benefits and millions more out of our pockets. And that out of our pockets represented at least 40 percent in excess of the $750 million.

We thought that our purchasing power would give us leverage with the health industry. We were interested in supporting new forms of

health organization and expanding such systems as prepaid group practice and hospital-based delivery systems.

We also wanted the health insurance industry to help us in monitoring costs and quality and giving us information that we could use in measuring the performance of various kinds of providers. So we formed the California Council for Health Plan Alternatives Act as a research and educational development and policy coordinating body for the unions who were seeking the same goals.

We have had excellent help and still do from many outstanding health professionals, economists, health administrators, universities, public services, and others.

We have had many meetings of the major health provider organizations telling them of the needs and the wants of our group and what we are willing to do to work cooperatively with them to achieve those wants.

We try to develop positions and programs that would serve all Californians. We recognized that we could not just serve our union members, but that we were going to have to represent all consumers of health care.

We are good bargainers with our employers. We know how to make the most of our situation when it comes to wages, working conditions, and those things that are part of the employer-employee relationship. But the health industry is something else.

First, we need them. They don't need us.

Second, they have a good thing going the way it is and are not interested in change.

Third, they know we can't take consumer reprisals against them. We can't boycott doctors or stay out of hospitals when we are sick.

In other words, we learned the hard way that having millions to spend and millions of people needing services does not carry much weight with the health industry.

The providers knew something else: they knew that medicare and medicaid were in trouble; that the Congress and the public generally were going to call for some major changes in those programs and the providers wanted to wait and see what happened in the national and State legislatures.

Because health policy is now too big and too complex for us to handle in the marketplace because the big purchaser of health care is government, as great as it is, now at least $1 billion annually, our purchasing power is both too fragmented and too limited to bring real pressure on the health industry. Policy must be made by national and State legislatures, because that is where the real strength lies. So I and others became active in the Committee for National Health Insurance, and the California Council for Health Plan Alternatives is actively working on State legislation.

We need all the assistance we can get, and it would appear to us at this time that there is nothing but legislation on a national level that is going to in any way materially change either the delivery system, the quality, or have anything to do with the availability of health for the people that need it.

There is a great deal more in our experience that motivates us to support S. 3. Our bitter experience with private insurance, our lack of confidence in voluntary quality control methods in the health industry, our frustration in trying to get better distribution of health manpower

and resources, all these and many more items of discontent all add up to the imperative that brings us here and brings you here.

We need the Health Security Act now without compromise or qualification, and organized labor in California is devoting its resources to working for the passage of that bill in this Congress.

Senator KENNEDY. Very good. Thanks very much.

Mr. Piercy.

STATEMENT OF WILLIAM PIERCY, OF THE INTERNATIONAL LONGSHOREMEN AND WAREHOUSEMEN'S UNION, LOS ANGELES, CALIF.

Mr. WILLIAM PIERCY. Americans are now spending some $70 billion a year for health care, more than double the amount spent 10 years ago. Over 60 percent of this growth, however, has gone to meet price inflation, not for additional services. During this period medical care costs have gone up twice as fast as the overall cost of living. Hospital costs alone have risen more than five times as fast.

The sharper increases in medical care expenditure in recent years have not improved the quality of care, do not mean that more and more people have access to care, and are not indicative of a general improvement in health among the population. In fact, just the opposite is true.

For millions of Americans, comprehensive preventive care has become too expensive and thus not available. The general level of health of the population, when measured in terms of life expectancy and infant mortality, has deteriorated relative to other countries in the world.

By common census, our present health system is bankrupt and in a state of crisis. Five major causes of the system's deficiencies can be readily cited:

1. The prevailing payment system, called "fee-for-service," whereby practitioners charge a separate fee for each service rendered places a premium on sickness and encourages practitioners to charge all the market can bear.

2. The most common delivery system, solo practice, is ineffective. Doctors practicing alone cannot deal with the wide range of ailments they are confronted with without sending their clients to specialists and away from their offices for laboratory and X-ray work. In addition, when practicing alone they alone must meet the high costs of equipment overhead.

3. The geographic distribution of available medical care services in both urban and rural areas is insufficient. In rural areas doctors and hospitals are often not available for miles around. In cities medical and dental practices are usually found in the high rent, affluent neighborhoods and are few and far between in ghettos and working class communities.

4. There is a critical shortage of a variety of medical care personnel, and there is poor use of existing manpower. Medical schools are simply not turning out enough doctors to meet public needs, and an increasing number of physicians is engaged in research rather than in treatment.

5. Government, both Federal and State levels, has failed to effectively respond to public needs.

What is needed is a national health care system, one which is guided by two basic principles:

1. Everyone should get the care he needs when he needs it for as long as he needs it and without regard to his ability to pay.

2. The quality and comprehensiveness of medical care should be as excellent as possible.

After years of lobbying and educating by the International Longshoremen's & Warehousemen's Union, and the rest of organized labor, there is now widespread support for national health care of one variety or another.

Progressive forces led by such groups as the organized labor movement, the Committee of One Hundred for National Health Insurance, and the California Council for Health Plan Alternatives, have supported legislative means to reform the entire existing system.

Conservative forces, led by the AMA, various insurance company organizations, and backward elements of the two major parties, are sponsoring programs which will widen the availability of care but do nothing whatsoever to reform the basic ways in which such care is provided and paid for.

The President's plan has been attacked by the executive council of the AFL–CIO as being both piecemeal and inadequate. The council notes, and the ILWU agrees, it places main reliance on discredited private insurance which has been largely responsible for the high cost, low quality medical care we have today.

There is no indication that either the private insurance organizations or the providers of medical care would be subject to effective cost controls or quality incentives.

In reviewing the competing proposals for national health care, the International Longshoremen's and Warehousemen's Union has kept in mind various factors which have directly contributed to our present medical care nightmare. Medical, dental, and hospital associations operating without consumer involvement and direction have consistently failed to take the steps necessary to reform and revitalize the existing delivery system. The insurance companies, preoccupied with profitmaking, have merely stood in line for their slice of the action, failing to take any action whatsoever to protect the purchasing power of the medical care dollar and insure the quality of medical care provided.

Programs such as medicare, which have allowed the providers of care to be compensated according to their usual and customary fees, have merely fanned the fires of inflation.

There is absolutely no reason to believe that doctors, hospitals, and insurance companies can be relied on to create, develop, and administer a national health care system which serves the best interests of the American people. Their record in the past suggests dismal prospects about their ability to deliver in the future. We do not believe that just because a particular piece of legislation pretends to create a national health care system that it deserves our support.

In short, a bad bill which is poorly conceived and fails to come to grips with what is wrong with our present system would be worse than no bill at all.

The recently concluded convention of the ILWU has gone on record in support of the National Health Security Act, S. 3 and H.R. 22. It is our firm conviction that this particular bill offers the most practical

solution to our present medical care miseries. We joint with the rest of organized labor in urging its prompt enactment.

Senator KENNEDY. Thank you very much.

Mr. Arywitz?

STATEMENT OF SIGMUND ARYWITZ, EXECUTIVE SECRETARY-TREASURER OF THE LOS ANGELES COUNTY FEDERATION OF LABOR, AFL-CIO

Mr. ARYWITZ. Senator Kennedy, I am Sigmund Arywitz, executive secretary-treasurer of the Los Angeles County Federation of Labor. I have a prepared statement here which, in the interest of time, I will submit for the record and make a few remarks which, hopefully, won't take as long as to read my statement.

The Governor of California, in his efforts to drive a wedge between the rest of society and welfare recipients, has often made the point that he doesn't think Medi-Cal recipients here should get better care than working people. The truth is that Medi-Cal recipients aren't getting adequate care, and working people aren't getting adequate care. And if there is any difference, the solution should be to get the best possible care for working people.

In fact, the truth of the matter is that nobody in America is getting the kind of health services that this richest nation in the world should be able to provide.

I would like to tell you a story. Last night the county federation had its delegates meeting, and a member took the floor and he asked:

> When will it be possible for a working man who is not yet 65 years old and is not eligible for any other kind of care to get the kind of Medicare he needs?

He told the story of a son-in-law who had been economically wiped out by catastrophic illness. And it is for this reason that we feel that there is such a tremendous need for the enactment of S. 3.

We in the labor movement have negotiated plans which go to some very great lengths in meeting the medical needs of our members, but we know that every time we get improvements in our economic package the cost of the care goes up, the amount of care we are able to purchase is diminished, and we are in a never-ending cycle of paying more and more for less and less.

We have come to the conclusion that only through a national comprehensive health plan is it possible for everybody, working people, welfare recipients, and those of the higher middle class who even, whatever money they have, are not able to meet their medical needs, can get the kind of attention and care that they need.

This is the reason that George Meany, the president of the AFL-CIO, has stated that the enactment of S. 3 is labor's No. 1 priority for this year.

And I would like to take the pledge that throughout this country everybody in the labor movement is going to work tirelessly and do everything we can to make the enactment of S. 3 a reality.

Thank you.

(The prepared statement of Mr. Arywitz follows:)

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SIGMUND ARYWITZ
EXECUTIVE
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TESTIMONY OF

SIGMUND ARYWITZ
Los Angeles County Federation of Labor
AFL-CIO

before the

Subcommittee on Health
Committee on Labor and Public Welfare
United States Senate

Senator Edward M. Kennedy
Chairman

May 18, 1971
Los Angeles, California

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Senator Kennedy:

As you have undoubtedly observed, Los Angeles has a great variety of people, neighborhoods, and even climates. There is no other American community with as much diversity in style of living and structures as exists in this enormous metropolitan area.

Our health services are equally diverse. From university medical centers to store front free clinics; from traditional community hospitals to health industry entrepreneurs, we have a little of everything, including two of the nation's oldest pre-paid group practice plans.

"Diversity" has become one of those magic words to the AMA and other champions of the status quo. I recently heard the Health Security Act criticised because it would allegedly stunt the growth of "diverse" health systems and create a monolothic health plan.

Obviously, the charge that S-3 is monolithic is false and the AMA knows it. But if diversity is such a fine thing to have, why hasn't it helped improve health care in Los Angeles, where there are almost as many kinds of health plans as there are automobiles?

I think the answer is that most of our health plans vary only in the way the doctors and dentists profit from them and not in the way the patient is treated or the community is served.

As consumers, we do not have any real choices between health plans. The major pre-paid group practices have limited enrollment opportunities and in addition, Kaiser's rates in Los Angeles have risen as much as 33 per cent over the past two years for some groups (Teamster). That rate of increase puts Kaiser beyond the reach of many unions not to mention other less affluent population groups.

Except in isolated cases--such as OEO programs and some union owned and operated services--there are no consumer sponsored programs.

Much of our variety in health services in uncoordinated. Specialty services such as centers for eye care and multi-phasic health testing have spring up with little relationship to other services.

In fact, diversity in Los Angeles is just another word for fragmentation. We are still forced to shop around among service organizations trying to piece together a comprehensive program for our families.

It is clear to us that coordination of health services can be achieved only when coordinated payment mechanisms are used. We have supported the capitation payment concept for some time, not because we want to make all health organizations just alike in every community, but because we see the capitation payment method as the key to making the providers of health care responsible for organizing services.

Another AMA battle cry heard a lot these days is that the Health Security Act goes too far too soon, that if everyone has health benefits, the system will be flooded and overburdened.

That argument is not only phoney, it assumes that the present system is worth continuing, and assumption that those of us who use the system are not willing to make.

It seems strange to me that the health industry--unlike any other industry in our society--is afraid of too much business.

Is it because we have too little manpower? Maybe, but we know that the productivity of dentists and physicians can be greatly increased by the use of auxiliaries and even further increased by the use of new diagnostic and screening technology.

Is it because we are short of facilities? We have too many hospital beds already, so that isn't the problem. The shortage lies in ambulatory care facilities, but we have learned over the years that those facilities won't be built until people can afford to pay for them and under present private insurance structures, we are having enough trouble keeping up with the cost of hospital care without being able to expand our ambulatory benefits.

The real reason is a political one. Some elements of organized medicine know very well that if everyone in a community is financially able to pay for care, then everyone will demand it.

And if the health industry does not provide it, there will be demands made that the industry get itself organized so that the care is available. That means the industry will be forced to become responsible for the health of our communities and submit to some disciplines that do not now exist.

But if we don't put the pressure on through universal coverage and uniform benefits, when does the magic day come when the doctors and dentists are ready? How will they tell us that they can now serve everyone? Will they hold a press conference in the year 2000, maybe, and say that they have now got themselves all together and are ready for everyone to receive health care?

The health industry is never going to be ready and is never going to try to get ready until the public demands it. And the public can't demand it until we can pay for it.

Underlying the argument that we need to go slow is a pernicious and anti-social attitude. Some wealthy people are now getting complete health care and can afford it, even with the present system. Others are getting it at great sacrifice. Still others are facing financial ruin to get care. Still others must go through the humilitating welfare system to get help. And many others just don't get health care for financial reasons.

When someone argues that we should not implement a universal and uniform health benefits package because it will overload the system, he is really saying that we should keep out all those people who aren't getting care now until they can get care without inconveniencing the rest of us. And since the

people who aren't getting care are those unable to pay--regardless of their medical needs--then the argument boils down to a statement that health care should be restricted to those able to pay until the health industry thinks it has room for those who can't.

If it is true that the health industry can't care for more people, the only fair thing to do would be to refuse any services to some percentage of the population each year regardless of their financial resources. That way, we could assure the health industry a predictable and manageable population. The rest would do without health care. Millions do without health care now, but only because they can't afford it, not because they don't need it.

Obviously, my solution is absurd. But so is the argument that we can't open the doors to health care by removing the financial barriers. The lack of money is the least relevant and yet the dominant factor in preventing adequate health services.

George Meany has said that the Health Security Act is the major legislative goal of the AFL-CIO. The need is clear--your hearings here and in other cities across the country demonstrate that.

And the time is now. We cannot afford more years of aimless drift in American health policy.

Senator KENNEDY. Thank you very much, Mr. Arywitz.
Mr. Schrade, of the UAW.

STATEMENT OF PAUL SCHRADE, UNITED AUTO WORKERS UNION, LOS ANGELES, CALIF.

Mr. SCHRADE. I would like to thank you, Senator Kennedy, and the committee for sponsoring this legislation because it is so vital to every American.

You are also witnessing here today what is true nationally, and that is those of us who are privileged to lead labor organizations here in California are united behind S. 3 and H.R. 22. And although we have our disagreements, there is no disagreement on the need for national health insurance. That, of course, means a commitment to work for S. 3 and H.R. 22 as well as to speak out for it.

We of the UAW consider these hearings and the National Health Security Act as a tribute to the late Walter Reuther, because it was his determination and leadership that put together the Committee for National Health Insurance, and the movement of many groups to formulate the Health Security Act.

The president of our union now, Leonard Woodcock, is now the chairman of that National Health Insurance Committee and has testified and given the UAW's position adequately in terms of the needs of legislation, in terms of the need for this kind of a program.

I would like to point out, too, that health costs are not only expensive in and of themselves, but increasing health care costs helped create the General Motors strike which put some 400,000 members of our union on the bricks in order to prevent the General Motors Corp. from putting the burden of additional and increasing medical care costs on the back of workers. And we resisted that effort of General Motors. We struck that corporation, and we won on that issue.

Yet, it is only a limited victory because collective bargaining more and more is not doing the job of providing adequate and high quality health care.

