COSTS AND DELIVERY OF HEALTH SERVICES TO OLDER AMERICANS

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH OF THE ELDERLY

OF THE

SPECIAL COMMITTEE ON AGING UNITED STATES SENATE

NINETIETH CONGRESS

SECOND SESSION

PART 3—LOS ANGELES, CALIF.

OCTOBER 16, 1968

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

24-798 WASHINGTON : 1969

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402 Price $1.00

SPECIAL COMMITTEE ON AGING

HARRISON A. WILLIAMS, JR., New Jersey, *Chairman*

ALAN BIBLE, Nevada
FRANK CHURCH, Idaho
JENNINGS RANDOLPH, West Virginia
EDMUND S. MUSKIE, Maine
FRANK E. MOSS, Utah
EDWARD M. KENNEDY, Massachusetts
RALPH YARBOROUGH, Texas
STEPHEN M. YOUNG, Ohio
WALTER F. MONDALE, Minnesota
VANCE HARTKE, Indiana [1]

EVERETT McKINLEY DIRKSEN, Illinois
WINSTON L. PROUTY, Vermont
HIRAM L. FONG, Hawaii
JACK MILLER, Iowa
CLIFFORD P. HANSEN, Wyoming
GEORGE MURPHY, California [1]
PAUL J. FANNIN, Arizona [1]
EDWARD J. GURNEY, Florida [1]
WILLIAM B. SAXBE, Ohio [1]

[1] Five vacancies in committee membership were caused by the departure from the Senate of Senators George A. Smathers (Democrat, Florida), Wayne Morse (Democrat, Oregon), Edward V. Long (Democrat, Missouri), Frank Carlson (Republican, Kansas), and Thruston B. Morton (Republican, Kentucky). With the adjustment early in 1969 of committee party ratio from 13–7 to 11–9, one Democratic vacancy existed and was filled by Senator Hartke. Senators Murphy, Fannin, Gurney and Saxbe were appointed to fill the remaining vacancies.

WILLIAM E. ORIOL, *Staff Director*
JOHN GUY MILLER, *Minority Staff Director*

SUBCOMMITTEE ON HEALTH OF THE ELDERLY

GEORGE A. SMATHERS, Florida, *Chairman*

WAYNE MORSE, Oregon
EDMUND S. MUSKIE, Maine
EDWARD V. LONG, Missouri
FRANK E. MOSS, Utah
RALPH YARBOROUGH, Texas
HARRISON A. WILLIAMS, JR., New Jersey
EDWARD M. KENNEDY, Massachusetts
WALTER F. MONDALE, Minnesota

EVERETT McKINLEY DIRKSEN, Illinois
FRANK CARLSON, Kansas
HIRAM L. FONG, Hawaii
THRUSTON B. MORTON, Kentucky

Part 1—Washington, D.C.
Part 2—New York, N.Y.
Part 3—Los Angeles, Calif.
(Additional hearings anticipated but not scheduled at the time of this printing.)

CONTENTS

APPENDIXES—Continued

APPENDIX 1. ADDITIONS, INFORMATION, OR EXHIBITS FROM WITNESSES—Continued

APPENDIX 2. LETTERS AND STATEMENTS FROM INDIVIDUALS AND ORGANIZATIONS

APPENDIXES—Continued

APPENDIX 2. LETTERS AND STATEMENTS ETC.—Continued

APPENDIX 3. REPORT ON MEDI-CAL PROGRAM, BY CALIFORNIA DEPARTMENT OF JUSTICE AND RESPONSE BY NURSING HOME ASSOCIATION

COSTS AND DELIVERY OF HEALTH SERVICES TO OLDER AMERICANS

WEDNESDAY, OCTOBER 16, 1968

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE ELDERLY
OF THE SPECIAL COMMITTEE ON AGING,
Los Angeles, Calif.

The subcommittee met, pursuant to recess, at 10:30 a.m., in the assembly room, Old State Office Building, 217 West First Street, Los Angeles, Calif., Senator Harrison A. Williams, Jr. (chairman of the committee) presiding.

Present: Senators Williams and Randolph of West Virginia.

Also present: William E. Oriol, staff director; John Guy Miller, minority staff director; Shalon Ralph, professional staff member.

OPENING STATEMENT BY THE CHAIRMAN

Senator WILLIAMS. The hearing will come to order. With this hearing, the Subcommittee on Health of the Elderly of the U.S. Senate Special Committee on Aging continues its study of the costs and delivery of health services to the elderly.

With this hearing, the Subcommittee on Health of the Elderly of the U.S. Senate Special Committee on Aging continues its study of the costs and delivery of health services to the elderly.

Testimony taken at two previous hearings has made several major points clear about the quality and availability of health care for older Americans.

First, there can be no doubt that medicare is already having tremendous impact. On July 1, when medicare was 2 years old, President Johnson reported that 20 million Americans of age 65 and over—10 percent of the Nation's population—were covered by the program.

More than $8 billion had been paid for expenses incurred in 10.6 million hospital stays and 45 million medical bills. Well over a million persons had received care after their stay in the hospital, in nursing homes or—when home health care is available—right in their own bedrooms.

Another million and a half persons had received hospital outpatient diagnostic services.

Judged strictly in terms of statistics, the medicare program certainly has produced results. But it is impossible to measure the amount of dignity and security it has provided to the elderly, as well as the assurance it has brought to younger families whose parents need no

longer live in dread of financial disaster because of extended hospital treatment or major medical costs.

But even if medicare has already proved itself to be a blessing, it should not be regarded as a cure-all for all that may be wrong with our health care services today.

Medicare, after all, merely provides the wherewithal to pay for certain health care expenses. It may have some effect in improving the quality of such care, but it can't be held responsible for long-standing deficiencies or failures in the organization of health care.

At its field hearing in New York City, for example, the subcommittee took testimony in a part of the Bronx where there is only one doctor for every 10,000 people. Twenty or 30 years ago there were five times as many doctors and only about half the number residents. We learned that much the same was true in some parts of St. Louis, too. And of course it is the elderly—with a high rate of chronic illness—who live in large numbers in the central city neighborhoods. They suffer severely from shortages of trained medical personnel. Much the same is true in many rural areas; we're not dealing with just a city problem.

How To Attain High Quality for All?

We have to ask ourselves: How are we going to organize health services so that high-quality care is available to all?

Another subject that received a considerable amount of attention at the first two hearings was the medicaid, or the title 19 program, as it is so often called. Congress intended that this program should help take away some of the welfare taint that overshadows the care given to low-income people. Congress declared that there was a large group in need of help, the so-called medically indigent who earn enough to take care of themselves, except when they are hit hard by high medical bills. Medicaid, of course, applies to all age groups, but it is important to many elderly people, especially when medicare benefits run out.

The subcommittee has found considerable confusion and concern about some aspects of the medicaid program. Some elderly people believe that their hard-earned nest eggs are placed in danger when they sign up. Others regard it as a welfare program, with a welfare stigma.

Within recent weeks, Congress has—I am afraid—contributed to the uncertainty by proposing major cutbacks, even after many States have made extensive plans for putting medicaid to work for their residents.

One of the major reasons for calling this hearing in California was to get firsthand information about your medicaid program—or Medi-Cal as it is called.

As I understand it, there was some fear 8 or 9 months ago that this program would produce a deficit.

Then it turned out that you had a surplus.

And now there are new State laws that permit cutbacks when costs reach a certain level.

What are the effects of the Medi-Cal program on the provision of health services for the elderly in California? We will look for some answers to that question today.

The first two hearings have also yielded much informative discussion about the need for prevention or early detection of chronic illness.

One of the hospital directors interviewed during preparations for this hearing was asked how to keep hospital costs down, especially those hospital costs supported by medicare. His answer was prompt. He said we should try to keep as many people as possible out of hospitals. One way to do that is to promote health maintenance programs, including regular disease detection screening. As things stand now, however, we focus Federal funds and attention on the obviously ill person, while withholding the funds and concern needed for actions that will prevent such illness.

Health Care in the Home

Another way to keep people out of hospitals is to provide the means to give health care to people in their own homes. I personally know of people who are in hospitals only because there was no one, not even family, who could give them their daily meals and a few essential services.

We'll look to our witnesses today for a few good ideas about home health care, too.

In fact, we expect to receive many good ideas here today. California has many problems; but it also has many people who care about solving those problems. We've found over the years that many far-reaching innovations have originated in this State, and there is no reason to believe that this is no longer true.

To close, I would like to thank Senator George Smathers, who conducted the first two of the hearings on this subject as chairman of the Health Subcommittee, for taking us so far along in our study. I know that he had hoped to be here today but I have agreed to conduct the hearing in his place in order to advance our work in this area.

We will move on to our first witnesses after a statement from one of our most eloquent and distinguished Senators, Senator Jennings Randolph of West Virginia.

Senator Randolph. Mr. Chairman, I have no desire to speak this morning. I think it is important that we proceed with the hearing.

I thank you very much. I am delighted to be here to join with all those present who want to make this program here today one of one purpose.

Thank you very much.

Senator Williams. Our first witnesses will be Miss Elsa Carrow, administrative assistant to Mayor Yorty, and Mrs. A. M. G. Russell, chairman of the California Commission on Aging.

Now, these girls know what they are doing here. They are already in place. Who goes first?

Miss Carrow. I am the chairman. Shall I go ahead?

Senator Williams. For the record, Miss Carrow.

STATEMENT OF MISS ELSA CARROW, ADMINISTRATIVE ASSISTANT TO MAYOR YORTY, MAYOR OF LOS ANGELES, CALIF.

Miss Carrow. Honorable Chairman and members, I am pleased to welcome your committee to the city of Los Angeles on behalf of our mayor, Sam Yorty.

A previous commitment prevents Mayor Yorty from welcoming you personally today. He asked me, as his coordinator for senior citizen activities, to bring you his personal greetings.

And further, he wished me to express his deep concern about the subject of your inquiry, the costs and delivery of health services to older Americans.

Los Angeles historically has been a mecca for the elderly and retired, who seek sunshine, comfort, and ease of living in their later years. Approximately 10 percent of our city's population is aged 65 and over—that is, some 300,000 senior citizens.

Senator WILLIAMS. Would you just repeat that?

Miss CARROW. Yes. Approximately 10 percent of our city's population is aged 65 or over—that is, some 300,000 citizens.

Senator WILLIAMS. That is just the city of Los Angeles?

Miss CARROW. That's right.

This important segment of our population comprises a community with few geographical limits but with special needs that must be met by special services from both government and private enterprise.

From the earliest days of his administration Mayor Yorty has taken active interest in the challenges and conditions encountered by our senior citizens. One of his first official acts was to form the Mayor's Committee on Senior Citizens Affairs.

Composed of outstanding persons in fields of endeavor identified with senior citizens, the committee explores and recommends improvements in such areas as recreation, transportation, housing, employment, and health.

Not all of these areas are within the province of the city health services for one is the concern of county, State, and Federal Government.

Even though health care is outside his jurisdiction, Mayor Yorty believes adequate medical care is a primary concern and a right to be enjoyed by all senior citizens. For that reason he has sponsored medicare and its California State counterpart, Medi-Cal.

He has urged a full measure of attention to the health needs of our senior citizens.

The path of medical assistance for the elderly has not been smooth, as you will hear from other speakers today. That is one reason why we welcome your hearing here in Los Angeles.

We believe, as Shakespeare wrote, "To lose thy youth in peace, and to achieve the silver livery of advised age," is one of the rights of all.

We hope and trust that the outcome of your hearings here and across the Nation will make that right a reality for all Americans.

Thank you.

Senator WILLIAMS. I would like to have you repeat that Shakespearean quote again.

Miss CARROW. Thank you.

"To lose thy youth in peace, and to achieve the silver livery of advised age," is one of the rights of man.

Senator WILLIAMS. Bill Oriol said, "I wish I had said that." Thank you, Miss Carrow.

Miss CARROW. Thank you.

Senator RANDOLPH. Longfellow said it another way. He said "For age is opportunity no less than youth itself, though in another dress," since we are talking about poetry.

Senator WILLIAMS. Thank you very much.

Mrs. Russell, from the California Commission on Aging.