And one other thing is happening to us in the aerospace industry. The cutbacks in defense and space, some of them legitimate, but without alternatives in terms of work for aerospace workers, means that we are narrowing our base further and further to finance programs and put health security agreements under collective-bargaining agreements in great jeopardy, as it does retirement programs as well.

In the automobile industry, particularly here in southern California, imports are having a tremendous impact on this industry, which has forced the cutback of half of the production of the Chrysler assembly plant here in Los Angeles.

Imports now have 43 percent of the market in southern California, as compared to 16 percent nationally, further reducing the number of workers involved in collective bargaining for health security programs.

In addition to the impact of imports, there is the impact of technology and the slowdown, the deliberate slowdown, of the economy by the Nixon administration. All of these things put our collective-bargaining health programs in grave jeopardy. And we believe that our responsibility to all Americans is to support a national health insur-

ance program for our members as well as other citizens who are not covered by collective-bargaining agreements.

Fo these reasons, you have our commitment from the UAW, and certainly from the entire labor movement, behind your efforts to win on S. 3 in this session of the Congress. Thank you.

Senator KENNEDY. I want to thank all of you gentlemen for appearing here. I have had a chance to familiarize myself with the various health programs that your unions provide, and they are among the most comprehensive in the country. But they are not, as you point out, as comprehensive as S. 3.

I think the fact that you are interested insures that millions of others will get full coverage is a great tribute to your concerns about the working people and the older people and the younger people and all people in the country. You could say, "Well, we have a pretty good program and we will just let others shoot for themselves."

But that certainly hasn't been the tradition of any of your organizations, and we appreciate it. Of course, we realize the enormous contributions that your groups have made to the development of the legislation, and helping and assisting us in the Senate and the Congress in the development of it. So we are enormously appreciative.

Let me just ask you gentlemen if you don't agree with me on this: I have difficulty in accepting the concept of the profit motive in the whole health system of this Nation. We think of free speech as a matter of right, free religion as a matter of right. I think Americans like to believe that quality education is a matter of right. We don't have it yet, but I think people feel that health as a matter of right is an inherent part of at least the ideal we should seek.

I feel that health is a matter of right. That is the underlying concept of S. 3, the Health Security Act. I wonder if you are troubled, as I am, in having a profit motive in the proposals that have been made by the administration? We don't include the profit motive in the education of the young people, and the question I would like to ask is whether you agree with me that we shouldn't include the profit motive in providing quality health.

Mr. ARYWITZ. Well, Senator, the problem goes beyond the profit motive. There is also the problem of the greed motive that some of these plans envisage. We agree with you that health care is a right, and there is certainly no need whatever for writing profit into the law.

Mr. SCHRADE. Yes; I would hope that you would prevent that from becoming part of the law, because the profit motive is a very dangerous thing and a demeaning thing in terms of the people who are involved that way.

Certainly we don't want the profit motive in education or health. We have it in terms of war. And I think that that is one of the things that keeps us involved in the kind of war production and the wars that we are involved in, although it is not the only reason.

So I would hope that the Senate of the United States and the House would stand up on this question and make health care a human right.

Senator KENNEDY. I want to thank you. Unless you have any further comments, thank you very much for appearing and the strong support that your organizations have been giving to this program. It will make a great deal of difference.

Now, Dr. Gerber.

Doctor, we welcome you here. I know you have some testimony. Why don't you proceed in your own way? We have a time problem, but we are very interested in hearing from you, so why don't you do the best you can?

STATEMENT OF ALEX GERBER, M.D., LOS ANGELES, CALIF.

Dr. GERBER. Thank you very much, Senator, for inviting me to discuss medical quality.

Of course, I am painfully aware of the socioeconomic conditions which have led to some of the horror stories that I have heard this afternoon. But I am going to restrict myself to simply a discussion of the medical aspects of low quality or poor quality medical care.

We claim that there is a crisis of medical care in this country, and how can this be? This country leads in industrial production and in the wizardry of our weapons systems, and certainly in the number of hospital room TV sets. And still we lag far behind many countries of the world in such indices of health care as infant mortality and maternal mortality and life expectancy. So it seems that there is an uneven texture to health care in this country because, unfortunately, World Health Organization statistics not only take into account what happens in San Marino, Calif., and in Searsdale, N.Y., but also what happens in Harlem, and Appalachia, and on the Navajo Indian reservations. And when it is all homogenized in, we are found wanting in the balance.

So, why isn't the richest and the most powerful country in the world also the healthiest? I think I am most interested in trying to improve the quality of medical care by eliminating the double standard of medical practice.

I think I first must qualify what I mean by quality medical care.

I consider high quality medical care chiefly in the realm of the professional competence of those rendering this care and the facilities which they have available. I want to distinguish this, I want to make a distinction between quality medical care and equality of medical care. I think under any system of health care in this country we are going to, in a free economy society, have people ride first class and economy class on the health care plan.

The important thing is not the accommodations of those passengers, but the fact that a single qualified pilot flies that plane for both classes of passengers.

So, to me, the amenities of medical care are not nearly as important as the competency of those rendering the care.

As a matter of fact, at this very hospital a patient in a six- or eight-bed room, sharing a common bathroom, waiting for laboratory tests, maybe waiting to get on the surgical schedule, can get far higher quality medical care than the wealthiest patient in a private hospital with carpeted floors, color TV sets, electric beds and an intercom system to the nurse.

The point is, that if that private patient had an incompetent doctor, and in my field if that patient had an unnecessary operation or an ineptly performed operation, he would have had a far lower degree of quality of medical care than the patient at this hospital who had a competent doctor operating upon them.

Now, we are told that the measurement of quality is very elusive; that it is difficult to discuss competence of doctors. Now, I would agree that you can't measure the competence of doctors in the same way that you can measure batting averages out to the third decimal point, or the percentage of completed passes by a quarterback. But certainly medicine knows how to distinguish between a superior quality medical care, excellent quality medical care, good medical care, poor medical care, and lousy medical care or, as Melvin Glasser would put it, rotten medical care.

In my particular field of surgery, at the present time, there are many unnecessary and ineptly performed operations by unqualified and untrained men. And these lead our statistics to go askew. Right here in California the medically indigent children under the Medi-Cal plan have their tonsils removed 10 times more frequently than the other children in the private sector of medicine.

Senator KENNEDY. Well, now, President Nixon said it was only four times as many.

Dr. GERBER. That may be the general average, but I happen to be familiar with the average in California.

Senator KENNEDY. No, four times as many in California. When I told that to the medical society up in San Francisco they said that the source wasn't right. And then I indicated that it was President Nixon.

Dr. GERBER. I think I know where that statistic came from, because a certain bureau in Washington called me about that statistic. It appears in my book, as a matter of fact.

The exact incidence of tonsillectomies among indigent children on the Medi-Cal program in California, those under the age of 16, is 40 per thousand. And I know plenty of fee-for-service group practice clinics where the incidence is only four per thousand. So, that makes it 10 times higher.

Senator KENNEDY. Do we have too many surgeons in California?

Dr. GERBER. I don't think so. I think that there probably is a maldistribution of surgeons.

Senator KENNEDY. Well, I mean, do we have too many tonsillectomies

Dr. GBRER. Well, I would think so.

Senator KENNEDY. You would think so?

Dr. GERBER. Pardon?

Senator KENNEDY. You would think so?

Dr. GERBER. Yes; because I think Swedish children are just as healthy as American children and the incidence of tonsillectomies in Sweden is one-tenth as high as it is in California. And I think these children who go to private fee-for-service clinics, or to the Kaiser Permanente Foundation for their health care——

Senator KENNEDY. Why do you think there are that number of surgical operations?

Dr. GERBER. Because we have a double standard of medical care in this country. Because we have one group of patients who get the very best that the world has to offer and another group of patients who get probably some of the worst. And the reason is that we do not control the practice of medicine strictly enough in our hospitals.

Now, ostensibly, medical care in hospitals is controlled by the Joint Commission for the Accreditation of Hospitals. But figuratively and

literally this is a "paper tiger" organization. They audit the quality of hospital charts far better than they audit the quality of patient care. And so we find that doctors who would be barred from operating at the veterans' hospital, or at a well-regulated civilian hospital, can operate with impunity at some of the smaller unregulated hospitals in this country. That is why I say we have a double standard.

To make it worse, you can't tell the player by his number. It is perfectly possible for a doctor who has not had a single day of surgical training in his life beyond his internship to list his name in the yellow pages of the directory as a surgeon, or in any other specialty, for that matter. There is no law that says that a doctor can't call himself a pediatrician or a gynecologist, or what have you, just by self-proclamation.

Evidently our laws are more concerned with bad food and mislabeled drugs than they are with bad medical practice and mislabeled doctors.

Now, how are we going to adequately control the quality of hospital care?

Senator KENNEDY. Now, if you could try to take about 3 or 4 minutes and summarize——

Dr. GERBER. All right; all I can say is that we don't have adequate controls at the present time. The external controls are bad because the joint commission has not lived up to its responsibility.

Internal hospital controls by peer review do not have a very impressive record, or the abuses which I have cited would not have taken place.

Certainly the insurance carriers, those who handle the purse strings, have been uninterested. They talk about computerized control of medical care at the present time, but I can assure you that if an untrained, unqualified surgeon performed an obsolete and unnecessary operation upon a young girl and the results were disastrous, which is a euphemism for you know what, the insurance company's computers wouldn't blink an eye if the fee that the doctor turned in was reasonable.

So, I will close on a higher note than the way I started. I just want to congratulate you, at least, on introducing into your bill some quality controls, such things as seeing to it that laboratories perform up to a certain standard, national licensure of physicians, ongoing and continuing education. But, most importantly in my field, the concept that any patient walking into a hospital should at least have the same protection that a passenger has when he steps into an airplane. That passenger is not concerned at all that the pilot is not qualified or trained to fly that plane, because that pilot is responsible for many human lives.

I can assure you that anyone who is placed on an operating table also has his life jeopardized So I am most interested in seeing that surgical procedures are carried out by those who are trained to perform surgery.

Senator KENNEDY. Thank you very much, Doctor.

Now, we are supposed to adjourn at 3. We have about 10 minutes. Gerardo Martinez?

If you could, just take a couple of minutes.

Will you tell us your name and where you live, Gerardo?

STATEMENT OF GERARDO MARTINEZ, OF SAN FERNANDO VALLEY, CALIF.

Mr. GERARDO MARTINEZ. Yes. My name is Gerardo Martinez, and I live in the San Fernando Valley.

Senator Kennedy, I would like to preface my statement by urging this committee that any future hearings that may be held in the Southwest, a greater effort shall be made by your staff in trying to seek the opinion of the Mexican American community as the problems that we have, especially in health, are compounded by unique variables that are not part of the rest of the national picture in regard to the problems in health.

The particular experience which I have, negative experience, if I may say, in regard to medical health is that my daughter, who was born after 6 months' pregnancy, weighed 1 pound and 4 ounces, and was given only one chance out of 20 to live. She is an adopted daughter. She was born in this hospital. The mother was destitute, and was presented with a bill of $5,000 after 3 months of being here in this institution.

We are fortunate enough, my family, in being one of a very few within the Mexican American community that do have job-related insurance. We are insured with a group carrier, Kaiser. I have to take my daughter at the age of 8 months, who is still very much underweight, at noon because she developed clear signs of being very ill; high temperature, very high, 103, difficulty in breathing, every sign for a lay person to notice that the child was very sick.

I have to call first. I call first to find out if they will be able to get the charts, or whatever, and be ready when we arrived. I was informed that I could not take the child as it was noon and the doctors had to take a lunch break and they were only able to take care of emergencies. This is a lay person that answers the phones, and this type of service, and he is not a registered nurse, or anybody else that have any type of medical treatment, as I was able to find out later, or medical education that would be able to diagnose, even by phone, which I am sure even the best doctor will not attempt, to be able to judge that a child in that particular case as I explained it would be able to wait an hour and a half until the doctor will see her.

I decided not to wait for him to call the doctor for him to tell me his advice whether to take her or not, but to take her immediately.

There again I have to face just the receptionist, no one that has been trained in any way in the medical field.

I was advised again that if I had called and the doctor had advised me to bring the child in. I refer again to the previous conversation a few minutes earlier over the phone, and the people got very upset. Nevertheless, I was able to force my way, and I do mean force my way, in order to get a doctor to see the child.

The baby was found to have what the doctor, after he knew everything that had been going on between me and the receptionist, qualified as a touch of pneumonia, was put under oxygen and was kept in the hospital.

My question was that after this happened I tried to reach the medical director of the institution because I well know that in that partic-

ular geographic area many of the people that are insured to them as they are job related are Mexican American and many do not speak the language. And if I had not been able to speak the language, I am sure that I wouldn't have been able to make that hour and a half and get my child to be treated immediately.

Now, I don't know, doctors on the outside who I have talked to about it assured me that under those circumstances it could have been fatal. This I do not know. But I do know that the child was very sick and needed treatment and yet the treatment that you are getting through your insurance, which is not free because we are paying $35 per month for this, plus $7 that the employer pays for it, we are not able to get it. Trying to reach the medical director, I was informed that he will not receive anybody and that I will have to write a letter to him and explain why do I want to meet with him.

I would like to at this point emphasize that I was not violently seeking a meeting with him, but I was trying to be as polite and as calm as anybody can be.

Finally, I have to write a letter asking, with copies to the insurance commissioner of the State, and to some people that are supposed to be the parent company in California, in Oakland, Calif., trying to seek an appointment with the medical director in order to find out if this is a practice in this place. I was told that I was—as I requested that I be—he would be giving his own time in order to insure that I be able to see him, I was told that at 7 o'clock in the morning——

Senator KENNEDY. Can I ask you to take about one more minute?

Mr. MARTINEZ. I was told that medical care should be judged by doctors, not lay people. And it was not my business. And there were doctors who should sign the medical way it should be administered.

I happen to disagree with that when it is the life of my own child that is at stake. I am sure everybody would agree with that.

Senator KENNEDY. You could tell when your child was sick, couldn't you?

Mr. MARTINEZ. Yes.

Senator KENNEDY. You could understand that very clearly?

Mr. MARTINEZ. Yes.

Senator KENNEDY. And all you were trying to do was to get some treatment for her?

Mr. MARTINEZ. Yes; but the point, Senator, is that many of our people in the Mexican community cannot bypass those barriers that are being put in front of us like the one that was put in front of me. I happen to be pushy, and I can find my way through. But they will not find their way through in more than 60 percent of the cases, and that child could have died if it would be somebody else's child.

Senator KENNEDY. Thank you very much.

Dr. Rex Green will be the next witness. He is a house officer.

STATEMENT OF REX GREEN, M.D., LOS ANGELES

Dr. GREEN. Thank you, Senator Kennedy.

Senator KENNEDY. We will ask you to keep within the time limit.

Dr. GREEN. I realize that the brain can't absorb what the rear end can't endure.

My organization has a 2-year history of activism for patient care issues in this hospital, and I would like to briefly share with you some of our problems and our aspirations.

Two years ago we became confronted with an untenable situation here where we felt the number of patient admissions to the medical service was beyond where we could deliver any decent semblance of adequate medical care. So through a long series of discussions and threats, and what-have-you, we have finally come this last year to serve a lawsuit against the administrators of our hospital and the Board of Supervisors of Los Angeles.