You are chairman, as I understand it?

STATEMENT OF MRS. A. M. G. RUSSELL, CHAIRMAN, CALIFORNIA COMMISSION ON AGING

Mrs. RUSSELL. Senator Williams and Senator Randolph, and gentlemen, I am Mrs. A. M. G. Russell, chairman of the California Commission on Aging, and on behalf of myself, of Mr. Charles W. Skoien, Jr., executive director of the California Commission on Aging, and of Mr. Carel Mulder, director of health care services of the State of California, and as representative of Governor Reagan today, we welcome you to the State, a State with a senior population of nearly 2 million, approximately 10 percent of our national senior population.

Senator WILLIAMS. I will say we are going to be a little less than formal here. I don't know what your full name is. I have it A. M. G.

Mrs. RUSSELL. I'm Bonny Russell.

Senator WILLIAMS. They call you Bonny?

Mrs. RUSSELL. That's right.

Because of the importance of this hearing today, and those you have had in the past in Washington and in New York, I would like to provide you with a little bit of background regarding activities that relate to the delivery of health care services in California.

It is the role of the California Commission on Aging to advise and counsel, and cooperate with all governmental and private agencies that are serving the senior Californians.

It is the job and responsibility of the commission to work as enablers in the provision of health services.

It is our sincere belief that in order to render quality health services it is vital that the responsibility not be vested in any one agency or organization—but, must be shared by all. This means that our national society must work together to create an adequate health program for all.

It has been our privilege in California to see our senior Californians give of their time, their talent, and energy—and most of all, their experience to the local community not only for their own personal benefit, but for the benefit of the health and welfare of each of their communities.

Also, through many innovative and creative ideas, California is developing many new ways to serve the elderly through preventive means.

For example, there are two senior Californian regional education centers, one in San Jose and one in Los Angeles; centers funded through the Older Americans Act with programs which bring the local community and the local college or university together to provide a comprehensive senior program.

Through this effort, in the field of health we will be providing daily meals, nutrition program health lectures, training of health leaders, and—most of all—a public education program showing the community the need for adequate health planning.

Other aspects of this program will be a 7-day-a-week multipurpose program, a training center for college and university students, a community outreach program utilizing the senior Californians in the community on a paid basis, and an extensive training program for administrators of nursing homes, board and care homes, homes for aged; administrators in the fields of housing, employment, religion, educa-

tion; for civic leaders, for those in charge of service clubs or women's organizations; and, of greatest importance, a training program for the seniors themselves.

Funded by Older Americans Act

This example is one of the 44 Older Americans Act programs administered and funded by the California Commission on Aging.

The Older Americans Act programs in California are providing protective services, information and referral services; there are multipurpose centers, Foster Grandparents type programs, reachout programs, shutin programs, counseling services, visitation programs, education classes, casework and group work programs, volunteer services, part-time employment services, training of professional and volunteers and the Older Americans Act in California helps provide complete coordination of services.

With these programs and through the efforts of the 58 counties and the 401 cities in our State, we believe that we can successfully meet the needs for delivery of health services to the people of our State through good sound planning and the development of new and creative ideas.

Full cooperation must be given by the family, community, and society in helping the senior Californian realize an adequate health program. It is our desire and the Governor's desire—in California—to provide every senior Californian a retirement that is productive, creative, and meaningful.

Some of the health service needs are being met through the funding of the Older Americans Act, and as additional funds from this act and others are provided, more services can be made available. We are aware of many of the needs and will continue to work, as a powerful force composed of government, business, industry, and concerned individual Californians, toward meeting the health needs of all our citizens.

We shall be here throughout the day, gentlemen. We shall be very glad—the three of us—to answer any questions that you might have concerning our program here in California.

Thank you.

Senator Williams. Very good. Your statement indicates a most enlightened program here in California, which is what I would also describe as a retirement State.

So your percentage of people who are in retirement here probably equals Florida, Arizona, and places where——

Mrs. Russell. Our percentage is a rather normal percentage, because California attracts the young as well as the old. It is under the national average—percentagewise.

Mr. Williams. You are moving across the board to meet the needs of the older people.

You are moving across the board to meet the needs of the older people.

Mrs. Russell. We are certainly trying to.

Senator Williams. How do you—I hate to talk money—but as a budgetary matter, how do you budget the programs, and how much do you put into the programs you discuss?

Mrs. Russell. Of course the amount varies as to the kind of program and the size of the community. The regional educational programs

that we are establishing—the center programs—have been funded by the commission at around between $32,000 and $35,000.

Of course the community adds a great deal to this, too, in matching funds. They are required in the first year to only match up to 25 percent. But I think in the two places that we have programs established at the moment, they are matching to a much greater extent than that.

Senator WILLIAMS. The two places are San Jose and——

Mrs. RUSSELL. San Jose and right here in Los Angeles.

Senator WILLIAMS. Yes. And you have many more communities to reach.

Mrs. RUSSELL. Yes. These are regional programs, and we intend to reach into five areas of California, and hope that these centers, on an educational basis, will serve the entire region.

Senator WILLIAMS. Is there any great resistance from the taxpayers?

Mrs. RUSSELL. There seems to be a readiness, certainly, to provide programs in California for older persons. We do have 44 programs funded under the Older Americans Act. And a good many of these are entering their third year of funding and hopefully, some of them, will receive funding by the local community or by private agencies, in the fourth year.

We had perhaps hoped that some of them would have a fourth year of funding allowed.

Senator WILLIAMS. I presume, to make the conclusion, that you unequivocally approve of continuing the Older Americans Act, and you speak for the Governor of the State of California?

Mrs. RUSSELL. Yes. Thank you.

Senator WILLIAMS. Yes. Very good.

Senator RANDOLPH. Mrs. Russell——

Mrs. RUSSELL. Oh, I am sorry.

Senator RANDOLPH. That's all right. I shall not keep you very long.

I wanted you to tell us what percentage, if you have it as a fact, of the persons over 65 in California who reside with a son or daughter, rather than live in a house or in an apartment which is maintained by that older person.

Mrs. RUSSELL. I don't have that figure, Senator, I think probably along the lines of the national figures—which are rather high in this category.

A good many of our older people continue to live with their children, particularly the very elderly—the people in the over-85 group.

A great number of them live with a son or a daughter.

Senator RANDOLPH. Now the areas in California, as in other parts of the country, where the older people have been grouped together: How are they working out in California?

Just to use Leisure World as an example——

REACTION TO RETIREMENT COMMUNITIES

Mrs. RUSSELL. Well, it is very interesting to discuss that, and I think that perhaps for the most part they haven't been established long enough to really know their impact on the community.

Reports from individuals living in the communities are very favorable. They like it. And very few of them have, really, moved away from them. On the whole, they are a rather young group at the mo-

ment, speaking about the older people in the community. They move there in their younger years—of their retirement—so that, in years to come, it will be an older group and perhaps will change in complexion to some extent.

Senator RANDOLPH. Thank you, Mrs. Russell.

Senator WILLIAMS. We are grateful to you ladies for your very helpful testimony on questions of vital interest to the whole Nation, and of legislative concern to ourselves.

We will pause for a moment. I understand the speaker of the Assembly of the State of California, Jesse Unruh, is beleaguered by television interviewers with political questions outside the door.

Senator RANDOLPH. Mrs. Russell, how long have you been in the work in which you are engaged?

Mrs. RUSSELL. Thirty-seven years.

Senator RANDOLPH. You know, I sensed this as you spoke. You were very well grounded in the subject matter. I didn't want to pursue it with further questions—I can tell.

Senator WILLIAMS. I did overlook introducing John Guy Miller, who is one of the members on our staff for this discussion—for the Committee on Aging, and I forgot to ask you if you wanted to ask any questions, John, but we will catch up with that later.

We are honored, indeed, to have a television personality—all those cameras were out there for you, weren't they, Mr. Speaker?

Mr. UNRUH. Well, they are really out there for the Governor—what I had to say about him.

Senator WILLIAMS. The Honorable Jesse M. Unruh, speaker of the Assembly of the State of California.

We want to express our gratitude to you. You came here today to help our discussions on an important matter dealing with older people.

STATEMENT OF JESSE M. UNRUH, SPEAKER OF THE ASSEMBLY OF THE STATE OF CALIFORNIA

Mr. UNRUH. Mr. Chairman, members of the committee, let me introduce Mike Manley, who is my legislative assistant in Sacramento and is here with me today in case you have any detailed questions beyond what I might, with my somewhat cursory knowledge of the detail in this field, be able to answer.

Let me apologize, first of all, for my having absorbed what I am afraid is far too much attention that should be directed on the activities of this committee. Unfortunately, I had little control over what the Governor said yesterday about the legislature, and that is what attracted the television attention.

The attention should be focused on this hearing, because what you are doing here today is far more important than anything the Governor and I might have to say about each other.

I do express my thanks to you and your staff for asking me here to testify before you on something which I think is of central, present public concern, which is provision of health care to our senior citizens.

As I said, I am not an expert in depth in this field, but I am very concerned over it. It seems to me there are two fairly obvious comments about the problems of costs and delivery of health care services to older Americans. The first is that using health care in its strictest interpre-

tation, the problems of providing health care services for the elderly are much the same as for the rest of the population, the major difference being that the elderly require more services. In the broader use of the term health, there are fairly significant differences in the life styles of the elderly which must be taken into consideration in developing a program of comprehensive health care for them.

Health Cost Escalation a Symptom

My second comment is that the recent rapid increase in health-care costs is merely a symptom of much deeper problems of health care. It is for this reason that the actions of both our Governor here and to some extent the Congress have been irresponsible. Because those actions have been aimed at control of the symptoms by reducing expenditures at the governmental level they are trying to protect. These actions have been in the form of either service cuts as here in California or recipient cuts by the Congress. In neither case has there or will there be any meaningful effect upon the total costs of health care; there will merely be a shift of costs to some other governmental level—in California, to the counties.

All of this activity in an attempt to cut costs has tended to belie the official position of HEW that medicare and medicaid have not been a cause of recent spiraling increases in the cost of health care. Two examples from the Medi-Cal program in California should suffice to illustrate what a basically open-ended program will produce.

Prior to Medi-Cal, the public assistance medical care, PAMC, paid for physician services on the basis of a fee schedule using a conversion factor of $4. Two years later, allowing billing on the basis of usual and customary charges, the average conversion factor is $6, an increase of 50 percent. If we had remained on the old fee schedule, our costs would have been $40 million per year less and a 25-percent increase to a conversion factor of $5 would have cost us $20 million a year less than the present system.

The second example involves county hospitals. Part of the financing for Medi-Cal involved a guarantee by the State to county governments that if they chose an optional method of contributing to Medi-Cal, they would not have to spend any more on their county hospitals than they did in 1964–65, except as adjusted for population increases.

Most large counties chose the option method and this year it will cost the State about $50 million more even though there has been no appreciable increase in the number of persons served in county hospitals, and even a decrease in some cases.

This committee has asked for a summary of the conflicting arguments made over the Medi-Cal program late in 1967 and early this year. That comprises, I think, one of the most astonishing episodes of governmental incompetence and medical irresponsibility. It illustrates two very important points. The first is the extent to which the State administration can and did manipulate dollar figures in an attempt to undermine a medical care program for the people of California. The second is the ability of an independent and well-staffed legislative branch to thwart such an attempt by obtaining the facts before acting and then acting on the facts instead of on propaganda.

The story is fairly complex. It involves a great number of varying, and I quote "official," estimates of the program's cost as well as various legal opinions of provisions of the basic law which affected those estimates. It also involves the fact, which is hardly a secret to anyone, that our Governor is out of sympathy with programs like Medi-Cal which attempt to meet the health care needs of the needy citizens of California. Thus, when the Governor was presented with estimates which indicated originally, although those estimates were very sketchy and based on a very short experience span, he jumped at the chance to ask for a major cutback——

Senator RANDOLPH. In Medi-Cal?

Mr. UNRUH. In Medi-Cal.

Senator WILLIAMS. Well, now, could we pause? I won't interrupt you again.

Mrs. Russell said that your budget was—what was it?

Mrs. RUSSELL. I am speaking of the older Americans budget at this point. The older Americans emphasis is different.