The basis of our lawsuit is because we don't have any answers to our problems. We are bitterly frustrated by these problems. They are extremely complex. There is no simple solution, though we have tried. But we have discovered in our efforts in the last 2 years that we are not administrators. We don't really know how to run a hospital very well. At best, we know how to identify our own problems as physicians here and we seem to have many opportunities to identify these from 1 day to the next.

The substance of our suit is, and at least it is important to us, we feel as physicians, our organization, that it is unprofessional and unethical to deliver two-standard medical care. We have asked our board of supervisors to enjoin the hospital administrators to prevent our delivery of this care in the future, and at least to prevent the delivery of patients to beds which don't exist in this hospital.

I am sure you recall this morning mention that the utilization of some medical wards is greater than 100 percent in this hospital.

Senator KENNEDY. Which means what?

Dr. GREEN. Which means that patients go on beds in the public hallway with no privacy, no facilities for their care. On that level, the problem seems simple. But it is not. We have tried.

Again I say we are not administrators and we are not politicians. We have tried to find answers for 2 years. We wish there were some forthcoming.

So, rather than dwell on the history of our frustrations, I would just like to briefly mention a few things we hope to get results in in the future. Our greatest worry is a fear that there is a great deal of preoccupation and competition only on one aspect of medical care, and that is the financial aspect. We feel there is a tremendous problem——

Senator KENNEDY. Finances come before health?

Dr. GREEN. Yes, always; we feel that there is a tremendous problem in that the structure of medical care has to be changed. When Dr. Bauer mentioned this morning that if a patient feels he is an emergency he is an emergency, we feel that is true. There is an absolute need for access to medical care. Patients can't just be left sitting because a physician or one paramedical person feels that might be an emergency case.

But, more importantly, the whole structure of care needs to be reanalyzed. The anachronisms of having university hospitals which are tax-supported, but which the taxpayer can't get into, and the county hospitals, which the taxpayers pay for but can get into sometimes at their jeopardy, and so forth. The complexities are endless.

We hope these issues are not lost in the effort just simply to pay for the cost of medical care.

Senator KENNEDY. That's a good comment. He tells it like it is. Mike Wood? Is he here? Mike Wood?

STATEMENT OF MIKE WOOD, RESIDENT

Mr. WOOD. Can I have more than 1 minute?

Senator KENNEDY. The same as Mr. Martinez and Dr. Rex Green. If you can do it in less time, we will appreciate that.

Mr. WOOD. I will try to read as fast as I can.

In 1967, out of the hippie subculture a new model of health care delivery was derived, basically, free clinics organized by the communities for the communities, the purpose being as stated in one of the particular bylaws: to serve that portion of the community whose needs are not adequately met by existing facilities.

In southern California the free clinic concept has grown from one free clinic which opened in 1968 to 30 now, treating originally 20,000 people in 1968, 200,000 in 1970, and this year we expect to treat over 300,000 people.

The statistics don't mean a whole lot, except the fact that a need is being fulfilled in the community. We don't lecture, moralize, judge, or preach. We help. We don't look down our noses or assume someone a lesser person because he is black, Indian, Chicano, Oriental, or poor. We only help. The free clinics are supported by donations of staff and volunteers.

Our average cost per patient is about $2. The clinics try to help anyone in any way and to treat the whole person rather than a symptom. The services in the clinic range from medical, dental, psychological counseling, legal, job counseling, food, schools, as well as many others.

The increasing emergency situation in health care, one of our county hospitals is going to have to close their doors to certain cases that are not being met by the Government. Medi-Cal cutbacks. The local government doesn't have the money to do the job, much less keep up with it, and the community can't be expected to fully support the clinics.

The free clinics are, have been, and will continue to do their best with what they have, a feeling, which is the most important factor. We don't think of our job as being our brother's keeper, but rather his friend, his helper, and his brother. I feel that our priorities in this country must be reevaluated. For example, if the money spent on one rocket that is sent up and blown up, was taken and spent in the free clinic thing, the free clinics could do a job that would be unparalleled in the history of this country as far as the health care delivery is concerned.

The Constitution of our country has great rhetoric guaranteeing a lot of rights. These have been lost and misinterpreted. Rockets, the SST, the southeast Asia war do not protect or fulfill any of these rights. Education is considered a right and is even considered a law. Health seems to be considered a privilege. It is not a privilege. Health, in my opinion, is life. And life is one of those supposed rights that we are guaranteed by the Constitution.

With your bill we are embarking on national health insurance which will enable the consumer to receive the health care that he deserves and needs. The free clinics, as providers of medical services, as well as social related services, look forward to comprehensive national medical health insurance with humanization. I emphasize that again: with humanization.

During the interim, until it is implemented, the free clinics of California need support to continue to help serve the people that we do.

I would like to thank you for the time.

Senator KENNEDY. Thank you. Good statement.

(Whereupon the hearing was adjourned at 3:10 p.m.)

HEALTH CARE CRISIS IN AMERICA, 1971

TUESDAY, MAY 18, 1971

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Los Angeles, Calif.

The Subcommittee on Health met at 4:20 p.m. in the UCLA Medical Center, Los Angeles, Calif., Senator Edward M. Kennedy (chairman of the subcommittee) presiding.

Present: Senator Kennedy (presiding).

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

Senator KENNEDY. The meeting will come to order. We have an hour, maybe less; about 55 minutes. Perhaps it would be useful if everybody identified themselves, just so we get some kind of feel for who is here and the various groups that are present. A lot of you may know each other, but perhaps not.

We want to thank the staff of the school for being kind enough to permit us to have this extremely fine facility and to make the arrangements. We will just start off by introducing each other.

Mr. MCKINNEY. I am Vermont McKinney, Director of the TBA program in Venice and also with the Venice Health Council, trying to meet the needs of the Venice community.

Dr. MELINKOFF. Sherman Melinkoff, M.D., dean, UCLA Medical School.

Dr. TRANQUADA. I am Bob Tranquada, associate dean of the USC Medical School.

Dr. SPELLMAN. Mitchell Spellman, dean of the Drew Postgraduate Medical School.

Mr. BRAYTON. Donald Brayton, coordinator of area IV, California regional medical program.

Mrs. BUSCH. Mrs. Lynn Busch, administrator of the Venice Health Council.

Mr. CANTRERAS. David Cantreras, president of the Venice Health Council.

Mr. DIMITROFF. Steve Dimitroff, assistant manager, Venice Service Center.

Dr. BRESLOW. Lester Breslow, professor, chairman of the Department of Community Medicine, UCLA.

Mr. HARRIS. Jeff Harris, fourth-year medical student from UCLA with an interest in pediatrics and public health.

Mr. FERGUSON. Randy Ferguson, community organizer, East Los Angeles health task force.

Mr. MARTINEZ. Claude Martinez, East Los Angeles Congress of Mexican-American Unity, a local development corporation.

Mr. COMACHO. Andy Comacho, East Los Angeles Health Center.

Mrs. GUZMAN. Carmen Guzman, also of the East Los Angeles Health Center, but also a community person from East Los Angeles.

OLGA TAMSKAC. Olga Tamskac, dental patient and also medical technologist.

Mr. FEDOUSKY. Stephen Fedousky, fourth-year medical student.

Miss FIELDS. Anastasia Fields, Southeast Community Health Council.

Mr. SKOW. Jim Skow, senior surgical resident, UCLA Medical Center.

Mr. MCKAY. Bob McKay, resident in psychiatry.

Dr. MELINKOFF. And there is Harry Parker.

Senator KENNEDY. Well, I think one of the things that I would be interested in, and perhaps some of you might comment on, is the role of this medical institution in the community and what is expected of it by the community. How realistic is it to expect that an institution like this is able to meet these needs? What ought to be done to try to change it?

Maybe we can start off with this, and then we will move from there.

What is your feeling about the role that this institution should play in the community?

STATEMENT OF VERMONT McKINNEY, DIRECTOR OF THE TBA PROGRAM IN VENICE AND THE VENICE HEALTH COUNCIL

Mr. MCKINNEY. Well, maybe I can start. We see this university as having the resources and being able to get to those resources to help the nearby private community. We feel that no longer can a hospital of this nature remain in their own ivory tower, so to speak, and not particularly relate to minority communities. And I am talking about poor black and poor Chicanos. At this point we have been knocking at the doors here to try to point up an acute problem in the poverty areas, which is drugs, and it is a national issue. We are trying to get the staff here to relate to us in relation to the overall drug problem. We are concerned that if this institution is getting at the question, the real questions in the health field, and trying to improve the health care of the people, and particularly of the people who have done without good health care, that they have to begin to relate to the community. People have to begin to come down, there has to be many, many more sitting down at a table like this with people who really have some real needs.

And we think that there is no question, the community doesn't have the resources. They don't have the contacts. The way things are set up, they are almost caught in a vacuum. We think that at this point, in terms of this being a teaching institution, that the way to learn about the real needs, that doctors, nurses, everyone concerned is going to have to get out in the community.

We are talking about trying to develop a concept of street doctors, and that would mean that doctors have to be close to the people in the

community that are really having the problems and whose needs aren't being met. We know that the resources are here, but this means some official change in direction from the departments of psychiatry, and from other parts of the hospital, to begin to move in this direction.

We know right now that in terms of inadequate health care in the communities, there are more people from the Venice area who know what is happening. This community has been isolated, and we need support. Some of the people in the community, and also some of the major providers, such as Dr. Breslow, and some other people in this area, have gotten together to try to look at what can really be done in terms of endowment, and the health crisis, and I believe there is a health crisis in this country.

There is more crisis than just health crisis, so far as that is concerned, but there is definitely a health crisis also. And we have people, of all kinds and ages suffering. But I think that we have to start sitting down at the table and not just presenting more tokenism to poor people, but allow poor people to really participate in the decisionmaking process.

This is what I am concerned about. We are raising certain questions about citizen participation, particularly for those that have been excluded, and that means from the board which may be established from HEW all the way down. From the top down, we are talking about citizen participation and involvement of the minority communities in decisionmaking when it comes to the delivery of health services. And this is important, very important, when it comes to the people who feel excluded.

I think also that those who are presenting certain kinds of health plans, such as yourself, must visit those communities, let them know what kinds of things are being thought about, and how they can possibly have input to these considerations. What kind of input can they have? Right now we are trying to form what we call the health congress for this area to allow the presentations of certain kinds of bills and other things, to the people so they begin to understand.

This health congress, we are trying to establish in September, and we would like people like you to come down and present what you really see, you know, as an answer to the health crisis in this country.

STATEMENT OF MRS. LYNN BUSCH, ADMINISTRATOR OF THE VENICE HEALTH COUNCIL

Mrs. BUSCH. I think there is one more issue that should be brought up, and I think that there is a dichotomy in health care delivery that causes a great deal of confusion.

For instance, in our area, which is in such close proximity to UCLA, the Venice-Santa Monica area, we, on one hand, are hearing about national health insurance and improved health delivery systems, and on the other hand the consumers are hearing about budget cuts and fee increases.

You hear it at places like UCLA, which causes a great deal of confusion in terms of health care delivery.

Too, there are situations that don't function well. Last summer, there were some students who were to be studying health problems,

and in Venice we may have made a mistake. We assumed that a couple of students would be coming down to study the local health problems that are within 13 miles of the university. Instead, they were sent to Alaska and Arizona. And I think that this represents a situation that creates a lot of problems for the people who are in the general area of these big institutions, that could be helped easily.

STATEMENT OF JEFF HARRIS, FOURTH-YEAR MEDICAL STUDENT FROM UCLA

Mr. HARRIS. I would like to go on from there. I think the university has done a few positive things, one of them being——

Dr. MELINKOFF. Thanks, Jeff.

Mr. HARRIS (continuing). One of them being working with the Charles Troost School, and that development. Another being working with RMP and OEO involving the health care network in the San Fernando Valley. But I think they have been very deficient in exposing medical students and house officers to any other situation than the traditional hospital settings. We don't really have any formal outpatient experience as students, as a requirement in our curriculum. We really don't get out and wrestle with some of the community needs as they are in the neighborhoods. And I think Venice is one example where we could be doing more and helping out, perhaps, with the community, to set up a neighborhood health center that would interlock with UCLA.

But I think if we are going to look to solutions in the future as far as health care delivery systems, we have to have students and young professionals getting involved in that solution process early in their training.

Senator KENNEDY. Does the community want young interns coming out to it? Or does it feel that this is just sort of a continuation of the teaching process and, "They are using us poor people as guinea pigs"? How do they react to that?

Mr. HARRIS. I think there is some——

Senator KENNEDY. Well, maybe they have—I don't know, how do you react to it? Do you want an Outreach program from this university with some of their topflight students going on out, that does have some supporting help and assistance from the school? Or would the community feel that, "Here comes some young students and interns and they are practicing their medicine on poor people"? What is your reaction?

STATEMENT OF ANDY COMACHO, EAST LOS ANGELES HEALTH CENTER

Mr. COMACHO. Well, my response to that, coming from the East Los Angeles area and working closer with the medical center of the University of Southern California, I don't think we want interns and residents out there practicing medicine. But they can help us do other things, such as planning, such as program development for the area, for the community; program development for the health network that we mentioned, for instance. They would have the inside information as to what goes into the programs of that nature.

They could also help recruit minority people, minority students into the medical schools and the schools of allied health. But I don't think that the poor people want second-class medicine. I don't think we want interns and residents practicing on us. I don't really think that that is what we want.

Senator KENNEDY. What kind of medicine do you think is practiced here?

Mr. COMACHO. I really don't know. I don't know too much about UCLA because Venice and Westwood, west Los Angeles and Santa Monica areas are more closer to the university here, where east Los Angeles is quite a way off. And I don't know how many people from east Los Angeles would be coming out this far for medical service, or psychiatric services.

Mr. MCKINNEY. We think it is primarily research oriented, as far as the practice of medicine here, and we are saying that it has to include service at the same time. And we have had people coming from the community saying they have been treated like guinea pigs, or there is a wall, and other kinds of things that happen here because this is a strange world to them as compared to down in the community.

And so we recognize it as institutionalized racism. We know this.

The community people want some kind of services, but they know it goes back to costs again. The cost factor comes up again and the poor people can't go any place to get services, so that they have to become research animals because they can't afford to pay for the medical services.

Mr. FERGUSON. Senator Kennedy, I think that you will find that the same problem exists here as in the Los Angeles-USC Medical Center, with the medical staff not speaking Spanish and not being able to communicate with the patients that are Spanish speaking. We at the health task force do get complaints from Spanish-speaking people in this area that utilize this facility, and they are the same.

They bring their children up, the doctor can't make a proper diagnosis or can't dispense the medication properly because of the language barrier, and this definitely should be corrected in terms of Spanish-speaking representation on the staff of the medical center. Training for these paraprofessions should be set up so the Mexican Americans and Spanish-speaking people can be included in the medical profession.

Senator KENNEDY. Why don't we talk just a little bit about the minorities in the medical schools.

STATEMENT OF MISS ANASTASIA FIELDS, SOUTHEAST COMMUNITY HEALTH COUNCIL

Miss FIELDS. I am Anastasia Fields, from Southeast Community Health Council. We are in a unique position. UCLA is so far removed from us, it is something we read about, or see on television. And we receive very little contact or benefits from the school in our community.

At the same time, USC General Hospital is quite a distance from us, but that is the place that we are most closely connected with.

A part of our concern is that we have few or no black or Chicano administrators or doctors. The patients go into the hospital, but the training that is received is not brought back into the community. We

have no avenue to bring it back into the community. We have been trying to determine how many black students graduate from USC, and how many black students have graduated from UCLA in the medical, dental, and nursing departments. I can't quote a definite figure, but we do know that it is a very limited number, and with as many people as there are in Los Angeles and the surrounding area it seems that we should be able to have more of the minority all the way from the administration down, rather than to have maybe a far-away assistant. This would help, especially with this language barrier.

Back to our unique position. We have little services in our area. Our community council has been working on an emergency service, an interim service. We work very hard on it. But then when the cutbacks came, we found that we couldn't get any money. So a part of our concern is students. There is a 2-year nursing course in the junior colleges. We are not objecting to this, but the tuition, and the costs of going to a 4-year college is rather prohibitive for the minority students.

We are wondering if there isn't some adjustment that can be made wherein these students who are interested in the medical professions couldn't have some assistance in attending the 4-year school to begin with.

STATEMENT OF RANDY FERGUSON, COMMUNITY ORGANIZER, EAST LOS ANGELES HEALTH TASK FORCE

Mr. FERGUSON. Senator Kennedy, I think there is another problem that may be contributed to here today. There is a problem of representation of community people. I don't believe that there has been much effort to notify the community people in Los Angeles and in east Los Angeles that you were going to be here today. And they, you know, didn't really have the opportunity to come up here.

At the medical center, I was there about 1:30, 2 o'clock, and I found the community people were being locked out and kept out, and there were nurses and county employees and professional people allowed to come in. There was about 500 people there, and I think 75 percent of them were county employees. And the community people were in the hallways and could not come in.

I think that this is another problem that we have. The people keep the community people away from decisionmaking places and from attending the meetings where, maybe, they could have some effective input.

Senator KENNEDY. You mean at the last hearing you couldn't get in?

Mr. FERGUSON. That's right. I believe a sergeant at the door told me that he didn't care where I was from, that he wasn't going to let me in the door. This is the type of attitude that you run into.

Senator KENNEDY. I think in fairness it was pretty crowded. I think that they opened it up later on. I did hear that there was a pretty good flow of people through there. But, obviously, this is important.

We all have these difficulties that we face in terms of notification and sufficient time, because the Senate is in session at this time. But I think that we ought to make a better effort at it.

STATEMENT OF MRS. CARMEN GUZMAN, OF THE EAST LOS ANGELES HEALTH CENTER

Mrs. GUZMAN. Senator Kennedy, I don't think that is an excuse, because I think we are going to have to sacrifice many things. It is time that we—if you are coming from so far to listen to us—communicate with you.

I do not see Indians here. I do not see Asians here. The Asians, too, are hurting by the bilingual communication, or not being able to speak English. And they come and they have their problems, too. They are more conservative and they probably are not coming in on this yet.

Yesterday I heard a young man at the end say, "Senator Kennedy, are you going to do anything about the narcotics or the police brutality?"

I have brought you some literature from East Los Angeles, and I hope you read it on your way back, and maybe we can, through the health task force, continue to send you literature. We have been too busy with other things that we haven't communicated in this way, but without having a comprehensive help in every area with creative ideas from people who know what is needed in the community, or with the people suffering in narcotics, or child guidance, or family planning, we are never going to get anywhere. And these things have to be included in whatever insurance you have.

It has to be pinpointed, which way it can be done better. Only the people who live there can help you.

No matter what, if you do not arrive here, we would understand. A lot of poor people cannot get out. That's all I have. Thank you.

STATEMENT OF MISS OLGA TAMSKAC, DENTAL PATIENT AND MEDICAL TECHNOLOGIST

Miss TAMSKAC. I think we need a better, well-informed public, and the communication media is ideal because children of junior high school age are discussing among themselves programs that have been on TV, and they are very intelligent, mature. And another thing, the reaction of former patients of UCLA is nothing but favorable. And in my own experience with the dental clinic, they are so thorough and so competent that I have no excuse to complain, nor have I heard complaints.

Mrs. BUSCH. You know, the people in the individual communities know full well what the major problems are, and each community has problems that are universal, and at the same time they have problems that are unique to that particular area, a particular ethnic group population.

I think one of the biggest problems that all of us are faced with is m-o-n-e-y.

I heard the lady—I am sorry, I forget your name—from the southeast talking about money to help students to get into the health profession. We need money to implement the drug programs and family planning programs that Mrs. Lewis was talking about in east

Los Angeles. In a community like our own, which is a small community compared to southeast, or east Los Angeles, we have on our own, with creative and innovative ideas coming from the community, established our own medical center on a very small premise compared to something like UCLA. Like Mr. Harris was talking about. We have gained the backup support from UCLA and from two other major hospitals in the area. We are struggling for survival.

We have managed to open up a clinic under control and supervision of the community that relates to the problems in our own community, and we have managed to gain the support of the hospitals in the area. We have seen over 2,000 patients in 8 months. Probably many of them would not have received any medical care if we had not been right there in our own community.

And now we are facing doom. And in a short period of time we may be forced to close our doors because of lack of money. We have spent, I guess, maybe 50 percent of our time just struggling for funds. There seems to be a real problem with filtering money from the top to the bottom where people are struggling to do things for themselves and where they have managed to get things done, and then these programs fall apart; are crucified, really, by lack of small amounts of money.

These small neighborhood programs don't cost as much as sustaining a war in Vietnam, or other big projects that this country manages to keep going.

We are not talking about billions and billions and billions and billions of dollars to keep small health clinics going in individual communities or small drug programs going. We are talking about money in terms of thousands of dollars and hundreds of thousands of dollars. And it certainly seems to me that there needs to be a change somewhere in the system for dividing money in this country so that these programs can be given life instead of death sentences.

Mr. FERGUSON. Senator, community people look at the medical institution as a place where their illness is held. Institutions usually look at what they are doing as teaching, research, and healing also. But what I would like to interject is, perhaps, another function of our city, or of the medical school and the hospital, and that is an economic function.

The hospital, both here at this medical center at UCLA and the USC Medical Center, purchases goods. They buy quite a lot. Quite a lot of economic units. But where do they usually buy it? The USC Medical Center is based, and it is right in east Los Angeles, one of the largest buyers of goods in that community, and I venture to say that less than 2 percent of their budget, other than personnel, is spent inside of that community. I don't want to add to the indictments that have gone on here today, but I would think that it behooves the administrators of these medical centers that they should encourage economic development in their community.

This would help the problem that the young lady here was talking about for programs. It would help to bring alive a community, and I am speaking of east Los Angeles right now, that is dying. If a hospital's function is to save lives, I submit that a community has a life that has to continue in existence, and if the university closes its eyes

to the surrounding community, then it is not fulfilling its function.

And again I submit to you that these administrators should begin to think in terms of bringing to life a community that is dying.

Miss TAMSKAC. I would like to see more paramedical courses introduced into the junior colleges and into the regular colleges, also. There seems to be a lack of training in particular colleges, anyway.

STATEMENT OF STEPHEN FEDOUSKY, FOURTH-YEAR MEDICAL STUDENT, UCLA

Mr. FEDOUSKY. I don't believe that there is a resentment and reaction to interns and residents going to the community. UCLA dental school has created the Venice clinic for impoverished people, and the reaction is nothing but very good. And I think they are getting the same treatment as families of much higher income are getting here at UCLA.

I think that it is important to recognize, that there is a good reaction in the community.

STATEMENT OF MISS ANASTASIA FIELDS, SOUTHEAST COMMUNITY HEALTH COUNCIL

Miss FIELDS. Well, in my community I should like to see more assistance from our University of Southern California. We sit just outside of their boundaries, and health is an overall thing. Homes are just rundown. It seems that the medical department could encourage the architectural department to lend some assistance to people in the community in planning to redevelop our cleanup—not necessarily cleanup, because the area is old. But we need a redevelopment program.

However, the people who live in the area are senior citizens, or they are on welfare. And the people who own the homes are absentee landlords. But those people who do own the homes are senior citizens who are not willing to pay to rebuild the whole area. But they would repair their homes. And it seems that the improvement of the home would improve the thinking of the people, or the overall health of the people who live in the area. It would help to eliminate some of the rodents and the other problems, that we are having.

So, to me, and to some of us in our group, it does seem that this health thing would sort of trickle down into the other departments of the school. Transportation is a big problem in our area, even from the school, from the home to the General Hospital. You know, those are big problems. It seems that the school could help us work out some means of transportation that is more convenient than having to ride about an hour to get out to the hospital.

Senator KENNEDY. What do you think is at least a partial answer to bringing health into the communities? I mean, do most of you subscribe to the neighborhood health center concept, or do you find problems with it? What direction would you think?

Mrs. BUSCH. If it could be financed in a way that is part of an ongoing and workable health network, then I think, it is the ideal health program because you are talking about health services within walking distances of people who are trapped by things like she was talking

about, lack of transportation. But it should be a way of filtering people into the major services. You can't possibly talk about putting a hospital in every couple of blocks in each little community. But if you talk about a mininetwork that filters people into the major services, and then filters them back into the community, a place that is well-equipped enough to do the necessary followup, and that has the backing and the finances to move the people into these institutions where the costs usually prohibit their using it and then back into the community, I think it is the ideal answer in the small communities.

Mr. FERGUSON. Senator Kennedy, I would like to ask for your commitment to look into the plan that the East Los Angeles health task force has for a comprehensive health network. It is a plan to deliver a first-class medical system, first-class medical care to the community. It has community input. And I think that if the universities, the Government, that deal in medical services would let the community people do the work, have the input, have the say-so, that we would be a lot better off in terms of meeting the needs that do exist in the community.

If we can have your support, after you see the plans that have gone into this, it would be greatly appreciated.

Alcoholism is something that I would like to talk to you about a little bit. I think there are about 400,000 alcoholics in the county of Los Angeles. And out of that 400,000, I think 85 is the percentage of alcoholics in the east Los Angeles area. The work that has been done in alcoholism is very minute. The problem is so intense, and yet there hasn't been that much input by, again, the universities, the Government facilities, at all. There is the problem again, of language. The problem of money. The problem of giving quality care to alcoholics, done by the people that have the expertise, the recovered alcoholics, the people that know the problem. This is another problem that we have.

Senator KENNEDY. We have your program. I received it last night down there, and I am extremely interested in it.

Mrs. GUZMAN. I wanted to add one more thing, Senator, because I don't think that you have dealt with Mexican people.

(Mrs. Guzman addresses the subcommittee in the Spanish language.)

Mrs. GUZMAN. Now, the reason I am talking to you that way, Senator, is that many of our parents or mothers do come very recently from Mexico, and many of the families, the head of the family is the man, whether he has a lot of money, little money, or no money. He has a say-so if the wife goes to the clinic to get a Pap test, or to practice family planning.

We have need to do a great job in education. And like Randy says, we don't even have any alcoholism treatment. We don't have it in any area. And we haven't even touched mental health, and all the areas; just name them. Nothing has been done.

Now last night you saw that beautiful little child and youth clinic. But do you remember how you climbed that hill? Did you walk it?

Senator KENNEDY. No.

Mrs. GUZMAN. Did you see the beautiful lights when you were coming down in your automobile?

Senator KENNEDY. Yes. We got there just at sunset.

Mrs. GUZMAN. It is a very high hill. Very high. And at one time there was no transportation. Imagine a woman carrying a child up to 8 or 9 months, close to 9 months, in the rain and in the hot sun. Not until recently did they start putting a little bus going up there.

Why did they put that thing up there? And imagine two people who need a job, they don't have the fare for that. Even the three tokens, we call that the TJ bus. Now it is a little higher.

For years and years while this was built, they had to climb that hill. By the time you got there I don't think you even wanted a job or you wanted to go to the clinic. Now they have that transportation. I just wanted to let you know.

But as far as our culture or the culture of the Orientals or the Indian, we must respect their dignity. We must respect their ideals. We must respect their ways of living. And we will make a better America because we contribute something beautiful. We cannot be a melting pot. I don't think it is a very attractive thing to have everything look alike. I think it is more beautiful, like in art, where you have a variety.

So, we must look into the culture of the pople and service those people as they need it, just like Lynn says. She knows in her area how much they have fought, not only for the English-speaking people, but they have a wonderful way of even getting translators or having Spanish-speaking people.

But this we have to really go back to the individual people in their own culture and their own—like if I went to your area and I forced you to eat chili beans, which a lot of Anglos try to make me eat chili beans, because that's all I know how to eat when I work in the home. They make me a big pot of chili beans.

I say, "What's that for?"

They say, "Well, Carmen, don't you eat chili beans?"

You know, even though we are poor, and everything, I know how to eat filet mignon, lobster, crab. And now they have TV—I would like to have a home something like those rich people have. The children see Cadillacs, and television has opened the eyes of the people. We want a little piece of that. We are never going to get it if we don't get out of poverty, which is the worst thing, more than anything else. If we alleviate some of the poverty, I think we are going to have a little answer to some of our problems.

Mr. MCKINNEY. How does the plan that you are proposing affect poor people?

Senator KENNEDY. Well, it is going to provide one standard of quality health care for all people, not just poor people, but for all people. And that is to be recognized. It will be universal. It will be comprehensive. It will be a matter of right and it will be of one standard. And that is obviously one thing that we don't have.

Mrs. BUSCH. How will it affect the people in this country who are not employed?

Senator KENNEDY. It will cover them. That's one difference between our program and the administration's program.

The administrations' program doesn't include unemployed people unless they have children. It didn't in their initial recommendation. But this does. This is universal. It is comprehensive.

Mrs. BUSCH. How is it set up to meet the costs for the people who are of no income or an income that prohibits medical care?

Senator KENNEDY. They have every right to go and utilize the system. There are no deductibles, no coinsurance. It eliminates those features. And they have as a matter of right to fully utilize the system.

Mrs. BUSCH. Without cost?

Senator KENNEDY. It is based upon funding under two mechanisms. One is funding through the income tax system, and the other from employers'-employees' tax, which is 1 percent for employees and 3.5 percent for employers. Self-employed persons pay 2.5 percent. Benefits are universal and comprehensive. A matter of right.

Mrs. BUSCH. Can I ask another question? Excuse me, I want to get one more thing. How do the neighborhood health networks that we were talking about a little bit earlier fit into that program?

Senator KENNEDY. They will be developed. They will be encouraged. We will find new ways of creating additional kinds of neighborhood health services in the community. The importance of preventive care is emphasized under the Health Security Act.

Mrs. BUSCH. Will it provide funding for health, neighborhood health centers like our own?

Senator KENNEDY. Yes.

Mrs. BUSCH. Before they die?

Senator KENNEDY. Yes, it will.

Mr. MCKINNEY. What will be the makeup of the board?

Senator KENNEDY. Well, it could include consumers. The best examples, I would think, would be the health boards of federally funded OEO programs. And they are made up of individuals within those communities.

The purpose is to bring the consumer into the whole health system. And that is what we are attempting to do.

Mr. MCKINNEY. How would that affect the doctor's role in it?

Senator KENNEDY. Well, in what respect? The doctor would be encouraged to go into prepaid group practice, but he will also be permitted to practice fee-for-service. It would provide front-end budgeting. That means you will allocate a certain amount of money that will be spent for health needs for the country.

You don't have the wide-open situation which you have at the present time. I think it is the best way of getting costs under control.

Mrs. BUSCH. If I may, are you talking about the consumers in direct planning roles?

Senator KENNEDY. Yes.

Mrs. BUSCH. And in decisionmaking roles? Or are you talking about more "consumer input"?