Mr. UNRUH. Well, this is the——

Senator WILLIAMS. Say that again?

Mrs. RUSSELL. I am speaking of the older Americans program.

Senator WILLIAMS. I asked about the budget on Medi-Cal.

Mrs. RUSSELL. I am sorry, I misunderstood you.

Senator WILLIAMS. But it is your position, Mr. Speaker, that it is inadequately budgeted, and without an adequate budget, you certainly aren't going to get the appropriation; is that it?

BACKGROUND OF MEDI-CAL CONTROVERSY

Mr. UNRUH. No. What I am trying to relate now, Senator, is the entire background of the raging controversy over the whole Medi-Cal program in California, which always involves medicare because, in general, in the public mind the programs are relatively indistinguishable.

So when there is an attack launched upon the Medi-Cal provisions, title 19 provisions of this program, it invariably slops over and causes the same kind of resentment that generally takes place in these programs against the medicare portion of the program.

And we had, as you may remember, last year, about a year ago now, a special session of the legislature which was called by the Governor. We were already there on another matter, but the Governor added the Medi-Cal question to that special call.

When he got some preliminary figures which indicated there might be a deficit in the Medi-Cal program, he called a special session. He first of all tried to shift that program, as the money had been appropriated by the legislature. After a court case which indicated he could not make those cuts unilaterally, he then called us into special session to give him the right to make those cuts, so that he could meet what he said was, at that point, an original $210 million deficit in the entire program.

Now, the $210 million deficit—we got varying estimates along the way reducing that, and as a consequence, we eventually after we got all the facts together, we put a bipartisan, two-house committee of the legislature into that, and hired actuaries to check the estimates.

That program actually wound up in the 1967–68 budget year on the basis of the figure the Governor was using with a $185 million surplus. And actually if you throw out the fluff and get that down to actual costs, it was a $135 million total gubernatorial error. And that's a pretty big error in what amounted finally to a $200 million program.

As you know, in California, like many other States, we have to live within our budget. We cannot rely upon deficit financing.

Senator WILLIAMS. What was that gubernatorial accounting error—$135 million?

Mr. UNRUH. Well, reduced to actual dollars, it was a total error of $135 million.

Now, the program, instead of having—if you want to use the same figures that the Governor did when he utilized the $210 million, which was the total figures for the program—then it would amount to considerably more than that. It would be around a $400 million gubernatorial estimate.

But if you break it down to actual State dollars, which is what we were talking about—what we are concerned about at my level—it was a mistake of $135 million on a $208 million program.

Senator WILLIAMS. You had better get that office computer on it.

Mr. UNRUH. Well, the computer still answers according to what you put into it, and if you put in something expecting to get out an answer, that is generally what the machines give you.

Now, to insure that Medi-Cal will stay within its budget, we have to develop a real program. The Governor, of course, recommended that he be allowed to reduce or eliminate services to recipients. That was his answer to the fiscal crisis that he said threatened.

CATEGORICAL ELIMINATION OF SERVICES

There are, of course, a number of problems with this approach. One is the administration's proposed elimination of services on a categorical basis so that some persons would be denied services they needed badly, while other persons would still receive other services that were not needed nearly as much.

In other words, what he wanted to do was cut out a block of recipients, totally and completely. Another is that——

Senator WILLIAMS. What kind of blocks? Could we have some detail on that, Mr. Manley?

Mr. MANLEY. At one point, Senator, he threatened to completely remove from the program those people classified as medically indigent. And that amounted to—as I recall the figure—600,000 people.

That figure may be high. He never did do this. That was his threat at the time he called the legislature into session. In other words, if they didn't pass the——

Senator WILLIAMS. I thought that's what Medi-Cal was all about.

Mr. MANLEY. That's correct. That's what title 19 is all about.

To continue the story, the result was that he did not make those cuts.

Mr. UNRUH. Well, because we refused to give him the authority.

Senator WILLIAMS. But it was a cliffhanger for a while?

Mr. UNRUH. That's right.

The other thing that is wrong with that kind of an approach is that many of these services are also provided by the county hospitals for these people. Any decrease in Medi-Cal services just results in an increase in the county-provided services in their costs.

Still another is that such an approach may have no relation to the causes of increased costs. For example, hospital and physicians' services are very understandably among those exempt from reduction or elimination.

However, the cost of these services are the ones that have increased most rapidly, and should their costs continue to rise, other services would have to be cut to compensate for any unexpected increase.

Now, we, as I said, rejected that approach and came up with one which was more nearly geared to the causes of the problem, although we don't propose that this is perfect, either.

This changed the law so that if cuts are required they must first be made in the amount of payments for services not to exceed a 10-percent cut. If this is not adequate, then the administration may postpone those services, which are elective, regardless of their category.

These measures are designed to reduce program costs until the legislature can decide to make an emergency appropriation or make other program modifications.

The legislature also required that if any one service item threatens to exceed its budgeted amount, and that's the way we budget in general areas, the amount of payment for that service, that particular service, may be reduced by 10 percent. This approach we think comes closest to meeting the problem head on. It may tend to discourage fee increases and overutilization by providers since these, if they get out of line, could result in an immediate 10 percent reduction.

If I could look back with hindsight on the results of California's manufactured crisis with its Medi-Cal program, I would say that our experience indicates what can be done to any new governmental program—which in this case has not been fully tested out—by somebody who simply does not like the program and is out to wreck public confidence in it.

It appears clear to us and to most California observers familiar with Medi-Cal that our Governor did not like this program and his disagreement with the Federal legislation which authorized it which was largely to blame for this State's crisis over the program.

Among other things, during the course of that controversy we had when we were there, we were expected to give the Governor the power to unilaterally cut this program. He had a television appearance, in which he got on television, and utilizing the Medi-Cal card, the one which goes to welfare recipients, and displayed this card and said, "If you have one of these welfare cards—" or words to that effect, "you can get better treatment"—or "they can get better treatment than you can," pointing to the television audience, "than if you don't have one and you have to pay for it out of your own pocket."

In addition to being just in general disagreement with that kind of an approach to government, at this point I think that is one of the most dangerous things that can happen is when we try to put one group of our people against another. We have too much of that in our

society, already. It certainly is damaging to a program that has just been instituted for any public official to get on before the program has really had a chance to settle down—and make those kinds of charges.

The fact that we disagreed with the Governor's position on this is not really the point. The point that I would like to stress is that as a result of these pretended claims of bankruptcy, the very real methods of controlling Medi-Cal's costs were overlooked.

Fee Schedules for Physicians

The fact is for quite a while and still to some extent, although I think it is considerably less now, due to the scrutiny they have been getting, a few irresponsible doctors have made outrageously exorbitant profits out of the operation of this program. The people really getting well under this program are the doctors—and some of them are getting awfully well indeed.

Last year a thousand California doctors collected as much as $70,000 each simply from treating Medi-Cal patients. Some of them are making as much as a hundred thousand dollars yearly off of this program.

Now, I don't know that we have very definitive figures on how much of this was profit, but we have been told by people in the medical profession that this is considerably more than the average doctor makes, and we estimate that some of them are making somewhere between $35,000 and $60,000 net profit out of this program each year.

It is obvious that the most direct method of controlling costs is through the imposition of fee schedules on doctors and the other providers of medical services. Yet, despite pleas from members of the legislature, the administration which we gave the authority to has refused to set such limits, and in my opinion that refusal, or the threat of using that, is almost totally responsible for those soaring, runaway costs which have occurred.

You know, it's very interesting—some of our Governor's conjectures about the use of the bomb in the Vietnamese conflict ought not to be ruled out because that gives away our plans to the enemy, and yet, at the same time, the administration has so steadfastly refused even to consider the threat of imposing a fee schedule that, quite clearly, there is no fear on the part of the people who are out of line on this, that it might be.

I don't advocate flatly at this point that a fee schedule be used but I think it clearly ought to be setting there as an alternative, and that those people who are out of line ought to understand.

Senator Williams. Are you a lawyer?

Mr. Unruh. No, I am not.

Senator Williams. Well, in the law, at least where I used to practice, we had a schedule of fees where somebody could go beyond the schedule, but we had an ethics committee that could receive complaints. Is there anything comparable——

Mr. Unruh. Yes, there is, Senator, and I was going to add that I think the ethical, reputable doctors in the business are doing their dead-level best to try to do something in this area.

I think, to some extent, they have been successful. It may well be that the medical profession may be able to contain this themselves; if so, certainly that is a better approach to this.

Senator WILLIAMS. I am glad you raised this. I think that this would be most appropriate in our hearing—testimony—what you said. We report to the full Senate, and we will make a significant point of just what you concluded on that fee situation.

Mr. UNRUH. Yes. The one weakness of this approach that I see, Senator, is of course that usual customary fee business. So that the basis of ethics is placed upon a broad based group without too much concern for the escalation of costs. And that's a weakness of the peer group ethics question, as I see it.

As long as the overall costs escalate, there is no obligation, that I can see, to contain or to agitate more businesslike procedures—the handling of billing and other things. They are concerned with keeping the individual doctor from profiting at an exorbitant rate on an individual basis, but if the entire fee schedule escalates, there seems to me to be no obligation on the part of the profession as a whole to hold that down.

Now, I may say as a result of all this, and certainly I would not argue that all of this could have been escaped, that the additional costs of the past 2 years of this program has been in this area of $40 million.

I think that the administration's refusal to at least consider or to resort to this, refutes pretty well the claim that they want to control the program costs. I think the medical profession owes it to the State to control costs, not only to restrain those few doctors who are out of line with their peer group, but to exercise some self restraint insofar as managing overall costs is concerned and the escalation of those costs.

I don't know, Senator, whether you would like me to go—I will skip the second part of my testimony at this point, if I may, which was on a program that the legislature devised some years ago for a relatively new total approach to this program.

Senator WILLIAMS. Would you like that part to be included in our testimony?

Mr. UNRUH. I think that would be of interest to the committee. We still think it has a great deal of merit.

Senator WILLIAMS. Senator Randolph suggested that, and I think we will not object to that. It will be included.

Mr. UNRUH. I will be very happy to discuss that, and answer questions on it.

It is on the basis of getting everyone into the program on the basis of need and also on the basis of what they can afford, or when they might get into situations where, no matter how affluent they are, the medical costs could reduce them to a poverty level.

We think it is a good program, but when the cut was adopted by Congress, we did not feel that we had developed this far enough to present it as a program in which they had to pick up the principal costs on.

The Cal-Med Proposal

Let me take several moments to outline to this committee, as you have asked me to do, the major features of the basic health care program which I suggested to the California Legislature in 1966. In keeping with the current practice of giving all new government programs catchy one-word names, we called this plan Cal-Med.

Cal-Med was suggested almost exactly 2 years ago. It was presented as an alternative to the proposal then before the legislature which was eventually to become the Medi-Cal program. It represented an attempt to break away from the past patterns of public medical care programs which were being advanced under title 19 and to avoid the copying of existing health insurance programs which were taking place under title 18. Like those programs, it was basically a method of financing health care, but unlike them, it also addressed itself to the problem of doing so as efficiently and economically as possible. It did not tackle the serious problems of health manpower, facilities or comprehensive health planning, but no financing mechanism can really do that directly.

Cal-Med would ideally include all citizens of the State within its protection although to differing degrees depending upon the basic variable of income and family size. There would not be any categories as there are under the present Medi-Cal program because of title 19 restrictions. There would be three basic classes of protection under Cal-Med.

The first would include those persons whose income is not adequate to provide health care services for them and their families. They would receive comprehensive health care services without cost as is now the case with cash grant recipients under Medi-Cal.

The second would include those persons who are now considered medically needy as well as those who are poor risks. These are persons who can pay for some but not all of their health care either because of low incomes or because their physical condition makes health care costly and insurance coverage prohibitive. These persons would have two alternatives; they could choose to make a monthly payment toward the purchase of a health care plan when they were either sick or well. This monthly payment would be supplemented by Cal-Med to the extent necessary to obtain comprehensive coverage. The other alternative would be for the person not to prepay for health care protection, but then be required to spend down a given amount when he required services, as at present.