Senator KENNEDY. No; I am talking about them in active policy roles, in the development of this program.

Mrs. BUSCH. Then my other question is, How do we define consumers? Anyone who consumes medical services? Or are you talking specifically about the poor and near-poor consumers?

Senator KENNEDY. Well, I think it is up to the community. It is a reflection of those that live in the community and are going to be utilizing the services. That's the best way that I know how to do it.

Miss TAMSKAC. How will your program affect dentistry, or is it included?

Senator KENNEDY. It includes children up to 15 years of age, and it moves inclusion of them in 2-year steps up to 25 years of age. It is the only program that includes dental care. Let me ask just the medical school how you feel that the university can help in meeting the kinds of concerns that have been expressed here by these people?

Dr. MELINKOFF. Well, Senator, I would like to say that there have been a number of misconceptions expressed which I don't have time to explain in detail, as you can understand.

Senator KENNEDY. Yes.

Dr. MELINKOFF. Though I would be happy to if we did have time on some other occasion.

But let me just say briefly that no one at this hospital is treated like an animal or a guinea pig or experimented on. Everybody who comes here is treated to the best of the abilities of the faculty here, and staff, and is treated with dignity and all the medical expertise that we know how to summon.

We are very actively working on programs, for instance, in drug abuse. Dr. West and Dr. Parker have just recently launched such a program. I think some reference was made to some ways we have tried to help in Venice, and so on. But I would like to say this: We are in favor of a plan to make it possible for everyone in the United States to have the best possible medical care. I don't think the medical schools in the country can provide all the medical care that is needed. The medical school does have an obligation to provide education of the best quality because no matter how much money people have to pay for medical care, if the doctor who is there to provide it is a fathead, whether the health care is prepaid or spotpaid, if the doctor is a fathead it is not going to be very good care.

And so we feel that we do have an obligation which we are fulfilling to the best of our ability with the limitations in funds to provide good doctors. And that, we think, is our central objective.

Mr. MCKINNEY. You know, we have to determine, and I was talking to Dr. West about this yesterday. Yesterday we had a meeting——

Dr. WEST. Seems like last week, but it was just yesterday.

Mr. MCKINNEY. Yes. In fact, we were talking about really an official policy, and this is what we mean in terms of input from the community. And it is like if this hospital is set up primarily for research and training purposes, then the community, in terms of priority, is third on the list. Or it may not be on the list at all.

When we come to official policy, the community gets things by having to beg if, in fact, they get anything. Either the community has to beg or take. They either have to come humble and beg, or take. Those are the only two ways in terms of moving toward official policy changes, where there is going to be a way for poor people to get community services, or to become a part of the training and research, and other such things that are going on.

Then we think that some official policies are going to have to be put on paper and put out, and show in writing how the people are going to be able to participate and get services and at the same time participate in some training to answer the questions of the unknown.

We know one of those big unknowns that no one really talks about too much on the national level is alcoholism.

Senator KENNEDY. It ought to be talked about and something done about it. I just say that there are people who are trying to respond. That is what we have to try to do, get those who are representatives of the community interests and try to work these things out, working together with some of you. That is why we are here. If we weren't interested, we wouldn't be here. But we are, I think it is a good comment.

Maybe just a final comment, then we are going to have to run.

Mr. COMACHO. I would just like to revive your question that was never answered as to what the university is doing for the minorities. I think we have the dean of the UCLA Medical School and the dean of the University of Southern California, and also Dr. Spellman, who is the dean of the Martin Luther King, or the King-Drew post-graduate school, and I would like to have them answer that question. The question was never answered.

You heard here about lack of education of people of the east Los Angeles area, and I just want to tell you how many health educators we have, bilingual health educators, in the county of Los Angeles. We have about 1.6 million Spanish surnamed Americans in the county of Los Angeles, and we have two health educators that have graduated from a graduate school in health education. I don't know how many people are in this school of public health here at UCLA. I don't know how many people are in the Valley State College School of Public Health or in the school in Berkeley. But I don't think they are graduating too many minority students out of the schools, either the school of public health or the medical students.

I would like to have an answer from the deans here today as to how many minority students are in their classes and what size classes they have.

Dr. MELINKOFF. We have 136 freshmen, 135 freshmen at UCLA. Fourteen are black students, nine are Mexican-American, seven are Oriental. We don't have any quotas. We take the best students we can find. We spend a great deal of time searching out qualified students among minority groups.

Mr. COMACHO. And what about your selection committee—do you have minority representation there?

Dr. MELINKOFF. We certainly do. We have many minority people on our faculty, and many of them are on the admissions committee.

Senator KENNEDY. Thank you very much.

STATEMENT OF MITCHELL SPELLMAN, M.D., DEAN OF THE DREW POSTGRADUATE MEDICAL SCHOOL

Dr. SPELLMAN. Drew postgraduate school doesn't have undergraduate medical students, that is to say it doesn't give medical degrees. What it is trying to do in this area, as a matter of fact, is privately provide scholarships to minority students in the country, and through this the funds through the whole span of health occupations, not only medicine and dentistry, but nursing and allied health professions, tuition costs, tutoring, or whatever the needs may be.

The Drew School recently was granted a Federal contract and is going to assemble a faculty of the allied health sciences and assemble a consortium of institutions ranging from high schools at one end and universities at the other, and try to develop a system of accrediting so that one institution accepts the accreditation of another.

We can then increase the pool of minority students and those students aspiring to medicine or dentistry could enter the schools that can train them in the consortium.

STATEMENT OF ROBERT TRANQUADA, M.D., ASSOCIATE DEAN OF THE USC MEDICAL SCHOOL

Dr. TRANQUADA. Senator, let me respond in the interests of USC.

The incoming class of 96 in September will have 10 Chicanos and nine blacks. The representation in this year's freshman class, again of 96, is approximately that. I think 18 total, about equally divided. And the numbers above that are smaller. We are making an effort. It is not enough.

Senator KENNEDY. What about in the nursing school?

Dr. TRANQUADA. The nursing school does not have such a good record. Some special efforts have been made.

Dr. MELINKOFF. I don't have the figures available, Senator. I can get them for you. It is a separate school.

Senator KENNEDY. Yes, all right, thank you very much for coming.

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

(The material referred to follows:)

UNIVERSITY OF SOUTHERN CALIFORNIA
SCHOOL OF MEDICINE
2025 ZONAL AVENUE
LOS ANGELES, CALIFORNIA 90033

IN REPLY, REFER TO
DEPARTMENT OF MEDICINE

225-1511
225-3115

May 17, 1971

Prevalent problems encountered in the American Free Indian Clinic

(1). Alcoholism.
(2). Psychiatric problems including overt schizophrenia, mild to severe endogenous and exogenous depressive reactions and mild to severe anxiety reactions. Much of the stress is directly related to
  (a). Lack of employment.
  (b). Loss of or lack of MediCal support.
  (c). Inability to obtain or lack of knowledge of aid in the form of welfare grants, food stamps, or job training.
  (d). Although I have not had contact with such a case, the high rate of suicides amoung the indians in urban areas is well documented.
(3). Lack of prenatal care. There is no means presently to insure that the prenatal patients we see receive any care before delivery.
(4). Infant immunization and preventive care is not good as many of the mothers become very discouraged about visiting Public Health Centers.

Immediate Needs.
(1). Adequate pharmacological supplies. We should be able to maintain a large enough stock so that we don't have to give adults pediatric suspensions, or have to substitute one drug for another we would rather use, ie tetracycline may have to be substituted for amphicillin.
(2). Adequate funding to run program as it now stands, no grandiose amount, assurance of several hundred dollars a month would make a big difference.
(3). A continuing recruitment program of indian personnel for training immediately in clinic skills. More indian aides are needed to assist the Indian nurses now working in the clinic.

Future Needs.
(1). Recruitment of students for training in all of the health sciences, particularly physicians.
USC School of Medicine is carrying on a minority recruitment program. I hope to get students exposed this summer to

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225-3115

possibilities of training in the medical sciences in cooperation with the Community Medicine department at UCS.

(2). The American Indian Free Clinic should be expanded slowly to full day operation and addition of more rooms as more indians are recruited to participate in running the clinic. Non-indians should not be assigned responsible roles and should only give suggestion when asked. It will not work for us to build a big new beautiful clinic and/or hospital and tell the indians how to run it. They have to do it themselves. Funds should be made available, without strings attached, for administration by the indians as they organize expansion. It cannot be overemphasized that the indians can and should be given the means to run this clinic without us telling them what to do.

Some of us try to americanize the indians, some of us empathize with them, some of us criticize, but we will never understand them because they do not think as we do. The indian should be free to continue his heritage of religion, crafts and tribal life without any interference on our part but with our active encouragement in the form of adequate funding which he manages.

Thank you,

Lois Boylen MD

Lois Boylen, MD
Assistant Professor of Medicine

13181 Lampson Ave., # 226,
Orange, California, 92668,
May 21st, 1971.

Senator Edward Kennedy,
Washington, D.C.
Dear Sir:

I was unable to attend your hearing in Los Angeles last week, but will give my testimony by mail.

My wife entered Palm Harbor Hospital in Garden Grove on Jan. 30th this year. She died ten days later, Feb. 9th. She was under Medicare, and her hospital bill for the ten days was $ 3,9991.05. Medicare paid $,3901.05 and I paid $ 90. Naturally I have no complaint as my cost was small, but I keep wondering what will become of Medicare if these proprietary Hospitals are allowed to continue to plunder Medicare. This is the most outrageous hospital bill I ever saw, and we have had plenty of bills in our life time.

Can you imagine a hospital charging over four hundred dollars a day for care, one day over $ six hundred dollars, and seven hundred dollars for medicine in ten days?

I am enclosing a zerox copy of the bill and my recapitilation of same. I am sending this to you for your information. Please keep it, I am sending other copies to other people.

When I first saw the bill, I thought Cosa Nostra had started to buy up proprietary hospitals with their surplus funds, so they could start plundering Medicare. Maybe it was a good guess.

This corporation, American Medical Enterprises, Inc., P. O. Box 17040, Los Angeles, CA 90017, which owns Palm Harbor Hospital, owns about ten other small hospitals in Southern California, and are buying more according to local papers.

Will you please do me one favor? I would like to hav . the name of the chairman of the Senate committee, which each year checks on what hospitals are charging Medicare; I wrote my Senator, Joh nTunney, but received no answer. I will be glad to send the original hospital bill to the committee.

Thanking you in advance, I am

Yours truly,
Cecil R. Nipps
Cecil R. Nipps

Hospital Care of Florence W. Nipps at Palm Harbor General Hospital from Jan. 30 to Feb. 9
A TOTAL OF TEN DAYS.

	Daily Care	X-Ray	Laboratory	General Supply	Pharmacy	Miscellaneous	Total Day for Credit Co.	Grand Total
30	$ 60.00	$ 89.00	------	$ 5.25	-------	$ 10.00	$ 154.25	$ 101.25
31	130.00	19.00	142.00	4.25	51.75	--	367.00	471.25
1	130.00	-----	68.00	207.75	54.50	--	560.25	1,031.50
2	130.00	19.00	118.00	282.60	63.25	--	612.85	1,644.35
3	130.00	-----	32.50	159.25	73.00	--	394.75	2,039.10
4	130.00	19.00	------	120.95	127.75	--	397.70	2,436.80
5	130.00	-----	45.50	111.20	101.25	(337.95)	368.05	2,824.75
6	130.00	-----	-----	33.25	68.25	--	231.50	3,056.25
7	130.00	25.00	50.50	63.85	140.25	--	409.60	3,465.85
8	56.00	-----	12.00	151.40	70.75	--	290.15	3,756.00
9	Passed away at 3:45 a.m. Feb. 9th.			176.00	95.20	147.80 less	147.20	3,903.20
10	-----	-----	22.50	5.35	-----	--	27.85	3,991.05
	1,156.00	171.00	491.00	1,441.10	721.95	10.00	3,991.05	
						Paid by Medicare	3,901.05	
						Paid by Family	90.00	

LABORATORY CHARGES

18	90.50	Complete Blood Count.
2	3.50	Urinalysis.
5	90.00	E. K. G. S
13	72.00	Cultures-Microbiology.
14	190.00	Blood Chemistry.
20	15.00	Special Chemistry.
31	30.00	After Hour Calls.
	$ 491.00	Total Laboratory Charges

CENTRAL SUPPLY CHARGES

1	$ 128.00	Dressings
2	14.00	Catheters
3	5.25	Ortho Surg Supplies
4	174.75	Intravenous Solutions
6	135.00	Special Equip (Rent)
9	71.35	Surgical Supplies
12	75.00	Pulmonary Function
13	832.50	Inhalation Therapy
	$ 1,441.10	Total Central Supply Charges.

EXPLANATION OF CODES

X-Rays

SPECIAL EXAMINATIONS
11. ANGIOGRAMS
12. ARTERIOGRAMS
13. VENOGRAMS
14. AORTOGRAMS
15. PLANIGRAMS
16. TUBOGRAMS
17. PELVIMETRY
18. INJECTION OF SINUS TRACT

THORACIC
20. OTHER
21. CHEST
22. HEART STUDY
23. BRONCHOGRAM
24. FLUOROSCOPY

SKELETAL
30. OTHER
31. RIBS
32. SHOULDERS
33. PELVIS
34. HIPS
35. EXTREMITIES

SPINE
40. OTHER
41. CERVICAL
42. DORSAL
43. LUMBAR
44. LUMBOSACRAL
45. COCCYX
46. DORSO LUMBAR
47. MYELOGRAM

HEAD
50. OTHER
51. SKULL
52. SINUSES
53. FACIAL BONES
54. MASTOIDS
55. ORBIT
56. EYE FOR FOREIGN BODY
57. TEETH
58. ENCEPHALOGRAM
59. VENTRICULOGRAM

GASTRO-INTESTINAL & ABDOMEN
60. OTHER
61. ESOPHAGUS
62. UPPER G.I. TRACT
63. G.I. SERIES
64. BARIUM ENEMA
65. AIR CONTRAST ENEMA
66. ABDOMEN

GALL BLADDER
70. OTHER
71. GALL BLADDER
72. GALL BLADDER WITH DYE
73. CHOLANGIOGRAM

URINARY TRACT
80. OTHER
81. KUB (KIDNEYS, URETERS & BLADDER)
82. I.V. PYELOGRAM
83. RETROGRADE PYELOGRAM
84. CYSTOGRAM
85. URETHROGRAM

X-RAY THERAPY OR RADIUM
90. OTHER
91. RADIOACTIVE UPTAKE STUDIES
92. RADIOACTIVE ISOTOPE THERAPY

AFTER HOUR CALL
93. T.C.
94. R.C.

LABORATORY
1. COMPLETE BLOOD COUNT
2. URINALYSIS-URINE TESTS
3. WBC AND DIFFERENTIAL
4. SEROLOGY
5. E.K.G.
6. HOLTER E.K.G.
7. BLEEDING & CLOTTING TIME
8. R.B.C. & HEMOGLOBIN
9. SIMPLE SMEAR
10. CEREBROSPINAL FLUID
11. E.E.G.
12. E.M.G.
13. CULTURE(S)—MICROBIOLOGY
14. BLOOD CHEMISTRY
15. TYPE & CROSSMATCH
16. PROTHROMBIN TIME
17. GLUCOSE TOLERANCE
18. BIOPSY
19. PATHOLOGY
20. SPECIAL CHEMISTRY
21. SEDIMENTATION RATE
22. HEMATOCRIT
23. HEMANTIGEN
24. VECTOCARDIOGRAM
25. PLATELET COUNT
26. SICKLE CELL MOUNT
27. BONE MARROW STUDY
28. LUPUS ERYTHEMATESUS PREP.
29. SKIN TESTS
30. TOXICOLOGY
31. AFTER HOUR CALL
32. OTHER

MEDICAL SUPPLIES & SERVICES
1. DRESSINGS & OTHER TRAYS
2. CATHETERS & CATHETER TRAYS
3. ORTHOPEDIC SURG. SUPPLIES
4. INTRAVENOUS SOLUTIONS
5. CRUTCHES
6. SPECIAL EQUIPMENT (RENT)
7. TRANSFUSION TRAYS
8. OTHER
9. SURGICAL SUPPLIES
10. ANESTHETIC SUPPLIES
11. TRACTION OR BELT — INITIAL SET-UP CHARGE
12. PULMONARY FUNCTION
13. INHALATION THERAPY
14. OXYGEN*

*APPLICABLE ONLY IF HOSP. DOES NOT HAVE SERVICE OF INHALATION THERAPY DEPT.

EVER800

PHARMACY
1. INJECTIONS, MISC.
2. INJECTIONS, MULTIPLE
3. INJECTIONS, ANTIBIOTIC, ETC.
4. ORAL MEDICATION(S)
5. SALES TAX
10. OTHER
11. PRESCRIPTIONS

MISCELLANEOUS
1. TELEVISION RENTAL
2. EXTRA INSURANCE-PAPERS FILED
3. TELEPHONE & TELEGRAMS
4. GUEST TRAYS
5. DOCTOR MEALS
6. EXCESSIVE LINEN
7. BLOOD
8. RED CROSS SERVICE CHARGE
9. EMERGENCY ROOM
10. PROFESSIONAL FEE
11. SPEECH THERAPY
12. NUCLEAR MEDICINE
13. PHYSIO THERAPY-IN & OUT
14. GASTRO LAB
15. OVERNIGHT GUEST BED
16. OTHER

2618

PALM HARBOR GENERAL HOSPITAL

CENTRAL ACCOUNTING OFFICES
POST OFFICE BOX 60535 - TERMINAL ANNEX
LOS ANGELES, CALIFORNIA 90060
(213) 483-4770

PATIENT [illegible] M.
ADDRESS [illegible] LANDON AVE [illegible]
CITY ORANGE STATE CALIFORNIA ZIP 92668
HOSPITAL NO. [illegible]
ROOM NO. 302
ATTENDING PHYSICIAN L. S. HARRISON/E. PRIETTO
DISCHARGE DATE: 2-9-71
RATE: TIME ADMITTED: [illegible] DATE ADMITTED: [illegible] DISCHARGE TIME: [illegible]

Expired 4:45

DATE	DAILY CARE	DISTRIBUTION OF CHARGES (SEE REVERSE SIDE FOR CODE DESCRIPTION)												BALANCE
		X-RAY		LABORATORY		CENTRAL SUPPLY		PHARMACY		OPERATING ROOM OR DELIVERY ROOM	MISCELLANEOUS		CREDITS	
		CODE	AMOUNT	CODE	AMOUNT	CODE	AMOUNT	CODE	AMOUNT		CHARGE	CODE		
														BAL FWD
														3,465.85
	36.00			12	12.00	13	45.00							
						13	65.00							
							1.40							
							7.50							
							5.00							
							5.00							
							15.00	1	2.75					
							7.00	5	45.00					
							2.00	5	15.00					
							2.00	10	4.00					
							108.00							
							66.00							
							1.75							
							1.50							
							2.75	1	32.00					
								2	62.00					
								4	1.20					
					22.50		.35							
							1.75							
							1.75							
							1.50							
							EDEMA	OR	292					

Totals

THIS CERTIFIES [illegible] INSURANCE BENEFITS
REPRESENTING [illegible] ADMISSION
HAVE BEEN ASSIGNED TO ABOVE NAMED HOSPITAL
P. O. BOX 60535 LOS ANGELES, CALIF. 90060

Daily Care $1152.00 | X-Ray 171.00 | Lab 491.00 | General Supply 1,441.10 | Pharmacy 731.95 | Misc 10.00

Grand Total $3,991.05

TOTAL CHARGES

DATE _____ 19____ SIGNED BY _____ INSURED

CHARGES OR CREDITS NOT IN BUSINESS OFFICE AT TIME OF DISCHARGE WILL BE BILLED LATER.

2619

BEST AVAILABLE COPY

PALM HARBOR GENERAL HOSPITAL

CENTRAL ACCOUNTING OFFICES
POST OFFICE BOX 60533 – TERMINAL ANNEX
LOS ANGELES, CALIFORNIA 90060
(213) 483-4770

PATIENT [illegible]
ADDRESS [illegible] LAWSON AVE [illegible]
CITY ORANGE STATE CALIFORNIA ZIP [illegible]

HOSPITAL NO. 12-1-0760-4
ROOM NO. 202
ATTENDING PHYSICIAN L. SANTINO/P. PRIETTO
DISCHARGE DATE: 2-9-71

RATE: TIME ADMITTED: [illegible] DATE ADMITTED: [illegible] DISCHARGE TIME: [illegible]

DATE	DAILY CARE	DISTRIBUTION OF CHARGES (SEE REVERSE SIDE FOR CODE DESCRIPTION)											CREDITS	BALANCE
		X-RAY		LABORATORY		CENTRAL SUPPLY		PHARMACY		OPERATING ROOM OR DELIVERY ROOM	MISCELLANEOUS			
		CODE	AMOUNT	CODE	AMOUNT	CODE	AMOUNT	CODE	AMOUNT		CHARGE	CODE		
[illegible]	[illegible]					5	7.00							[illegible] 3,898.50
						4	7.00							
						4	6.00	1	68.25					
						4	3.00	3	29.00					
						4	2.00	4	4.00					2,824.75
[illegible]	130.00					9	3.75							
						[illegible]	1.50							
						[illegible]	5.00							
						[illegible]	15.00							
						4	7.00	1	68.25					3,056.25
[illegible]	130.00	21	45.00											
		35	5.00	1	7.50	5	.35							
				[illegible]	30.00	5	.90							
				31	5.00	[illegible]	2.80							
						5	15.00							
						[illegible]	4.50							
						1	21.00							
						1	2.50							
						4	4.00							
						4	4.00							
						5	7.00							
						5	5.00	1	104.00					
								3	58.25					3,489.00
														BALANCE
												TOTAL CHARGES		

SBF 40 DATE _____ 19___ SIGNED BY _____ INSURED

CHARGES OR CREDITS NOT IN BUSINESS OFFICE AT TIME OF DISCHARGE WILL BE BILLED LATER.

2620

PALM HARBOR GENERAL HOSPITAL

CENTRAL ACCOUNTING OFFICES
POST OFFICE BOX 60533 – TERMINAL ANNEX
LOS ANGELES, CALIFORNIA 90060
(213) 483-4770

PATIENT [illegible], [illegible] W
ADDRESS 13101 Kirpsen Ave. #225
CITY Orange, Calif STATE ZIP
HOSPITAL NO. 12-1-0760-M
ROOM NO. 302
ATTENDING PHYSICIAN P. Prietto, MD
RATE: TIME ADMITTED: 1:45 PM DATE ADMITTED: 7/7 DISCHARGE TIME: DISCHARGE DATE:

DATE	DAILY CARE	DISTRIBUTION OF CHARGES (SEE REVERSE SIDE FOR CODE DESCRIPTION)											CREDITS	BALANCE
		X-RAY		LABORATORY		CENTRAL SUPPLY		PHARMACY		OPERATING ROOM OR DELIVERY ROOM	MISCELLANEOUS			
		CODE	AMOUNT	CODE	AMOUNT	CODE	AMOUNT	CODE	AMOUNT		CHARGE	CODE		
[illegible]														BALFOR
[illegible]	130.00			I	7.50	13	61.50							2,644.35
				14	13.00	12	35.00	BL.	6S					
				13	12.00	9	3.75							
						9	.50							
						6	15.00							
						1	.75							
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						4	7.00							
						4	7.00	3	69.00					
						9	2.25	4	4.00					
														2,039.10
[illegible]	130.00	21	19.00			13	61.50							
						9	.70							
						9	.56							
						9	1.50							
						6	15.00							
						1	24.00							
						1	.75	1	92.75					
						4	7.00	3	25.00					
						4	7.00	4	4.00					
						4	3.00	10	2.00					
														2,436.80
[illegible]	130.00			1	7.50	9	.70							
				14	35.00	13	61.50							
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						4	3.75							
						9	1.50							
						6	15.00							
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														BALFOR
												TOTAL CHARGES		

F 40 DATE _____ 19___ SIGNED BY _____
INSURED

CHARGES OR CREDITS NOT IN BUSINESS OFFICE AT TIME OF DISCHARGE WILL BE BILLED LATER.

2621

PALM HARBOR GENERAL HOSPITAL

CENTRAL ACCOUNTING OFFICES
POST OFFICE BOX 60533 – TERMINAL ANNEX
LOS ANGELES, CALIFORNIA 90060
(213) 483-4770

PATIENT: [illegible], FLORENCE M.
ADDRESS: 2161 LAMPSON AVE
CITY: ORANGE STATE: CALIFORNIA ZIP: [illegible]
HOSPITAL NO.: 12-1-0760-M
ROOM NO.: 302-2
ATTENDING PHYSICIAN: L. CHARIFO/R. PRIETTO
RATE: TIME ADMITTED: [illegible] DATE ADMITTED: [illegible] DISCHARGE TIME: DISCHARGE DATE:

DATE	DAILY CARE	DISTRIBUTION OF CHARGES (SEE REVERSE SIDE FOR CODE DESCRIPTION)											CREDITS	BALANCE
		X-RAY		LABORATORY		CENTRAL SUPPLY		PHARMACY		OPERATING ROOM OR DELIVERY ROOM	MISCELLANEOUS			
		CODE	AMOUNT	CODE	AMOUNT	CODE	AMOUNT	CODE	AMOUNT		CHARGE	CODE		
[illegible]														BAL FWD
[illegible]						4	21.00							993.00
						4	7.00							
						4	4.00							
						4	2.50							
						4	4.00							1,031.50
[illegible]	130.00	21	14.00	5	22.50									
				1	7.50	1	75.00							
				14	30.00	13	124.50							
				[illegible]	42.00	[illegible]	2.25							
				31	9.00	[illegible]	[illegible]							
						[illegible]	3.75							
						[illegible]	9.25							
						3	3.00							
						6	15.00							
						1	24.00							1,351.60
[illegible]						1	7.50							
						2	1.50							
						4	6.00							
						4	6.00							
						[illegible]	[illegible]	1	26.25					
						5	[illegible]	3	29.00					
						4	[illegible]	4	6.00					
						4	7.00	10	2.00					1,444.35
														N.B. F.D.
												TOTAL CHARGES		

DATE _____ 19___ SIGNED BY _____ INSURED

CHARGES OR CREDITS NOT IN BUSINESS OFFICE AT TIME OF DISCHARGE WILL BE BILLED LATER

2622

PALM HARBOR GENERAL HOSPITAL

CENTRAL ACCOUNTING OFFICES
POST OFFICE BOX 60523 – TERMINAL ANNEX
LOS ANGELES, CALIFORNIA 90060
(213) 483-4770

PATIENT [illegible]
ADDRESS 1[illegible]
[illegible], CALIFORNIA [illegible]
CITY STATE ZIP

HOSPITAL NO. 12-1-0750-11
ROOM NO. 302-2
L. SIMPIDO, MD./P/FRIETTO,MDS
ATTENDING PHYSICIAN

RATE: TIME ADMITTED: 1[illegible] DATE ADMITTED: 1-[illegible]-71 DISCHARGE TIME: DISCHARGE DATE:

DATE	DAILY CARE	DISTRIBUTION OF CHARGES (SEE REVERSE SIDE FOR CODE DESCRIPTION)											CREDITS	BALANCE
		X-RAY		LABORATORY		CENTRAL SUPPLY		PHARMACY		OPERATING ROOM OR DELIVERY ROOM	MISCELLANEOUS			
		CODE	AMOUNT	CODE	AMOUNT	CODE	AMOUNT	CODE	AMOUNT		CHARGE	CODE		
[illegible]	60.00	21	20.00											
		22	15.00											
		33	15.00											
		44	40.00				5.25	5			10.00	9		
								[illegible]T PMT			1[illegible].70		60.00	104.25
[illegible]	1[illegible].00	21	15.00	31	5.00									
		93	6.00	13	24.00									
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				21	9.00									
				14	31.50									
				1	7.50									
				1	3[illegible].00	4	2.2[illegible]							
						6	12.00							
				1	[illegible].00	4	7.00	1	3.25					
				1	7.50			3	43.50					[illegible]71.25
[illegible]	130.00			14	31.50	13	19[illegible].00							
				13	24.00	12	40.[illegible]		B.G.					
				1	9.00	3	3.75	9						
				1	7.50	2	12.50							
						2	1.00							
						4	2.7[illegible]							
						6	15.00	1	12.50					
						1	1.50	4	15.00					[illegible]03.00
							.75							
						1	24.00							[illegible]AL PAY
												TOTAL CHARGES		

F 40 DATE_____ 19____ SIGNED BY [illegible] INSURED

CHARGES OR CREDITS NOT IN BUSINESS OFFICE AT TIME OF DISCHARGE WILL BE BILLED LATER.

2623

TESTIMONY OF MRS. JUANITA C. DUDLEY, ASSISTANT REGIONAL DIRECTOR, NATIONAL URBAN LEAGUE, INC., WESTERN OFFICE

Mr. Chairman, Members of the Committee, thank you for the opportunity to present to you my concerns and suggestions around health care for all Americans.

As director of Health and Welfare of the National Urban League in the West, I have shared the frustrations of many health care advocates in analyzing the eight or more health bills which are now before the Congress. Whitney M. Young, Jr., our late director, served as a member of the committee of 100 which presented a health care program to Congress. Our National Health Advisory Committee has also presented a report "Toward a National Health Program." I will present this report to your committee with copies of my testimony.

Some of the problems we are anxious to have you made aware of are as follows:

Problems

1. Peer review of quality medical care. Peer review has been in practice as long as we've had licensed medicine. That system has proved to be inadequate. If health is a utility, as described by Gordon Cummings of the American Hospital Association, such as other public services are; then a commission of non-owned, non-providing reviewers must be brought into review the quality of care being given. Medicine and its ancillary health services have been provided under the mystique that "only the doctor knows what's best" much too long. We have a highly intelligent, highly informed and highly concerned consumer today! Verification of this concern is consumer participation in Watts Multi-purpose Health Center, Comprehensive Health Planning Councils and Regional Medical Programs in this state and county.

2. Use of provided owned, low quality hospital and clinic facilities. Pride of present ownership is not reflected in upgrading and coverage of such facilities i.e., doctors are on call—no round-the-clock coverage by a physician.

Dr. Alex Gerber wrote *The Gerber Report* from the vantage point of his role as senior attending surgeon at the Los Angeles County USC Hospital—one of the largest hospitals in America. Dr. Gerber describes the over-utilization of surgery as a primary cause of the overcrowded hospitals today as evidenced in privately owned facilities. He also describes the quality of that surgery as less than the best.