The third class would be those persons who are able to afford complete and comprehensive health care protection but because of some catastrophic situation their coverage is exhausted and they are faced with continuing high health care costs. These three basic classes should include all the citizens of the State who would require assistance in order to have adequate health care services. It is the purpose of Cal-Med to provide some or all of that assistance depending upon its level of funding.

One of the basic theories behind Cal-Med is that it is desirable for individuals to obtain prepaid health care protection. Consequently, Cal-Med would offer incentives to those who do so. Instead of forcing people to obtain such coverage, they would receive more services or Cal-Med would participate to a greater extent in their catastrophic coverage if they had comprehensive health care coverage. This is designed to encourage the further development of such plans.

Cal-Med and Rising Costs

Another factor in the development of Cal-Med was the issue of rising health care costs. It was felt that one of the best ways of combating such rising costs was by the encouragement of efficiency and innovation in health care organization through the stimulus of some healthy competition. This would be entirely different than the present title 18 and 19 programs which basically make payments on the basis of a fee for each service or on reasonable costs through a fiscal intermediary which takes no financial risks. Cal-Med would develop a comprehensive set of benefits and ask health care plans such as Blue Cross, Blue Shield, Cal-West, Occidental, Kaiser, Ross-Loos, the county foundations, and others to bid on providing the benefits.

Even though the bids might vary considerably, it would be desirable to have wide participation, especially at first, so that all reasonable bids would be accepted. This would give each recipient a wide choice of plans to choose from. It is also desirable for the recipient to be aware of the financial nature of his choice of plan. This can be done quite easily for those with a share of cost because their share can be made to differ depending upon the cost of the plan.

Those with no share of cost present a more difficult problem. One solution would be to provide more benefits for those who choose low-cost plans than for those who choose high-cost plans, but this would appear to conflict with title 19's comparability of services requirement.

This entire area is one which is vitally important as far as the future of public health care programs are concerned. In any vendor-type program there would appear to be two basic approaches to the problem of costs. One is to impose external controls upon cost and utilization and the other is to develop a program which will create its own internal controls. To date, most programs have followed the former pattern.

Even with all these controls there are still not very good means of knowing what Medi-Cal is purchasing and whether the price is right. How much better to use the competitive model which rewards efficiency, economy, and innovation which produces services at reasonable costs. Those plans which can produce will grow and those which cannot will wither and die. We know that there is a ready market for quality services at reasonable costs from the phenomenal growth of Kaiser in California. What is needed is the type of competition which is paid such lip service, but is really so feared and is a major reason why there is often such hostility to proposals like Cal-Med. Those who have been able to merely pass the costs of their decisions on to the patient or the insurance company, and at the same time make substantial incomes do not look kindly upon the suggestion that they bear some financial responsibility for the way they provide health care, but it is past time they did so.

Let me comment for a moment on the specific medical and health needs of California's aged and the coverage of the programs now available to them.

Theoretically, the elderly are being served very well by the Medi-Cal program. They have a wide range of benefits available to them as supplements to medicare. However, since Medi-Cal is basically a financing program, it has developed within the existing system which appears to leave a great deal to be desired as far as the elderly are concerned.

Health Care Versus Medical Care

Medicare, and to a lesser extent Medi-Cal, place primary emphasis upon fairly short term acute care although the greatest need of the elderly would appear to be for long-term chronic care. They also place a great deal of emphasis upon medical care as contrasted with health care which has a much broader meaning.

For example, medicare institutionalized the extended care facility as a halfway stop between acute hospital care and home. At the same time, title 19 allowed for skilled nursing home care which in California was seen as long-term care. Then HEW required all skilled nursing homes to meet ECF standards which place major emphasis upon medical and nursing services.

However, not all nursing homes in California can meet ECF standards and not all persons in California nursing homes need such a high level of care so that such a requirement is unrealistic and we think needs to be met by more flexible and understanding programs.

Congress evidently realized this and invented the intermediate care facility which will be much the same as California's nursing homes but will not be paid for under the medical care program. In addition to the almost complete lack of coordination which has occurred at the Federal level as to the decertification of nursing homes and the implementation of intermediate care facilities, this episode illustrates the arbitrariness of the distinctions that are made.

And I think that, more than anything else, what is needed is an effort to provide care for the elderly with little regard to whether it is called medical or not. The primary objective ought to be to assist elder Americans to remain as healthy and as independent as possible. This is in their best interests and it also makes sense from a fiscal standpoint. It is much less expensive to maintain an older person in his own home than to place them in an institution—and it is far, far better for him—whether it be nursing home or State mental hospital.

However, in order to do that we must develop flexible strategies which are directed to that end. An older person may need someone to assist with his housekeeping or taking a bath, bringing him groceries, drugs, or hot meals.

Even though these may not be medical services, they certainly have a direct bearing upon a person's health and whether he is going to require institutional care. It may be in many cases preventive. It is far cheaper, we feel, than the steps that have to be taken if we institutionalize him.

We also need to reexamine the impact of our policies upon the families of the elderly. The way our modern society has developed has

made it increasingly difficult for children to care for their elderly parents. This fact has evidently been reflected in the relatives' responsibility section of title 19.

Hardships on Families of the Elderly

One effect of that provision is to make it financially easy for children to place their parents in nursing homes. We could once again require relative responsibility as a deterrent to that action, but this might create added hardships for families of the elderly.

Let me illustrate, if I can, what I mean in regard to another program which the legislature developed in California in the treatment of our mentally retarded children.

For many, many years California had a mentally retarded program. That program provided simply that if you had a mentally retarded child, you would place him in an institution.

Now, the progress in institutions even of the best kind is generally slow for those children. In addition to that, it is very, very expensive, with the result that almost every 2 years we had to increase the facilities and even then we had a long waiting list.

We developed a flexible program which allows a family to acquire State financial aid for children, if they desired to keep that child in the home. We developed a system of foster homes and also local, private facilities, so that we now have alternatives.

We found, after conducting a very intensive survey, that the parents of these children, many times, did not want to institutionalize them. The financial burden, in addition to the emotional and physical difficulties in keeping this child in the home were just too much for the parent, particularly with other children, to bear.

If they could get a little help so that they once in a while can have a day or two rest from that, they still prefer to keep the child in the family. We think this would be the case with the elderly.

A more flexible system was devised so that instead of simply encouraging them, as the program now does to some extent, to institutionalize these people, many young people would keep the elderly, even those with some problems in the home, if they had some help.

And I think that is the general thrust that the program ought to take. A program would have to be devised in this area that is flexible enough to allow this. I think the program that needs to be devised ought also to be flexible enough to allow those who wish to resort to this kind of flexible approach, and other innovative ways of treating the elderly, or helping the elderly, to proceed with it.

I believe all Federal programs should provide floors, as I am flatly convinced that they must, because of the niggardliness of some of our States, and at the same time they ought not to comprise ceilings beyond which those States who wish to proceed with better care and more imaginative programs cannot proceed.

Senator Williams. I wonder if an idea that we have been advancing, but has not been enacted, fits in at this point. We call it the community service corps volunteers of older people in retirement, and one of the ideas that we thought could be incorporated into the program would be for older people who are active, energetic, and understanding could help in this home service situation that you are indicating.

I haven't described it fully, but does that idea suggest merit to you?

Mr. UNRUH. Yes, it does, Senator: I am very strongly in favor of that program, particularly I think it is apropos to the elderly who sort of get pushed out of our society now to feel, among other things, they aren't wanted. That is unfortunately, I think, too much the case.

I think the program in addition has broad social significance—socially significant values—and if we are indeed to have the change in the kind of politics that too often has pervaded us in government and in our society in the past, that is, I think, more and more people have to be concerned with something other than simply No. 1, and this is a group of people who obviously could be.

They have the time, they have the experience, and I think it has great, great value.

Senator WILLIAMS. Thank you.

Mr. UNRUH. Senator, I just want to conclude by saying that I think our goal should be the maintenance of the health and independence of our older citizens.

To accomplish this goal, we have to realize that health is dependent upon all sorts of nonmedical factors, as well as medical factors, that these ought to have equal priority with medical care in any programs devised for the elderly.

Thank you very much. That concludes my testimony.

Senator WILLIAMS. I have interrupted you many times. It has been a magnificent statement, and we certainly appreciate it—I am not sure everybody will, but any statement of importance will have to find some disagreement—whether they live in Sacramento or New York City. I know one person who will not be in disagreement, and he is from the most beautiful State of West Virginia.

Senator RANDOLPH. I can agree that that is the most beautiful State. I don't know if I can agree on the rest.

Senator WILLIAMS. Let me draw back, if I can. "The most beautiful State of West Virginia." That doesn't mean that I rule out my State.

Senator RANDOLPH. Well, autumn touches West Virginia with beauty just now, you understand.

Mr. Speaker, on page 2, would you refer to your informative statement—very informative statement.

You say that Congress has been irresponsible. Now, I think for the record, you want to be definitive in reference to such a statement. I imagine that I know what your reply will be, but I think it should be on the record.

CONGRESSIONAL CUTBACKS DISCUSSED

Mr. UNRUH. Yes. I refer to the capping action which Congress took after throwing out this program, and then finding that one State was somewhat more enterprising than perhaps they should have been in utilizing the open endedness of the program. That really pulled the rug out from under us on our Cal-Med program, which I think, if we had been allowed to develop it, would have provided a better cap to the costs of this program than is provided by the rather arbitrary action of simply saying, "This is the flat dollar amount that we will support."

I think a program which is devised to meet a particular social need ought not to be largely altered, as I think this was—the possibility of the program being developed was—by the capping of a flat dollar amount which had to significantly cut into the purposes of the program.

Senator RANDOLPH. Are you specifically referring to the 1966 social security cutback?

Mr. UNRUH. I think in 1967. The Mills amendment, as I recall.

Senator RANDOLPH. The medicaid cutbacks?

Mr. UNRUH. It was the Long amendment, I believe.

Senator RANDOLPH. Well, of course the Long amendment has not become law.

Mr. UNRUH. I am not talking about the——

Senator RANDOLPH. Mr. Oriol, let's have an explanation.

Mr. ORIOL. Well, there were two Long amendments, so-called because they were introduced by Senator Russell Long. That of 1968, which did not become law, and that of 1967, which did. You were referring to the 1967?

Mr. UNRUH. Yes. The 1967; that's right.

Senator RANDOLPH. And what was that amendment?

Mr. UNRUH. That was the amendment which said that the income of a person receiving this could not exceed 1⅓ times the AFDC limits.

Senator RANDOLPH. You recognize that the Congress was faced, Mr. Speaker, with, let's say, a cost squeeze. And not on one program, but across the board, and I am not attempting to argue the point, but would you agree with me that once this situation in the Congress——

Mr. UNRUH. Well, I am not in a position to argue with you, Senator. You know the facts better than I do, but I am inclined to believe in a system of alternatives that this ought to have had considerably more value than other things that Congress did spend money on. I am not prepared to argue that. It may serve little purpose. In fact it has been done.

I think the net result of that was to drastically cut back the quality of medical care in the State of New York, and to hobble innovation in the State of California which might have provided a considerably better health care program, and even at somewhat less cost, had we been allowed to develop a program as we thought we were being invited to do by the Congress, the year before.

Senator RANDOLPH. I think that is a valid statement; that there was encouragement given. I just wanted it to be on the record, because West Virginia is one of those States—38 in number—that have had the necessary implementing legislation on medicaid, as California, of course.

Mr. Speaker, would you turn to page 4.

You have underscored a statement here—a situation in California. You used language, let's say, which is very understandable—I would say it is strong language—you speak about the undermining of the medical care program to the people of California.

Now, where does California stand in this list of States—percentage-wise? Of course, New York—very liberal. Arkansas—very conservative.

Mr. UNRUH. Well, I don't have that in front of me at this point, but as I remember, the cap on our program, as far as income is concerned, was far, far below that of New York, and considerably below that of several other States. How many, I do not know.

Senator RANDOLPH. Mr. Speaker——

Mr. UNRUH. Our cap on income is $3,800—in the State of California. New York was $6,000. I think there are two or three other States with a——

Senator WILLIAMS. Notwithstanding the size of the family?

Mr. UNRUH. A family of four—which is the usual family.

Let me say that is one of the tragedies of not being able to develop the Cal-Med program, because we felt that quite clearly, $3,800 is not a very wildly irresponsible figure insofar as the cap is concerned. It is clear that any little extra jiggle in the health pattern of a family is going to upset that.

Those people with more income ought not to be thrown into the poverty level by an unforeseen health consequence. That is the kind of a program we were trying to develop here so that we could help those people above that level with unforeseen costs.

Senator RANDOLPH. This would not be in the category of the aged alone, but would go across the board, even including the middleaged; is that correct?

Mr. UNRUH. That is correct. That program would have covered, in effect, virtually everyone in the State.

PHYSICIANS' INCOME FROM MEDI-CAL

Senator RANDOLPH. Mr. Speaker, a final observation, and perhaps a couple of other observations.

Would you turn, please, to page 8. The percentage, Mr. Speaker, of these, let's say, unethical physicians—members of the medical profession—that you had spotlighted here by your use of the figure 1,000.

How many persons are involved in administering that program in the State of California?

Mr. UNRUH. I don't believe I could—are you talking about the doctors that are——

Senator RANDOLPH. The Medi-Cal patients.

Senator WILLIAMS. Patients, or doctors?

Senator RANDOLPH. No, the doctors that administer the program.

Mr. UNRUH. Somewhere between 2,200 and 2,400 doctors.

Senator RANDOLPH. You mean that when you say 1,000, you are speaking of, let's say, 80 or 60 percent—50 percent?

Mr. UNRUH. Forty percent—roughly 40 percent of the doctors would be making that figure.

That is a gross figure, Senator, I would hasten to add.

Senator WILLIAMS. That does not include the expense of medicines and nurses?

Mr. UNRUH. No.

Mr. MANLEY. May I add something here?

Mr. UNRUH. Yes, Mr. Manley would like to——

Mr. MANLEY. I am informed, Senator, that there are approximately 25,000 doctors who participate in some fashion, in some small or large fashion, in the Medi-Cal program.

However, there are only about 2,000 of them who participate in a large way in the program. So what we are saying here is about half of those doctors in the last fiscal year did gross $70,000 a year.

Mr. UNRUH. From the program.

Senator RANDOLPH. Thank you, Mr. Manley.

Mr. Speaker, now let's take the 40-percent-figure, and let's think in terms of the gross income.

I would like to ask you if those members of the medical profession are using, let's say, a major portion of their time—70, 80, 90 percent—on this program, or are they practicing other medicine? Is this the major proportion of their income, or is it only 20 or 30 percent of their income?

Mr. UNRUH. I think, Senator, probably that this constitutes a major portion of their income. In some cases it may constitute virtually all of it.

The only thing that I would add to that is that our indication is that exceeds the average income of those doctors who are not practicing in that field.

Senator RANDOLPH. Thank you, Mr. Speaker, and Mr. Manley.

Mr. Chairman, I think we might perhaps through staff research go into this matter. It reflects itself not only in this State, but I think we might study it more carefully in other States as well.

I am not attempting to——

Mr. UNRUH. There are other cases, but I did not list or go into them in depth because they are sensationalizing—pointing to the practices of some individual doctors which are part of the attorney general's investigation in this State,* which is supposed to be out, I believe, the first of next week—so far as the results of that are concerned. But we would be very happy to communicate that to the committee.

Senator RANDOLPH. Thank you very much, Mr. Speaker.

Senator WILLIAMS. A most helpful statement, Mr. Speaker, and the part that you did not read, as we said, will be included in the record.

I agree with Senator Randolph that further study is indicated along many lines that you discussed.

We will go off the record for a moment now.

(Discussion off the record.)

Senator WILLIAMS. On the record.

Mr. UNRUH. Thank you very much. I appreciate the opportunity to come before you. It is a very great problem, and I appreciate the opportunity to lay it before you.

Senator WILLIAMS. Thank you very much.

(Subsequent to the hearing, Senator Williams asked the following questions in a letter to Mr. Unruh:)

1. You will remember that there was some discussion of Governor Reagan's proposals to "cut out a block of recipients totally and completely." Mr. Manley gave as an example the "medically indigent," a group of some 600,000 individuals. May we have additional details on this proposal and other proposed cutbacks?

2. You noted that "ethical, reputable doctors . . . are doing their dead level best" to arrive at some kind of fee schedule that could be employed in Medi-Cal. Have you additional information on this point?

*Letter and report from California office of attorney general, see app. 3, pp. 811–836.

3. May we have additional details on your comment that the relative's responbility section of Title 19 has made it "financially easy for children to place their parents in nursing homes?"

4. Mr. Carel Mulder of the California Department of Health Care Services, said later in the day in regard to a fee schedule under Medi-Cal: "the physicians who customarily charge below the average will immediately move up to the average, and that physicians who customarily charge above the average will become disinclined to participate in the program, if it doesn't provide them with their usual fees." We would like to have your reply to this statement. (the full text of Mr. Mulder's testimony is enclosed, for whatever additional commentary you may wish to make. We are also sending to Mr. Mulder a transcript of your remarks.)

5. Your discussion of the CAL-MED proposal prompts three questions:

a. How would CAL-MED mesh with the Federal Medicare coverage?

b. Is it fair to assume that more emphasis could be placed upon health maintenance, or preventive medicine, than is now the case—particularly among people from age 45 and up, when such health practices and services can yield maximum benefits?

c. Your testimony mentions several private organizations that offer comprehensive health services on a prepaid basis. Would such organizations have the capacity to provide the services called for by CAL-MED? What incentives could be offered for organizing personnel into similar organizations? Could Federal resources be helpful here?

(The following reply was received.)

ASSEMBLY CALIFORNIA LEGISLATURE,
Sacramento, Calif., November 22, 1968.

DEAR SENATOR WILLIAMS: In response to your request of November 7 that I amplify on remarks I made before your U.S. Senate Committee in Los Angeles earlier this fall, I am enclosing answers to each question you posed. In addition, I am forwarding to you a copy of a report of the California Attorney General on our Medi-Cal program operated under Title 19.* This report was the one I alluded to in my testimony which had not then been published. It contains several illustrations of fraud current in our program, plus a wealth of other material and suggestions for improved administration. Since the report is perhaps the first of its kind to be attempted by any state operating a Title 19 program, you may wish to include it in your Committee's hearing record.

Suffice it to say that the Attorney General's report completely bears out my comments that some physicians and other providers of health care services in California are making exhorbitant and unjustified profits from the Medi-Cal program.

I hope this material is of use to you. If there is anything additional I can provide to assist your Committee please do not hestitate to let me know.

Sincerely,

JESSE M. UNRUH,
Speaker of the Assembly.

[Enclosure]

1. The correct number of medically indigent who would have been cut by Governor Reagan was 160,000, not 600,000. These are persons who are not quite as poor as those who are public assistance recipients and in the original Medi-Cal legislation were given a lower priority for services and continuation in the program. The Governor could have legally eliminated these persons from the program and threatened to do so unless the Legislature changed the Medi-Cal law. This threat was not considered seriously by the Legislature since the result would have been greatly increased county costs because the counties would have had to care for these persons.

The other proposed cutbacks by the Governor would have eliminated most of the non-required services except most drugs, emergency dental care and home health care. These were ruled illegal by the State Supreme Court. Other so-called cutbacks included a limitation of length of stay in private hospitals to eight days and a roll back of physician fees to the sixtieth (60) percentile of usual and customary fees. The latter program modifications are still in effect.

*See app. 3, p. 811.

2. Many physicians in California are not unequivocally tied to the concept of usual and customary fees which has been so vigorously advanced by the California Medical Association. A particular problem has been encountered by physicians in and around the Watts area of Los Angeles with whom I have discussed the problem. Because of the low economic status of their patients, the usual fee of these physicians has been relatively low. Thus the usual and customary concept, at least theoretically, requires that they receive the same low fee for Medi-Cal patients. This has a depressing effect in these areas, especially when physicians from other nearby areas receive higher fees for the same services. These physicians feel that payment should be on a reasonable basis for the service rendered and should not depend as much upon the desires of the individual physican regarding the fee he wishes to receive.

3. Title 19 does not allow states to require that children assume any responsibility for their parents. There are good reasons for this provision, but I merely wished to point out that it also has adverse effects. In California, under old age assistance, there is relative's responsibility. Thus if the children wish to keep the parent in their home or place him in a board and care facility, they must share in the cost. However, if the parent is placed in a nursing home under Medi-Cal there is no responsibility at all. This leads to inevitable pressures for placement in nursing homes which are the most expensive alternative. What I was proposing is that we develop a more flexible approach so that the least expensive alternative does not place a greater burden upon the responsible relatives.

4. The statement by Mr. Mulder appears to have a certain amount of validity. However, there is no evidence that physicians can't or won't raise their fees under the usual and customary concept; in fact, all the evidence would appear to be the contrary. It should also be noted that even now the state does not really know if the charge a physician makes to Medi-Cal is his "usual" charge. The best that is known is whether it falls within a range of fees which is "customary" in the community.

The observation that some physicians will be disinclined to participate under a fee schedule is undoubtedly true. We know that some do not participate today under the usual and customary concept at the sixtieth (60) percentile. The real question that Medi-Cal should ask is: What fee should we pay in order to get an adequate number of physicians to participate. I do not believe that question has really been asked. His answer should be the basis for establishing a fee.

5. (a) CAL-MED would provide supplementary coverage to Medicare depending upon the income and family size of the person involved.

(b) It would certainly be desirable for more emphasis to be placed upon health maintenance or preventive medicine, but I am not sure that such an approach would occur automatically under CAL-MED which is essentially a funding mechanism. However, to the extent that prepayment organizations accept the responsibility for providing comprehensive services to persons, it is hoped that they would develop such approaches as a means of reducing ultimate costs.

(c) Existing prepayment organizations would probably not have the capacity to provide CAL-MED coverage to all eligible persons. The incentive for organization will most likely be created by the demand for these services. This will occur, if it does, because of the lower cost in providing services. CAL-MED will operate on a competitive basis and only those organizations which can provide quality services at a reasonable cost will survive and grow.

Senator WILLIAMS. Congressman Reinecke has a time problem. Is Congressman Reinecke still here? Do you want to submit a statement?

STATEMENT OF HON. ED REINECKE, REPRESENTATIVE IN CONGRESS, 27TH CONGRESSIONAL DISTRICT, CALIFORNIA

Mr. REINECKE. Yes, Senators. I would ask the inclusion of a statement I have already delivered to the Secretary.

I would just like to express my appreciation for the care and time that you gentlemen are taking away from your schedules, when I am sure you have other requirements at this time of the year.

We appreciate that you would be here to concern yourselves about the health services for our citizens here in California.

Senator WILLIAMS. Well, we appreciate your time. I know we are working in a common purpose.

Mr. Reinecke. We are indeed.

(The complete statement of Congressman Reinecke follows:)

PREPARED STATEMENT OF THE HONORABLE ED REINECKE, REPRESENTATIVE IN CONGRESS, 27TH CONGRESSIONAL DISTRICT, CALIFORNIA

Mr. Chairman, I am deeply gratified to appear here today, and I welcome this opportunity to be able to participate in these Hearings. The fine work of this Subcommittee in probing the causes of the increase in the costs of health services has been widely recognized. Your impartial examination of present organization of services and present patterns of practice have shown that both human and financial resources are being wasted. Your investigations have also yielded valuable information as to how the deficiencies in our health services may be corrected so that public confidence in the programs of Medicare and Medicaid may be restored. I am pleased to be able to participate in these proceedings not only because of my deep interest in the subject, but also because of my long-standing concern for the well-being of those who have contributed so much to the growth of this Nation. We cannot afford to turn our backs on those of our elders, whether through no fault of their own, are no longer able to provide for themselves or whether they are able, at sacrifice, to pay their bills. Testimony given at previous hearings in Washington, D.C. and in New York City, certainly made this point clear. Hopefully, the hearings here in Los Angeles will prove equally valuable.

Los Angeles is a particularly appropriate place in which to continue your inquiry. Like any large city, it has its quota of problems. But it also has more than its quota of intelligent and innovative leaders and institutions. Their experience in dealing with the costs and delivery of health services in this area, will no doubt provide valuable lessons for the rest of the Nation.