An emphasis on quality care is in no way correlated to high cost of medical care. All bills presently before the Congress relate to the cost of health care. This includes most well publicized plans of the AMA, American Hospital Association, Health Insurance Association of America, the Administration Plan, and others.

One of the major private health insurance companies in America has its board loaded with physicians and other health care providers. That same com-

pany pays a physician in a gilded ghetto (Beverly Hills) a higher price, for the same service rendered, than is paid a physician in the inner city ghetto. This is based on the only differential that may exist in the two practices—the square footage cost of rent! The ghetto physician then tries to see twice as many patients per day in order to realize the same income as his Wilshire area colleague. What will the new cost analysis per patient offer him. I describe this fiscal dichotomy, for the patient is once again the victim of such fiscal games.

3. Health Maintenance Organizations:

This is a new nomenclature to both the health care providers as well as the consumers. Yet, it describes well known prototypes: Kaiser Foundation of California, HIP of New York, Ross Loos of Los Angeles.

As many groups begin forming HMO's, it appears that the triad of their planners (the economist, provider and marketing analyst) have not felt the need to include the consumer. The emphasis is once again on the "cost," not quality. The major serendipitous factor appears to be emphasis on preventative health care. Will they lower the high infant mortality rate by design, or close the galloping rate of infectious hepatitis, or lower the rate of pandemic venereal diseases? Will fatal heart attacks be decreased due to better emergency care? Will drug addiction and mental health be covered?

We suggest that before HMO's are awarded contracts on behalf of consumers that they present a plan for elimination of some of the aforementioned health problems. We further suggest that a marketing survey for cost analysis also include an epidemiological report on the incidence and rate of diseases for the catchment area under negotiation. Only then can a measure of effectiveness of their delivery of health care for that population be determined.

Many health bills state that standards will be determined by state councils or boards. Will all HMO units have the same standards; or as in medicare and medicaid, will the standards vary for the type of class of population served? Will the infamous "grandfather clause" be used to sweep inferior facilities into competition with newly upgraded or newly constructed facilities?

4. Manpower:

The upgrading and use of paraprofessionals in delivering health care is a most important factor, both as a financial stabilizer as well as an opportunity to close the critical manpower shortage. Our concern is that hastily proposed training programs may not be sufficient to prepare sub-professionals to take over the total role of medical doctors in hospitals, clinics or offices.

We are also concerned that such use of sub-professionals will not be used by medical professionals as a means of helping minorities out of medical schools. We've progressed slowly in this area since 1964.

UCLA has a single (one), black senior in its medical school. Their extension program for training sub-professionals has much better percentage figures.

JASON I. GREEN, M.D.
9735 WILSHIRE BOULEVARD
BEVERLY HILLS, CALIFORNIA 90212
TELEPHONE 274-0223

GENERAL SURGERY

August 24, 1971

Philip Caper, M.D.
Senate Health Subcommittee
Committee on Labor and Public Welfare
Washington, D. C. 20510

Dear Doctor Caper:

Thank you very much for your letter of July 29, 1971 which unfortunately I did not receive until two days ago. At your invitation I will be happy to submit my thoughts regarding Health Care Delivery in the United States.

Health Care costs must be subdivided into medical (physician) costs, hospital and others. To group them together only confuses the issue and places the blame for high costs solely upon doctors, whereas most of the costs increase has been in hospital bills.

There is no question, however, that methods of health care delivery and financing must change. With regards to delivery I believe it is advantageous to both physicians and the general public for doctors to practice in multi-specialty groups. The difficulties encountered with doctors practicing in individual offices in terms of patients getting to and from various doctors as well as the high cost to the physician of maintaining these offices has made them anachronistic. These groups should be large enough to provide all necessary and commonly used medical services but not so large as to become impersonal, cold, albeit efficient medical "factories". Many patients here in the Southern California area describe Kaiser Permanente in the latter terms. There is an intangible but crucial personal relationship between doctor and patient that must be preserved primarily for the welfare of the patient.

As concerns the financing of Health Care Delivery this too must be modified. No patient should want for good care nor be bankrupted in the process of obtaining it. I believe every human being has a <u>right</u> to good medical care. I believe it would be impossible financially to continue on a fee-for-service basis. It might be possible on the other hand, for regional fee schedules to be established which would be a compromise between what the physicians would feel to be adequate and what the government and/or insurance carriers felt reasonable. The problems we have experienced in the past have been primarily with the fiscal intermediaries who have been most arbitrary and delinquent in their payments. If any sort of fee-for-service (fee schedule) system is to continue these inequities must be removed.

To: Philip Caper, M.D.
From: Jason I. Green, M.D. PAGE TWO

Currently there seems to be a strong momentum developing for pre-paid programs. There is nothing inherently wrong with them and they may ultimately prove to be the best solution. I would only caution that they are as yet untested (except in selected age and occupational groups) and pose the potential threat of underutilization with gross patient dissatisfaction and eventual political backlash affecting those who advocated them initially. I would suggest pilot programs be developed and results carefully analyzed before embarking on this method as a major source of health care delivery. I would also emphasize again that groups of varying size and not just the medical corporate giants be allowed to participate in these pilot programs.

Finally, I would point out that in a trillion dollar economy such as this nation enjoys there is no question but that money is available for health care. The only question is the old one of ordering of priorities. This is the crucial question that must be answered by the people themselves through their elected representatives. Health care is costly. The cost can probably be reduced. But whether the financing is through private sources, fiscal intermediaries, or directly through the federal government I think that Congress must be honest and explicit in stating very clearly to the general public that the health of this nation is of paramount importance to all of us and deserves top priority for expenditures.

Thank you very much for giving me this opportunity to express my views.

Very truly yours,

Jason I. Green, M.D.

JIG/pg

Senator KENNEDY. At this point I order printed statements of those who were unable to be heard or could not attend:

(The information referred to follows:)

THE TRUE CRISIS

(By James S. McCaughan, Jr., M.D., Central Ohio Medical Clinic, Columbus, Ohio)

At a time when the very foundations of medicine are being threatened, I think the voice of the people who are "on the firing line giving health care" should be heard, and not just those of politicians, union leaders, professors of medical economics, group health association presidents, etc. Therefore, the following is the testimony I would have made had I been able to testify in person.

I am James McCaughan, M.D., and I practice general and thoracic surgery in Columbus, Ohio where I am on the staffs of several hospitals, one of which is located in the ghetto. I am also the Chief of Surgery at the Columbus State School for the mentally retarded. In the course of my medical career I was trained in a university and had training and experience in community hospitals, state-owned mental hospitals, city-owned general hospitals and military hospitals. I have been on the teaching staff of three medical schools, have had American Cancer Association and National Heart Association fellowships and several grants for research. Being actively engaged in taking care of ill people I do not have the time nor the huge monies nor facilities to prepare masses of data; however as a person actively participating in medicine and doing the work and not just accumulating data, and as a person who will have to continue in the system, I think I have some observations which cannot be made by any other group of people.

The rise in the cost of medical care is being called exorbitant, and the private physician is being charged as one of the main culprits. The same chart is repeatedly brought out showing physicians' fees rose 50% during the past decade while the Consumer Price Index rose only 20%. These speakers do not point out that the Bureau of Labor Statistics shows that the prices *of all services* are up 50% since 1957–59 compared to 20% for commodities. Medical care is a *service*, not a commodity. U.S. News, December 8, 1969, using U.S. Dept. of Labor statistics reported that while medical care had risen 12.9% since 1967, insurance and finance costs had risen 21.4%, public transportation 13%, meals at restaurants 12.7%, shoes 12.7%, meats, poultry and fish 13.6%, and owning a home 18.2%.

The cost of the U.S. Congress has risen 156%, federal employee wages rose 105%, and non-professional hopital workers wages rose over 200% during the last decade.

While the Consumer Price Index rose only 5.5% and physicians' fees rose 8.1% in the past year, the U.S. News and World Report of February 15, 1971 showed last year's average increase of pay of union workers including wages and fringes were: bricklayers 15%, building laborers 15%, carpenters 13%, electricians 12%, painters 12%, plasterers 12%, plumbers 14%, and in the construction industry wage increases are being sought of over 100% over the next three years. Remember, physicians have no fringe benefits, no paid vacations, no paid retirement plans, no paid health plans. Malpractice insurance costs have risen over 300% in the last five years.

The quality of medicine in this country is claimed inferior because of a supposedly higher infant mortality, the United States being thirteenth in selected countries. However, no cognizance is given to the fact that in some of these countries that have a supposedly low infant mortality, such as Sweden which is No. 1, a birth does not have to be reported for five years and a death might never be reported. In some of these countries the father, not the physician, voluntarily reports births; the criteria for live births are not the same in all countries. The Demographic Year Book of the United Nations, from which this information is taken, spends five pages pointing out why statistics of different countries are not necessarily comparable. "Answers to these questions will not be found through comparison of disconnected studies with varying study designs. Although few comparisons may be possible, fortuitously, they lack the assurance which is to be derived from a well designed study planned to give answers to specific questions".

In The Netherlands, which ranks No. 2, only 60% of infants are delivered by physicians.

The life expectancy at birth for males in the United States is eighteenth, with 66.8 years in 1965 compared to Sweden with 71.6 years. Does this mean that more men in the United States smoke and die of cancer of the lungs, that we have a greater incidence of coronary artery disease, or that we have more automobile accidents involving men? I don't think it can mean it is due to inferior medical care because the same United Nations Demographic Year Book of 1968 shows in Sweden the deaths per 100,000 population due to pulmonary tuberculosis are 25% greater, suicide 95% greater, benign peptic ulcers 78% greater, pneumonia 84% greater, influenza 186% greater, benign prostatic hypertrophy 116% greater, neplasm 25.5% greater, stroke 13.7% greater, diabetes 5% greater than in the United States.

Poor quality medical care or unavailability of medical care is blamed as the major if not only factor for a greater incidence of disease among the poor in this country by those promoting national health insurance. United Auto Workers' president, Leonard Woodcock, states: "In almost every category the rate of serious illness among the poor is two or three times higher than the population as a whole".

"The United States is seventh in maternal mortality".

"Among the poor in this country, infant mortality rates are five times greater than among the affluent".

Every other socio-economic pressure or influence or cause is completely disregarded, and inferior medical care is blamed for these sad statistics. I would like to present a case history to show you some of the real problems and let you try to fix the cause. I received a call at 3 o'clock one morning to come to an emergency room in the ghetto area. A nineteen year old black girl was brought in by the rescue squad after being stabbed in the chest during a fight with another girl in a bar. When I arrived there about twenty minutes later I observed that the veins in the girl's arms were sclerosed and she stated this was from shooting heroin. When I asked her how she got the money for this she stated by prostituting. On further examination of her I found she was about five months pregnant. She also had a seven month old child at home. She presently was receiving Aid For Dependent Children. After I treated this girl, about 4 o'clock in the morning, an elderly black woman came to the door of the emergency room with a little four or five year old neatly dressed black girl. They wanted to know if the little girl could see "Auntie", who was lying on the litter in the emergency room.

Many of the problems of the ghetto and the poor are summed up in this one case. If this nineteen year old girl or her unborn child died during or after birth it would only be statistics, and accordingly her death will be attributed to poor medical care. If this black girl dies of an overdose of heroin, alcoholism, or tuberculosis, or syphillis or stab wound at an age earlier than expected for the non-poor, statistics will show it attributable to poor or inadequate medical care.

When there are problems, the least we can expect is the whole truth.

Although this nineteen year old girl presents a tragic problem, far more significant is the problem of the four or five year old child, because left in this environment chances of her winding up on a slab ten or fifteen years from now would seem to be almost one hundred percent. Besides that, she probably will have a couple of children of her own, and the children of the nineteen year old girl presented will be out on the street.

You can put one of President Nixon's Health Maintenance Organizations or even a private physician next to this child and you will never appreciably improve the quality or quantity of her life until you change the socio-economic environment she lives in or remove her from it.

Senator Dominick on April 15, 1971 stated, "In truth, infant mortality for the most part is a social rather than a medical problem. Factors such as poverty, malnutrition, poor housing, poor education and racial or ethnic differences are much more highly correlated with infant mortality than such factors as the number of physicians or hospitals."

"Somewhere out of such a free debate, a national concensus must develop, concensus that rests on facts and solid theory, not on the whims of doing something to improve the situation or on notions of reaping political credit for the final product."

In Philadelphia during an influenza epidemic I walked the Puerto Rican and black ghetto streets at 1:00 A.M. seeing patients, and as I would leave one apartment building somebody would call from across the street to go see them. These people were being ravaged by this epidemic. They live in tenements with two

or three children sleeping in each bed, four to six adults in a 12 x 12 room, roaches running over the beds and kitchen table. About this time a television program showed the squalid living conditions of South American natives. I could have filmed that program right in the center of Philadelphia.

On another occasion, in the middle of the night, under police protection I delivered an unregistered black woman in a third-floor apartment where there was no electricity—only kerosene lamps. However, only six blocks away the best maternity care was available, free, at the Jefferson Medical College.

These people do not have inferior medical care, they have inferior everything. The spread of disease is dependent upon sanitation, nutrition, education, living habits, etc. More people die and are injured by stabbings and gunshot wounds in the ghetto areas than in the rest of the population. Why are these deaths not blamed on poor medical care?

Senator Yarborough stated in Senate hearings in 1970 that there are "thousands of small towns and countless urban slum areas where our citizens go years without seeing a doctor . . . All of this is because it is economically more attractive to work in Austin rather than Three Rivers, Texas".

If financial rewards were the only reason for practicing medicine, most physicians would leave the big cities and go to these small communities where there is a demand for them. However, as with every other human being and profession there are many factors that enter into a physician's choice for a region to practice. It is true, there are not many physicians in certain areas of the country; however, there are not many lawyers or other professional people there either. Some physicians choose certain climates; others are influenced by wanting to move away from their home; others want to remain close to their home; the availability of cultural and educational facilities are a strong influence on many people; the physical safety of working in certain areas is a factor. Many physicians and nurses will not make night calls to the hospital in the ghetto area that I attend because they have to drive through the ghetto area to get to it. I have a friend who is a surgeon in Cincinnati and every time he makes an emergency call at night in a certain section of the city, he carries a loaded 38 revolver on the seat beside him.

Thus merely providing financial incentives to practice in these areas will not have much of an attraction. This is especially true in light of the harrassment and discreditation that honest physicians and dentists have received when they went into these areas and worked there day and night at reduced fees and still made large sums of money because of the prodigious amount of work they were doing. They were immediately suspect and denounced as being greedy over-utilizers, and investigated by the government.

The public is being told that they will receive the same or better care under a national health program than they now receive from private physicians and it won't cost them any more money. The Department of Health, Education and Welfare itself has estimated the Health Security Act will cost over $77 billion annually by 1974 or over $1000 per worker annually whether ill or not.

What evidence do we have from past experience with government intervention in medicine that this new government medicine will be better? John Gilligan, Governor of Ohio, had motion pictures taken of conditions at the State Hospital for the mentally insane to be distributed around Ohio to show the horrible conditions that exist in a state-owned hospital. As a private physician as well as the chief of surgery at the state school for the mentally retarded in Columbus, I can state, conditions exist at the School which would not be tolerated for one day in a private hospital. The Division of Mental Hygiene notified Ohio's twenty-six State Hospitals in March 1971 that doctors not licensed in Ohio could be barred from practicing in state facilities. In the past, limited licenses were issued for doctors who had not passed state medical board examinations so they could work in state facilities. This is still prevalent.