EFFECT OF RISING COSTS ON MEDICARE PROGRAM

Mr. Chairman, perhaps the most important problem confronting Congress with respect to the medicare program is the effect that raising costs have had on the program and the older people it is designed to protect. As you will recall, last year Congress had to increase the payroll taxes which support the hospital insurance part of medicare, known as Part A, by more than one billion dollars a year—just to meet the increasing cost of hospital care. And I want to emphasize that this increase was not the result of greater use of hospitals by older people—it was solely the result of the increase in the costs of hospital care.

The American Hospital Association announced earlier this year that hospital costs will probably go up by 15% a year for at least three years. It is fortunate indeed that actual increases have not yet reached this level, but there is good chance that the AHA assessment may still prove correct. If Congress had been able to spend even half of the billion dollars for increased health benefits under the program, significant improvements affording additional protection to the elderly could have been made. Instead all of the increased taxes had to go for the higher costs of the existing program. In fact, the benefits under Part A were even slightly reduced.

As you know, Mr. Chairman, the premiums under the medical insurance part of medicare—the so-called Part B—had to be increased by one-third, from $3 each for the aged person and the government, to $4 each. This increase was caused largely by the fact that physicians' fees rose very rapidly during the year after the medicare program was enacted. Though earlier this year the aged were given a modest and much needed increase to their cash benefits, a good part of that increase had to be paid out for increased premiums.

EFFECT ON MEDI-CAL

The increase in the costs of health care dramatically affected the medicaid program here in California, known as Medi-Cal. The Department of Health, Education, and Welfare estimated last December that the Federal share of the medicaid program for this fiscal year would be a little over $1.5 billion. The estimate now for this year is one billion dollars more! While not all of this

change can be ascribed to increases in health care costs, probably a third of it can be so attributed.

Thus, Mr. Chairman, Congress is already painfully aware of the effect which increasing health costs have had on Federal programs designed to assist the aged in financing their health costs.

The effect of these increasing costs has been to bar countless numbers of older people from seeking the care they need under Medicare. This recently announced increase in the deductible under Part A of medicare from $40 to $44 is a straw in the wind—a sure sign that hospital costs will continue to rise. Next year the deductible may even go as high as $52, because of still higher hospital costs. The question of just when a deductible becomes a barrier to obtaining medical care is a question which cries out for an answer. I hope that the testimony before this committee will show, in more detail than is now available to us, the effects of the medicare deductibles and co-insurance provisions on the health of older people.

Those of us in Congress need to spur our efforts and the efforts of others to take the steps necessary to stem the swelling tide of increasing health costs. This is the bitterest form that inflation can take for our older citizens. Neither the Nation as a whole nor its older citizens as a group can bear indefinitely the increasingly heavy burden inflicted by the runaway inflation of health costs.

The problem of rising medical costs is a compelling aspect of the most serious of all the problems facing older Americans—that of achieving and maintaining an adequate income. The massive loss of real income through inflation must be recognized for what it is: the Number One economic public enemy in this Nation today.

Americans who have reached the age of 65 now number almost 20 million. By 1980 there will be approximately 25 million in this age group. With such a rapidly growing aging population, we will be faced continually with the necessity to deal with new problems as they arise. To deal effectively with new problems, whatever they may be, we must first solve the most basic of them all—the economic problem.

Economic Plight of the Elderly

The bills that I have introduced during the 90th Congress seek to relieve the economic plight in which so many older people live, while yet preserving their independence and sense of dignity. To strive for one goal without the other would be shabby treatment indeed for all those who fought and survived two world wars, who weathered the great depression, and who have borne the brunt of entry into the atomic age. It is a matter of plain justice for this Nation to help protect its older citizens against the skyrocketing cost of living—amounting to nearly 20 percent in the last eight years alone. Periodic increases in social security benefit levels will not suffice of themselves. For no matter how great the benefit increases are, they always lag behind the increase in prices. Nearly all of us are hurt by inflation; but no single group suffers more than older Americans. One obvious way to protect the elderly is to provide an automatic cost-of-living increase in Social Security benefits every calendar quarter, to adjust benefits according to rises in the Consumer Price Index. H.R. 5347, which I introduced in February of last year, would do just that.

There are other ways in which the economic situation of older Americans can be protected, and I have introduced several measures accordingly. H.R. 5158, for example, would amend title II of the Social Security Act to increase the benefits of a surviving widow to 100% of her husband's allowance.

Earnings Limitation Causes Problems

There is also injustice in the regulation that a Social Security recipient must keep his earnings below a certain level, or otherwise lose his benefits. I think that the limitation on allowable earnings should first be raised and then eventually done away with altogether. As a first step in this direction, I introduced H.R. 5157, which would permit those receiving Social Security to earn as much as $3,000 annually instead of the present $1,680 before their benefits are diminished.

From even the briefest review of the problems facing the majority of older Americans, we can see that new legislation to protect and assist them is essential. But legislation can only be as good as the architects who draft it. We must be sure that these architects are the best informed people available. They

must have a thorough knowledge and understanding of the complexities of aging in the modern world.

It is essential that we pause from time to time, to take stock of present programs and policies concerning the elderly, and to consider what directions our future efforts should take. The 1961 White House Conference on Aging is widely recognized for the vital role it played in stimulating significant new programs for older Americans. I am confident that the 1971 White House Conference will prove equally fruitful.

In summary then—we have a problem today—we will have a larger one tomorrow. Our attention today must be to reducing costs. Law generated requirements (red tape) must be reviewed and reduced. Private industry handles credit at a profit—so government could well learn from private industry.

Second, let us ask the Medical Profession for its recommendations for implementing the law without comprising quality or quantity of health services.

And finally let's ask the Hospital to recommend solutions to reducing costs. Legislation, subsidies, and political polemics are not the sole solution.

Thank you for your interest.

Mr. REINECKE. Rather than to summarize what is in the statement, because it is already in the statement—I would simply say that we hope it is recognized that the law alone will not solve the problems. We need a great deal of cooperation from the citizens, from the State and county governments, from the medical profession, and the hospital people.

I would hope that we could recognize, too, that perhaps a reduction in some of our own paper work that we have generated through our legislation—and I supported medicare when it came on the floor a few years ago, so I do support this program—but I recognize also the financial risk and the problems that have developed since that time.

It was not my intention to make any political comments, but in view of some of the statements that have been made by the previous witness, and in view of the fact that you gentlemen are vitally interested in getting an objective story, and further, in view of the Senator from West Virginia's statement that some of Mr. Unruh's statements called for further study, I would hope that part of that further study would come from a rebuttal statement from our own Governor's office.

I sincerely question several statements made—but I do not want to get involved in a political debate—it is unfortunate that politics does get into health problems. Certainly that is no place for it, but it is here, and you just heard it a few minutes ago.

I would hope very sincerely that you would submit Mr. Unruh's statement to the Governor's office [1] and ask him for his comments, so that you, in your judgment, could find from that the statements that would affect the future legislation of our country.

Gentlemen, I won't take any further time. I am most grateful to you, and happy that you did find a good day here in Los Angeles. And I say thank you, again.

Senator WILLIAMS. Well, I have just conferred with Senator Randolph. We feel that it would be appropriate to do exactly what you just suggested.

Mr. REINECKE. I thank you kindly, Senator. Thank you also for allowing me to appear here out of order.

Senator WILLIAMS. Of course we do have the Governor's representatives here, but we certainly will give the Governor an opportunity to submit a statement.

[1] Statement by representatives of the Governor appears on p. 675.

Senator RANDOLPH. What is your district?

Mr. REINECKE. Twenty-seventh Congressional District. It is part of Los Angeles. Most of the constituents do live in Los Angeles, or Los Los Angeles County. We have about 50,000 up in Kern County.

Senator WILLIAMS. The metropolitan area?

Mr. REINECKE. Yes, metropolitan. Many senior citizens projects are very much concerned. I have sponsored a great deal of legislation concerning benefits that are necessary to allow our senior citizens to remain their prideful selves and productive citizens of our community.

Senator WILLIAMS. Thank you very much.

What term are you in, by the way?

Mr. REINECKE. This is my third term—coming up.

Senator WILLIAMS. Confidence will get you everywhere.

Who is next here?

Dr. Lester Breslow. Where is Professor Breslow? There he is—from the UCLA health services.

STATEMENT OF LESTER BRESLOW, M.D., M.P.H., PROFESSOR OF HEALTH SERVICES ADMINISTRATION, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF CALIFORNIA AT LOS ANGELES

Dr. BRESLOW. Mr. Chairman and members of the committee, I am pleased to have this opportunity of appearing before you to discuss a subject of great consequence to the American people.

I am conscious of the fact that your committee has already covered a good deal of the subject in previous hearings, so I will confine my remarks to three points:

(1) Are the medicare and medicaid programs raising or lowering the quality of health care?

(2) What can the Federal Government do to favor higher quality of care?

(3) Can and should preventive medicine in the form of multiphasic screening be incorporated into federally supported health care?

One must carefully differentiate medicare and medicaid in considering their impact on quality because they have had opposite effects.

Part A of medicare, because the legislation specifically provided for it, has tended to raise the quality of hospital and related care. The legislative requirements of standards for hospitals, utilization review, agreements between hospitals and extended care facilities, standards for home care agencies, have encouraged nationwide attention to the problems of quality of care.

The impact of part A of medicare on the quality of institutional health services in this country has been favorable. It has been good not only for older persons but for the entire population receiving hospital and related care.

IMPACT OF MEDICAID

Medicaid on the other hand, the welfare medical care program, has tended to bolster the poorest kind of medical care. This has occurred because the basic legislation gave no attention to the matter of quality. Contrary to the medicare legislation which established a framework for quality standards, especially in part A, the medicaid legislation ignored this critical problem.

State and local welfare administrators have tended to purchase and pay for more of the same kind of care that poor people were obtaining previously. The personnel and facilities in neighborhoods where poor people obtained care were often inferior and, most important, medicaid offered no inducement to improve. It simply financially supported what was present.

In some parts of the country, particularly in California, those responsible for medicaid (or Medi-Cal, as we call it) have endeavored to link it up with the quality standards of medicare. To the extent that this has been possible medicaid patients have benefited from the medicare standards.

On the second question, what can the Federal Government do to improve the quality of health care, I would suggest three approaches. The first is to incorporate into all Federal medical care programs a legislative framework for establishing standards of quality, such as was done in the medicare.

Second, the Federal Government should assure payment of reasonable amounts for the services provided. It should not leave such determinations, as in the case of medicaid, to local officials who do not appreciate the fact that in health care, as elsewhere, you usually get second-rate service—or worse—if you try to get by cheaply.

Senator RANDOLPH. Could I interrupt at that point, without breaking your continuity?

Now, does your statement lend itself to an opposing or an agreeing viewpoint with that of Speaker Unruh?

Dr. BRESLOW. Well, he made a number of statements.

Senator RANDOLPH. Well, I mean on the matter of cost.

Dr. BRESLOW. The point that I would emphasize with respect to the fee issue that was raised by Speaker Unruh, is this: Much more important than the question of whether you pay $1 or $2 for an injection, or whether you pay $200 or $400 for the appendectomy is the question of whether you needed the injection or the operation in the first place. I believe that a tremendous amount of the waste in medicaid results from a failure to take into account that aspect of the problem.

So I must direct attention to the question of the quality of care. To provide the care that is needed when it is needed, rather than the issue of fees.

I think, really, that fees are a secondary issue although they have attracted the greatest attention.

Senator RANDOLPH. Thank you, doctor.

NEED FOR DATA ON QUALITY OF SERVICE

Dr. BRESLOW. Further, I believe the Federal Government should insist that its programs include a health data system that routinely turns out information on the quality of the service being provided. This is now possible through computer technology.

Senator WILLIAMS. I as sure you are right on your conclusion, but I am sure a fellow whose discipline is not medicine—not technology—who practices the inexpert profession of law and politics, I wonder just how would this help a doctor in his office?

Dr. BRESLOW. The State department of public health, in the early days of Medi-Cal, developed just such a system which disclosed partic-

ular physicians and other providers of care who were "way out" in their practices.

For example—and these are only crude examples—some physicians gave far more injections or did far more operations of certain types than usual in a community.

Now, to answer your question a little more fully—this system identifies and puts onto computer tape every service provided to every patient in medicaid, giving the place of the service, the name of the provider, the patient, the charge for the service.

Running out tables from such data, one can therefore identify individual physicians who, for example, give on the average more than one injection per patient visit.

Senator WILLIAMS. They have to feed that data in it?

Dr. BRESLOW. They have to feed that data in, because they must submit bills in order to collect payment for their services.

What this system does is to take advantage of bill submission in order to examine, not only the issue of the fees, which can also be done of course, but also to examine the issue of quality.

The system permits identification of physicians and other providers—not a few, there are several score of them—who have far exceeded the norms of practice.

One can identify physicians, for example, who do a great many operations for umbilical hernia on infants, which in most physicians' judgment can usually be treated effectively without the operations.

Senator WILLIAMS. By the way, this idea—who would be the recipient of this bank of information?

Dr. BRESLOW. In the early days of Medi-Cal, the information came to the State agencies, in those days to the State department of public health, which developed and maintained the State observation over the system.

It also, of course, was in the hands of the bill-paying agency—the fiscal intermediary, Blue Shield. Now, the State, I understand, has abandoned its direct surveillance of this operation, and has left it entirely up to California Blue Shield.

Senator WILLIAMS. Well, you used to be in State government?

Dr. BRESLOW. Yes, that's correct.

Senator WILLIAMS. You are no longer?

Dr. BRESLOW. No, except I am in the State university.

Senator WILLIAMS. Why didn't you stay?

Dr. BRESLOW. Well, sir, in California the director of the State department of public health, which was the position I occupied just before leaving, is an office for a term which expires 1 year after the coming in of any new administration.

That's when my time expired.

Senator WILLIAMS. I think I get the point you make.

Dr. BRESLOW. California Blue Shield has taken over this system. I believe, senator, it would be useful for your committee to explore this system in some detail with a view to incorporating some such system into all medical care programs that are supported by Federal funds.

It certainly would be a vast improvement over the situation in many States where there is no statewide medicaid data, even on the eligible population or on the services provided.

Information on each of the individuals served and each of the services provided them, as in the California plan, could become the basis for quality control.

Senator WILLIAMS. Would the doctors welcome this opportunity to contribute their information?

Dr. BRESLOW. There are probably some physicians who resent the fact that they are, so to speak, locked into such a system, but I think it is to the credit of the California Medical Association, and California Blue Shield, that they have supported this system.

I think there might be some debate about the vigor with which there is pursuit of the so-called deviant practitioners. But there is no doubt about the overwhelming support of the medical profession, in California, for a system like this.

PREVENTIVE MEDICINE; MULTIPHASIC SCREENING

On the last item, in which I know I share a considerable interest with you, Senator Williams, namely the incorporation of preventive medicine in the form of multiphasic screening into Federal health programs, I would say that this is desirable and feasible.

It is technically and economically possible, as well as medically useful to detect evidence of many significant diseases by a series of simple tests, now largely automated or performed by technicians under medical direction. When these diseases such as diabetes, certain forms of heart disease and cancer, anemia, and many others are detected in their early stages, the outlook for success in treatment is much more favorable than if they are allowed to progress into advanced stages. In fact, the difference not infrequently is life or death.

Such tests are now often incorporated into comprehensive health examinations for industry executives. The American Medical Association for several years has offered them to physicians attending their annual convention. The Kaiser health plan in northern California provides them. A joint labor-management trust fund in the California cannery industry has made them available through a mobile unit to thousands of cannery employees scattered throughout the State.

Several hospitals are now planning to install multiphasic screening.

I think that if it is good for all of these segments of society for physicians, for industry, for executives, for cannery workers and others then it has been tested well enough now to be able to say that it would be good for all the people.

Providing this service as part of Federal health programs would be a major contribution to improving health, especially for older persons who are more likely than younger persons to be affected by the chronic diseases that may be detected through multiphasic screening. It would be a positive contribution to health.

The success and growing acceptance of multiphasic screening make it timely for consideration of incorporation into Federal health programs.

Senator WILLIAMS. Are you familiar with the Kaiser program?

Dr. BRESLOW. Kaiser health plan is the name for the plan, I think.

Senator WILLIAMS. Are you familiar with how the—I talked about multiphasic screening. Someone, I don't know who it was, maybe it

was Bill Oriol, my trusted leader of the staff—who had tabbed it "preventicare."

I have talked about the Kaiser—they were pioneers, I believe——

Dr. BRESLOW. Right.

Senator WILLIAMS. I have talked about them a great deal and said that this is proof that it can work. An early incipient disease can be detected. And the earlier it is detected, the more likely we are to avoid costly treatment or surgery.

Now, how do they work? Who are the people who come in there to get tested?

KAISER HEALTH PLAN

Dr. BRESLOW. In the Kaiser health plan—and I think it would be well if you had an opportunity, Senator, to actually visit the installation and see for yourself what is being done there—the subscribers to the Kaiser health plan—that is, the individuals who are prepaid through their unions or employers or themselves—for health care——

Senator WILLIAMS. It is an in-house operation, is it?

Dr. BRESLOW. That is correct. These subscribers are eligible for examinations by physicians once a year, or oftener if necessary. A week or two before they see their own physician, they are scheduled to come in and have a series of tests called multiphasic screening.

When the physician sees the patient for the examination, he receives a brief history of the patient with the symptoms that the patient has written down ahead of time, and also the results from a quite wide array of laboratory, X-ray, and other tests. The physician can see these results when he first visits with the patient.

That means that he has a tremendous leap ahead in his examination. He doesn't have to order the tests of a routine sort that are included in multiphasic screening. He has the results when he first sees the patient.

He, of course, can and does follow up these screening tests with more elaborate examinations, X-ray, laboratory and others. This is the way it works in the Kaiser health plan.

They found a great economy as well as medical use for it.

Senator WILLIAMS. So it is a two-phase operation. The employee goes to the doctor, and then the doctor makes findings, and the next step would be the whole Kaiser program; is that it?

Dr. BRESLOW. The basis for the diagnosis and treatment plan is this survey which can be carried out now quite effectively through these series of tests organized, as has been done in the Kaiser health plan and in many other situations as well.

Senator WILLIAMS. I didn't know that there were two phases, to tell you the truth.

Dr. BRESLOW. Many of us feel that this is the best way to provide this service. You go first for the screening tests, provided incidentally at offhours, evenings, and so on, so as to make it more convenient for patients. This also uses their equipment most effectively.

Then the results are assembled by computer and given back to the physician at what you call the second phase, when he has an appointment to see the physician.

Now, multiphasic screening itself is of course just a series of tests, with results and the referral. All of this is of no value unless it is followed up by the patient's physician.

Senator WILLIAMS. Why does he have to go through the screening process with the physician? Why not just go right into the multiphase operation? Isn't that supposed to determine——

Dr. BRESLOW. Well, he does go directly into the multiphasic screening.

Senator WILLIAMS. I understand he went to a doctor first.

Dr. BRESLOW. I am sorry if I gave that impression. He has the appointment with the physician scheduled, but before he sees the physician—a week or two before—he has the multiphasic screening.

Senator WILLIAMS. So the first phase is the——

Dr. BRESLOW. The multiphasic screening.

Senator WILLIAMS. I understand.

Dr. BRESLOW. I am sorry if I didn't make that clear.

Senator WILLIAMS. I am sorry I misunderstood that.

Dr. BRESLOW. The point is the findings from the multiphasic screening are referred to the physician.

Senator WILLIAMS. That I understand.

Would you recommend that as a national program?

Dr. BRESLOW. Yes, I would.

EXPERIENCE JUSTIFIES NATIONAL PROGRAM

Senator WILLIAMS. By the Federal Government?

Dr. BRESLOW. I would; I would recommend that as a national program.

I think we have had sufficient experience with it in different forms, different places, different circumstances, that it is certainly justifiable as a national program.

It is something like the situation with respect to home care, a few years ago. There were some demonstrations of home care. There were some questions as to how useful it might be, whether it should be incorporated into a national program. When the issue arose about incorporating home care into medicare, some asked whether we had sufficient experience with it, whether there were sufficient resources for home care available to justify putting it into medicare.

Many of us, at that time, took the same position that I would take now with respect to that multiphasic screening. We have had sufficient experience with it. It is sufficiently well known in the medical community that, if the Federal government were to incorporate it into a national program, then it would expand with the impetus of the funds available to pay for it.

Senator WILLIAMS. Are there any dissenters on that point?

Any dissenters?

Mr. CUBBLER. As a matter of fact, it would be required for children after July 1, 1969, as a result of the 1967 amendments.

As long as it is used only for the purpose of identifying diseases in order to treat them, rather than excluding them from the program, it is a very, very good idea, sir.

Senator WILLIAMS. Will you identify yourself for our record?

Mr. CUBBLER. Charles Cubbler, C-u-b-b-l-e-r.

Senator WILLIAMS. Dr. Breslow, you don't look as healthy as the last time we worked together on arbitrary labor. I don't think you have been taking enough grapes. [Laughter.]

Dr. BRESLOW. We use grapes for a lot of things in California. I recall one time studying the problem of quackery in the treatment of cancer. We found that grapes were being offered as a cure for cancer, and action had to be taken against the individual who was advocating and offering that particular form of treatment.

I am sorry that my voice is hoarse.

Senator WILLIAMS. No, I was only kidding you about that. It hurt me when grapes were being served on the plane coming out, and they looked so good. But they were the forbidden fruit, because of the current boycott.

I wish we could get that all straightened out—but that's another matter entirely—bringing order, harmony, and agreement in the farm labor situation.

Dr. BRESLOW. The progress that you and others in the Senate and the Congress have made with respect to health services for farmworkers, migratory workers, has been quite important in bringing to the attention of the whole body politic the situation of farmworkers in California and elsewhere.

I think it is generally true that health services, as supported by government in such situations as the migratory labor camps are more widely accepted than some other approaches to the problem.

I hope that you will continue to pursue your interest in that matter of assuring that at least minimum health services are brought to people in that situation.

Senator WILLIAMS. Well, that isn't germane to our discussion, but I am glad you made the statement.

The last time we were out here talking about migratory workers we had Senator Bob Kennedy with us, and he certainly made an impact upon the farm community.

Senator RANDOLPH. Mr. Chairman, at that point I do want to mention, and I do want the record to indicate that as you had this colloquy with the doctor, that President Johnson yesterday signed the Medical Services Act of 1968, and as you well know, there is a provision in that act for medical care for the migrants of this Nation. That is a part of the complex, overall program, which has been enacted into law.

I don't want to be pollyanaish at this point, but I want the record to reflect that the Congress of the United States has perhaps made errors and committed mistakes, but that the recent Congresses have been most energetic and effective in moving forward the programs of health in the United States of America.

I don't want to attempt to be partisan whatsoever, but I do think that the record is one which is very clear, very understandable, to those who will study what we have been doing.

We may have retraced our steps, at times, for reasons, but just this one act alone, doctor, and Mr. Chairman, passed by this Congress and signed into law yesterday, it is a notable, a significant advance in program for the persons who need the medical care.

I compliment our chairman and this committee who have done so very much in our Subcommittee on Migratory Labor, and the Labor and Public Welfare Committee.

But you know, I think it is necessary these days to sometimes speak in praise of something—and not constantly to be negative. There are mistakes made and errors committed, and programs that are short-

changed, but I for one want to keep in balance the good with what I called the bad. [Applause.]

Senator WILLIAMS. I wish that the reporter would record that there was applause at that point.

Dr. BRESLOW. Senator, I would like, if we have just a minute, to go back to a question that was raised with respect to testimony that an earlier speaker gave on the Medi-Cal program.

MEDI-CAL BUDGET CONTROVERSY

I am not sure that I fully and directly answered the question concerning the estimates of cost of the Medi-Cal program. During its first year in office the Reagan administration publicized such wild estimates of the cost of Medi-Cal that it seems the distortion of statistics could have only been either malicious or based upon gross ignorance.