The Veterans Administration Hospital system with 166 separate institutions and a 1.9 billion dollar annual budget is one of the largest socialized medical systems in the world. This is a "true system" compared to the private medical system that Mr. Leonard Woodcock called "uncoordinated, wasteful, overspecialized . . . absolutely incapable of meeting the real health needs of the public". The physicians and all personnel are paid by the federal government. All equipment and facilities are owned by the federal government. Patients receive free care unlimited.

On June 1, 1970 Senator Edward Kennedy made a speech in Congress asking unanimous consent that Senator Allen Cranston's testimony about the inadequacy of the VA Hospital system be accepted into the Congressional Record. He introduced the statement, "it is disgracefully understaffed, with standards for below those of the average community hospital. Many wards remain closed for want of personnel, the rest are strained with overcrowding. Facilities for long-term treatment and rehabilitation, indispensable for the kind of paralytic injuries especially common in this war of landmines and boobytraps, are generally inferior".

Reports of the VA's own Chief of Services were entered into the Congressional Record such as: "tight budget policies have imposed serious fiscal constraints on our abilities to employ adequate personnel and provide necessary facilities"; ". . . insufficient equipment, insufficient personnel and grossly inadequate support in the crucial areas of pathology, radiology and clinical laboratory and physical medicine"; ". . . radiology equipment is obsolete in the worst sense of the word, broken down in the very true sense of the word".

Mark J. Musser, M.D., Chief Medical Director of the Veterans Administration stated in the A.M.A. News of March 8, 1971 in response to a question on the future of the VA Hospital system if some form of national health plan arrived: "We set out to do two things, first to determine how the VA as a health care and delivery system might better relate and hopefully cooperate with the private sector. Second, to determine how we can modify the resources of the VA so it has an expanding capability and is more responsive to the needs of a wide variety of patients—who some day might not be solely veterans".

This system of socialized medicine, the VA Hospital system that Senator Kennedy and the Veterans Affairs Sub-Committee have denounced as "holding back on giving first-class treatment when they are brought home in wheelchairs and stretchers", will be expanded to the private sector.

The Journal of the American Hospital Association of August 1970 shows the average stay in a private community short-term general hospital was 8.3 days in 1969. The average stay in a government hospital of the same type was 19.9 days. A major factor in this is certainly the fact that the appropriations for the VA Hospitals are strongly dependent upon the number of patient days of the year before, and since the hospitals are not one hundred percent utilized patients are kept in the hospital longer for the same operation or illness than in a private hospital. When the length of stay is multiplied by the cost per day and compared for identical operations or disease, the cost for a particular operation in a government hospital far exceeds that in a private community hospital.

A special committee on municipal hospital services appointed by Mayor James Tate to study the future of Philadelphia General Hospital (a city-owned service which received $30,961,946 for fiscal 1970) reported on April 20, 1970: "The present PGH is obsolete and beyond economic renovation. This manner of allocating money deals with health problems too late, costs the most, and does little to prevent illness. Administrative and management inefficiencies, were found in present operations of city personnel health programs". Per-diem charges in the Philadelphia General Hospital on June 17, 1970 were: in-patients $68.00, clinic visits $25.00, receiving ward visit $20.00. The average private physician office visit charge is less than $10.00.

Joseph T. English, M.D., president of the New York City Health and Hospitals Corporation warned Mayor John Lindsay in a letter in April 1971 that as many as eight of New York's municipal hospitals may have to be closed in wake of financial difficulties.

Jersey City's Margaret Hague Maternity Hospital, a 250 bed county facility may have to be closed on July 1, 1971 since it had a three million dollar deficit in 1970.

Similar reports can be made for Massachusetts General, Cook County General and other city and county-owned hospitals.

While stationed at Portsmouth Naval Hospital as a general surgeon, I frequently was assigned to the walk-in clinic to see the ambulatory ill. These people might have colds, gastroenteritis, allergies, etc. When they would return for their next visit they usually saw another physician who was a specialist in another field such as urology or psychiatry, and on a subsequent visit they probably saw a third physician.

The U.S. Public Health Service is another completely socialized system with physicians and all personnel being paid by the government, all facilities owned by the government, and patients receiving free care. HEW Secretary L. A. Rich-

ardson testified before Merchant Marine & Fisheries Committee that eight U.S. Public Health Service Hospitals and thirty Clinics may have to be closed because of "our inability to continue to provide medical care of high quality . . . through an increasingly inefficient and outmoded system".

Thus, in the government systems we have already experienced we have found no panacea for the health problem but actually a type of care which is inferior to that provided by the private sector.

Let us be quite candid, as Senator Kennedy stated in his speech on January 25, 1971 in the Senate: "Financial, professional and other incentives are built into the program to move the health care system toward organized arrangements for patient care". This will consist mainly of having a Board set fees for private physicians and allocating the amount of money for this type of practice as the residual of money not used for capitation payments. Let there be no mistake, most of these plans presented are either directly or indirectly aimed at eliminating the private physician fee-for-service practice of medicine and establishing a per-capita pre-paid system similar to the Kaiser-Permanente type. What will this mean? Dr. Sidney R. Garfield, the founder of the Kaiser-Permanente system, has stated: "In our experience a removal of the fee-for-service overloads the system and, since the well and the worried-well people are a considerable portion of our entry mix, the usurping of available doctors' time by healthy people actually interferes with the care of the sick." While non-medical people are espousing the great advantages of the pre-paid capita system. Dr. Clifford H. Keene, president and chief administrative officer of the Kaiser Health Plan Hospitals, who should be in a position to know better than anyone else the effect of this plan, when asked what effect pre-paid clinics had on the quality of care to patients stated: "I do not know".

Statements are made that more surgery is done on a fee-for-service basis than in pre-paid per-capita systems, with allegations that this is for financial reasons—that the surgeries are unnecessary. However, in the pre-paid per-capita system it is to the doctor's advantage not to operate. In other words, he is being paid much like welfare recipients, i.e. for not doing something. Who can say whether you need to have your hernia fixed this month or next year, or you need to have your veins stripped this month or next year, when there is an incentive financially not to do it. If you are willing to accept the premise that there are surgeons who will operate unnecessarily for fees, you must then accept the premise that there would be surgeons who would not operate in order to have a greater profit. Similarly, it is not to the advantage of the Kaiser system physicians to have less than 100% hospital occupancy. In an extensive study of the Kaiser system, Greer Williams, in Modern Hospital, Feb. 1971, states that in 1970 certain Kaiser hosiptals in the Los Angeles and San Diego areas reported occupancy rates between 100–110%. "This comes about by the patient being scheduled for major surgery without an available empty bed. He is prepared as an ambulatory patient, goes to the recovery room after surgery, and waits there for a hospital bed assignment. If a bed does not become available the administrative and nursing staff review the patient list to see who can be sent home, to another hospital, or to an extended care facility. If the backup is too large, the staff reviews the elective surgery schedule and postpones operations that 'will keep'."

When schedules become crowded they exercise their own priority system, based not on "health care as a human right", "a meaningful doctor/patient relationship", or "first come first serve", but on "sickest first".

To have more beds available for the sick would mean building more hospitals and decreasing the profit.

A fundamental principle of the Kaiser Health Plan has been "to insist that all subscribers shall have, upon joining or upon periodic renewal of contract, the opportunity to choose from two or more alternative health plans. This policy not only insures that enrollment will be voluntary within the employee group, but introduces open-market competition into a quasimonopolistic tradition of partially insured doctor and hospital bills paid through a plan imposed on the group by an employer arrangement with a single carrier supporting a fee-for-service system". This has been felt absolutely necessary to maintain the quality of the closed panel system.

Senator Kennedy has said "patients everywhere face a bewildering array of health personnel who know more and more about one disease or organ, but less and less about the whole patient". Yet these plans propose to eliminate the private physician/patient relationship and promote systems in which the patient/doctor relationship is further destroyed. Patients for these plans are told they

will receive the same or better quality care and attention than they would receive from a private physician.

However, a surgeon in Los Angeles told me when he was a resident in surgery, not Board-eligible, not Board-certified, in a Kaiser Hospital, he did twelve appendectomies one night himself. He also stated that if there was a major case to be done, the staff man would come in and help him. However, the staff men usually did not like to come in during the night (it should be noted there is no financial incentive for them to do so). If a patient had a bowel obstruction the staff man frequently would instruct the resident to put down a Levine tube, give IV fluids and get the patient in shape to be operated on in the morning. When I asked this surgeon if this was the way he wanted to be treated, he said "no". When I asked him if that was the way he practiced now that he is in private practice, he said "no".

James V. Maloney, M.D., in the presidential address at the 31st annual meeting of the Society of University Surgeons, gave a "Report on the Role of Economic Motivation in the Performance of Medical School Faculty". He compared "the effect of intellectual motivation and economic motivation on patient care and teaching and on the extent to which individual faculty members in institutions were meeting the needs of society in the field of medical education". After an extensive survey he concluded, "without economic incentive, clinical faculty of medical schools will not accept personal involvement in the care of the sick if they have any reasonable alternative which permits them to maintain their self respect".

Rashi Fein, Professor of Economics of Medicine at Harvard School of Medicine and a member of the faculty of the John Fitzgerald Kennedy School of Government and a vociferous proponent of national health insurance stated in Technology Review of April 1970, "A right to quality of care? A right to what amenities that accompany care? A right to how short a waiting period in a physician's office? Available how close to a person's residence? Available in what quantity?".

In the Kaiser-Permanente system waiting times for appointments commonly run from "three to six weeks", and in one large Kaiser-Permanente group, as high as fifty-five days. Each group has its cut-off point, beyond which appointments are not made. Dr. Cecil Cutting, executive director of the Permanente Medical Group in North Carolina states, "one of our big problems is developing an appointment system that will screen members so the sick can get in for service and yet the well and the worried-well can appropriately be taken care of without swamping our physicians".

Since 1966 the Kaiser plan rates have increased an average of 11–14%. Prior to that they had increased an average of 6–8% annually. Private physician fees only rose 8.1% last year, yet the private physician is still blamed for the rising cost of medical care although the Social Security Administration's own data showed that only 15% of the total cost of medical care of those over 65 was due to the physician's fees. Stated another way, if the physician had worked for nothing there would only have been a 15% savings in the cost of Medicare for 1969.

What other catastrophic events are we witnessing since the advent of Medicare-Medicaid intervention into medicine in 1966? MEDI-CAL is in serious financial difficulties. Thomas Bryant, M.D., Medical Affairs Director of the O.E.O. declared that Medicaid is an "unmitigated disaster". These pieces of legislation were passed when the medical profession warned that they would be disasters.

Above and beyond these problems, however, the loss of the fee-for-service, private physician/patient relationship will strike at the very core of the foundations of medicine, and here lies the true medical crisis and the true disaster that lies ahead.

Again I turn to Mr. Rashi Fein, one of the main proponents for national health insurance on a pre-paid per-capita basis. In his testimony September 24, 1970 before the Committee on Labor and Public Welfare of the U.S. Senate, he said: "One of the deficiencies in the production of health services is that the individual providers, institutions and people, do not really see themselves—or function as if they were—part of a larger system. They are concerned with those patients that come through their doors but often seem less aware of the large number of people who do not find their way of entry into the system". In his testimony before the Sub-Committee on Health of the U.S. Labor and Public Welfare Committee February 23, 1971 he stated: "A traditional financing ap-

proach will maintain the traditional delivery system organization—and we need change".

Hippocrates Oath has guided and maintained the ethics of the medical profession for centuries. It states: "I will use that regimen which, according to my ability and judgement, shall be for the welfare of the sick, and I will refrain from that which shall be baneful and injurious. If any shall ask of me a drug to produce death, I will not give it. Nor will I suggest such counsel. In like manner I will not give a woman a destructive pessary".

When a private physician has a patient, his only concern is, and must be, the welfare of that patient. When you are ill and go to a physician you do not want him to be concerned about the overall welfare of the masses or whether the money spent to keep an old patient alive would be better utilized elsewhere. I treat mentally retarded children, and we operate on them and treat them medically with the same zeal, care and attention that we would treat you, although we know that even if they get well from their acute illness they will be wards of the state, still will have to be maintained in institutions, still will have to be fed and looked after, and still will be a drain on the financial resources of society. If we let this overwhelming obligation to the patient be destroyed we will be destroying one of the few remaining fundamental moral principles left in this country.

What indication do we have that this can be destroyed by government intervention? Already another fundamental principle in medicine *is* being destroyed. Again from Hippocrates, "What in the life of men I shall see or hear, in my practice or without my practice, which should not be made public, this will I hold in silence, believing that such things should not be spoken".

It has always been considered a necessity and a right that the patient who has tried to commit suicide, the girl who has had an illigitimate pregnancy, a woman who has had cancer, a man who has had syphillis, know that what transpires between him and his physican is absolutely confidential. Right now, today, under Medicare and Blue Cross this privacy is being invaded without the patient or physician knowing it. When the patient enters a hospital he is required to sign an authorization for release of information. Following his discharge, Blue Cross or Medicare carriers merely write to the Medical Records Section of the hospital for a complete copy of progress notes or the complete chart of that patient, and it is being forwarded. The patient knows nothing of this, the physician knows nothing of this. Thus, even though the Medicare guide states that the history and physical and other information are not to be solicited, it is being done. Therefore, anyone who enters the hospital can have his personal history and physical examination reviewed by persons unknown.

In Louisiana a hospital refused to violate the patient's trust and refused to comply with these requests for complete chart copies, and had its Medicare and Medicaid funds cut off summarily. Why is it now necessary, when it never has been necessary before, for third party insurance firms to have complete copies of charts? Why should the patient's personal history become the property of the government? Why should the government be able to use economic force to invade the privacy of its citizens? Most patients do not realize when they accept Medicare and Blue Cross of Central Ohio that they automatically waive these rights.

Thus we already have government invasion of the individual's privacy, and the idea is being promoted that the physician must consider the welfare of society in general above the welfare of the individual.

In 1910 the Flexner Report maintained that we had too many "fly-by-night" medical schools and too many people practicing medicine who are unqualified. The answer to this problem was the creation of higher standards and more stringent requirements to be a practitioner of medicine.

Hippocrates Oath states: ". . . and to teach his art if they shall wish to learn it, without fear or stipulation; to impart a knowledge by precept, by lecture, and by every other mode of instruction to my sons, to the sons of my teacher, and to pupils who are bound by stipulation and oath, according to the law of medicine, but to no other."

Today we are coming 180° around from 1910. We are told the quality of medicine is poor, and we must improve this by developing a vast body of lay para-medical personnel. There are radiologists proposing that x-rays be surveyed by trained technicians; proctologists suggesting routine sigmoidoscopies be performed by para-medical technicians; corpsmen being trained to make housecalls to the extent that the patient "waves goodbye and says 'so-long Doc'."; the nursing profession has abandoned the scrub-nurse to the operating room technician.

Here is the True Medical Crisis: the loss of the private physician-patient relationship, where the physician reaches his responsible decision not by considering the economics, nor by considering the influence an action might have on the rest of society, but on the basis of what is best for this individual patient; the destruction of the private physician-patient confidentiality; the move from quality medical care to homogeneous mediocrity.

Senator KENNEDY. Thank you very much. The hearing for today is closed.

(Thereupon, the hearing was adjourned subject to the call of the Chair.)

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