The allegations that Medi-Cal would bankrupt the State apparently were designed to frighten taxpayers. Such allegations certainly had the effect of seriously disrupting the program by forcing cutbacks under the threat of runaway costs.

In fact, the original estimates of Medi-Cal costs and budgeted for the March 1966 to June 1967 period were very close to actual expenditures for that period. In the subsequent year—the one just ended in June 1968—expenditures were way under the conservative budget that was prepared under the fanfare of headlines about runaway costs.

Senator WILLIAMS. Very good. Thank you very much.

Dr. BRESLOW. Thank you, Senator.

(Subsequent to the hearing, Senator Williams asked the following questions in a letter to Dr. Breslow:)

1. Your prepared statement said that many individuals in California and elsewhere have endeavored to link up Medi-Cal with the quality standards of Medicare. May we have a summary of the suggestions most often made?

2. How would you implement your recommendation to "incorporate into all Federal medical care programs a legislative framework for establishing standards of quality." What programs would be thus affected? Would any be of special importance to the elderly?

3. Your strong recommendation for adequate health data systems in federally supported health programs is of great interest to the Subcommittee. In your suggestion that the Committee "explore this system in detail with a view to incorporating some such data system into all medical care programs supported by federal funds," what do you see as the major questions that should be explored?

(The following reply was received:)

UNIVERSITY OF CALIFORNIA, LOS ANGELES,
Los Angeles, Calif., November 26, 1968.

DEAR SENATOR WILLIAMS: * * *

The way to link up Medi-Cal (the California version of Medicaid) with Medicare is simply to require that all services paid for by Medi-Cal must conform to the standards established for Medicare. This policy would disallow payment for care under Medi-Cal in hospitals, laboratories, home health agencies or other facilities whenever these facilities had not been certified for participation in Medicare.

For example, this policy would not permit what many regard as dissipation of Medi-Cal funds in individual home services that are not a part of organized home health agency services.

Each state, of course, could establish such requirements for its Medicaid program, but it would be far preferable to have this established nationwide as in Medicare.

To incorporate into all federal medical care programs a legislative framework for establishing standards of quality, I would suggest following the pattern of the Medicare (Part A) pattern. You will recall that the Medicare Law (Title XVIII) specifies in considerable detail the standards which must be met by hospitals and other providers of care, and extends a framework for state participation in determining compliance with the standards as well as an opportunity for states to establish higher standards than those in the nation as a whole. I believe that every federal program for health care should establish the same kind of legislative framework as that now embodied in Medicare (Title XVIII). This would affect primarily the Medicaid program which provides services to the elderly as well as the other services, and all other major federal health programs.

In exploring health data systems for federally supported health programs I would suggest attention to the following questions: 1) Will the data meet the needs of program administration, and the Congress for information on the costs and utilization of the various types of health services provided to the population groups that are to be served? 2) Does the data provide information concerning the quality of care provided? 3) Is the data system linked to administrative action? For example, if the data disclose providers of care who are deviating so extremely from the norm that investigation is needed, is there a system for investigation of these deviant providers under appropriate professional direction, and is necessary action taken, including when appropriate, recovery of money that has been paid and suspension from the program. 4) Should national minimum standards and reporting be established for the data, as in the case births and deaths, and certain diseases such as tuberculosis and cancer? 5) What would be the cost of such a system incorporated into present administrative providers, and would it contribute to cost control of the program?

I believe that your investigation would disclose answers to the above questions that would strongly support the establishment of a health data system such as I have proposed.

Sincerely yours,

LESTER BRESLOW, M.D.,
Professor of Health Services Administration.

Senator WILLIAMS. Dr. Malcolm Todd, president of the California Medical Association.

STATEMENT OF DR. MALCOLM C. TODD, PRESIDENT, CALIFORNIA MEDICAL ASSOCIATION

Dr. TODD. Mr. Chairman, members of the Senate Special Committee on Aging, I am Dr. Malcolm C. Todd, president of the California Medical Association, representing 24,000 physicians in this State.

As a surgeon engaged in the private practice of medicine in Long Beach, Calif., I take care of people when they get sick, I operate on plumbers for ruptured stomach ulcers, I remove breast cancers on professors' wives, and I operate strangulated ruptures on little children.

I also remove diseased gall bladders on preachers, take out colons for cancer on machinists, and I do hysterectomies for tumors on secretaries.

For years I have operated at the county hospital and have taught at the University of California without remuneration. In other words, I receive no pay, whatsoever, for my skill and time, but there is one great satisfaction, and that is to know that I have helped restore many injured and sick indigent patients to good health.

Accompanying me today is Dr. Marvin J. Shapiro, who is a member of our association's council, or the board of trustees. Dr. Shapiro is a radiologist in private practice in Encino, Calif.

I wish to sincerely thank you and the committee for the opportunity to appear here today.

In the question sheet accompanying your letter of invitation, Mr. Chairman, several excellent questions were raised for possible discussion in my statement. I shall address myself to these inquiries.

But before I enumerate current activities of organized medicine on the subject of utilization and peer review, I would like to point out that these were ongoing activities of organized medicine prior to the passage of Federal legislation. The importance of this pioneering activity has been adapted to Federal-State funded medical care programs to the benefit of both the taxpayer and the beneficiary under these government-financed medical care programs.

The important result of these pioneering efforts has been a dramatic adoption of these activities by the county medical societies. This reaction by county medical societies is not to be minimized.

Guidelines for Utilization Review

As the committee knows, utilization review procedure was part of the medicare law and our association has encouraged this activity as a regular function of the hospital staff. Our manual, "Guidelines for Utilization Review," is used as a guide in California and in many other States.

The California Medical Association program of medical staff surveys in hospitals were developed, and we recognized the importance of utilization review as an educational hospital staff activity and so incorporated it as one of the six basic staff review activities. We were cognizant that utilization review is primarily a function of the medical profession and it requires determinations not only of medical necessity, but also whether the most efficient use of available facilities and health services is being made.

I feel the effectiveness of utilization review in the newly established and not-so-well-understood extended care facility needs some improvement. With others, we are experimenting with regional utilization review practices by increasing emphasis on this responsibility, and in some cases, our county societies are currently providing utilization review for extended care facilities.

We have published a booklet entitled "The Physician and the Long-Term Care Facility" to assist component medical societies in developing a structure for close liaison between the medical community and facilities providing supportive care for chronically ill patients.

Concurrent with this effort, we have attempted to define and determine guidelines for the level of care to be supplied Medi-Cal patients in extended care facilities as distinct and separate from custodial, that is, room and board care. I know these guidelines have assisted physicians in designating the type of facility required by patients.

Another example of activity in the field of utilization review is the California Hospital Association-California Medical Association "Procedure for Review of Effective Utilization of Hospital Services."

This plan was adopted by the State Office of Health Care Services, on June 12, 1968, for the title 19 Medi-Cal program.

I will be pleased to submit this full procedure as an appendix to my statement [1]—but I can briefly state our aim is to provide Medi-Cal with a system of safeguards in the utilization of hospital services and to assist hospitals to maintain and strengthen standards of care.

We recognize that as providers of health services, we have a responsibility for assuring that the public interest is being served in the delivery of hospital care. We also believe that quality is the most important component to effective hospital service. Therefore, in cooperation with the carriers for the Medi-Cal program, we have agreed that standards of quality can best be judged by professional peers, functioning expressly to review patterns of hospital practice.

The methods are: first, screening for irregularity; second, detecting irregularity; third, referring for peer review by a panel of practicing physicians and hospital administrators. We also make provisions in this plan for evaluation of these procedures on the basis of their effectiveness.

To discuss peer review is a broad assignment. It can mean the grievance or mediation committee of a county medical society which attempts to fairly adjudicate a patient's complaint based on the considered judgment of a panel of involved physician's peers. Or it can mean a tissue committee in a hospital which reports on the attestable need for the surgical procedure performed.

It can mean an ethics committee of physicians charged with the interpretation of ethics involved in the professional conduct of a colleague. Or it might mean a claims review committee in a county society advising an insurance company, a consumer or his designated representative on the propriety of the medical procedure and the reasonableness of the charge.

Certainly a utilization committee is an example of peer review. Our medical review committees help evaluate and advise on variant medicare claims in cooperation with the carrier. Both carriers for title 18, part B, and Medi-Cal have instituted a very sophisticated system—a medical adviser system composed of about 150 practicing physicians over the State who have served on claims review committees.

These doctors work in liaison with the county societies in behalf of the carrier to assure the highest quality of care at the most reasonable cost.

There is inquiry as to the results of peer review. Gentlemen, I can say with the deepest sincerity that we know we get results. I have served on various peer review committees in my own county society—California physicians give freely of their time, which adds up to thousands of hours annually, to serve on these committees.

Yes, gentlemen, I repeat—these reviews have been carried out at no cost to the government and none to our patients. It is truly a voluntary effort on the part of physicians performing these services and performing them at their own expense in behalf of making the program work.

Our county societies have recommended suspended participation in Medi-Cal for deviant doctors and they also adjust claims in a forthright manner, according to a program regulation and medical

[1] See app. 1, p. 7017.

appropriateness. We pledge continued effort to further strengthen all aspects of peer review.

Now, we as a profession testified and warned government social planners, back in 1962 and 1964, for example, that hospitals would be crowded, that costs would rise, and the program would be inflationary.

And frankly, we have not been wrong in this prediction.

Availability of Health Services

Now, a second question is asked if there is a significant number of elderly persons in California who encounter difficulty in securing health services because of unavailability or increasing costs of such services.

In all candor, I believe there are yet a number of people of all ages, young and old alike, who do not receive adequate medical care for some reasons. Accessibility is sometimes a reason, but, I must add two other reasons for this difficulty; they are ignorance and psychological barriers such as fear, mistrust, and apprehension.

I believe many of these deprived people live in our city slums and in rural areas. Our recommendations—well, let's recognize the social problems along with medical problems. Ignorance has to give way to education; favored home remedies have to give way to desires for scientific medical care—and quackery has to be eliminated.

And we have to overcome our shortage of health care professionals if we are going to be capable of giving medical care to every citizen of this country in the most ideal terms of modern scientific medicine.

What then are we doing? The medical profession is involved in several OEO neighborhood health center medical programs in addition to rural migratory health care programs. We are working with the health insurance industry and Blue Shield to improve voluntary prepaid health insurance. Our association is now compiling the "Essential Components of Adequate Health Care Coverage" as a guideline and standard for the consumer public.

We are also trying to educate the public to the advantages of preventive medicine. Los Angeles County Medical Association supported a public education program on the necessity of "Pap smears" in a portion of Los Angeles called the Watts area. We have sponsored our State's cancer antiquackery law which has saved patients' lives—by preventing futile treatments and wasteful expenditures.

Our delegation to the American Medical Association supported advocacy, in a preliminary report, of the concept of income tax credits to provide financial assistance to that segment of our population unable to afford complete and adequate health insurance coverage—regardless of the age of the needy individual. We hope and urge this concept will receive legislative consideration by Congress during the next session.

Now, we all have a responsibility in programs for the aged. First, to lower the cost of health care. Second, at the same time to maintain quality of health care. I say to you, doctors will accept their responsibility. But we feel that the patient, his relatives, and his family, must also accept theirs, and not demand a stay in the hospital longer than is necessary, and not try to remain in extended care facilities for a longer period of time than is absolutely necessary.

And that they not ask for unnecessary medical services. I also feel that social workers have a responsibility to try to control health care costs. She should not side with the patient on every request that is submitted, but must carry out just what is provided in the terms of the law itself.

The third injury concerns the impact of medicare and Medi-Cal on the quality of health services provided for the elderly. While some feared that these programs would greatly overtax our present system of providing health care, I do not believe we are in a crisis.

Yes, our hospitals are crowded—and yes, we do need more health care professionals. But I believe the quality of care rendered today reaches a broader segment of the public. I realize this is a generalization, but I am speaking from my experience and that of many of my many colleagues over the State.

The quality of mainstream health care in California is high—yet it is most important that we work together getting all of our citizens into that mainstream of medical care.

Questions About Physicians' Fees

Too much attention has been directed toward the physician's fees. Figures can be made to mean anything that they want to. But in an effort to achieve solutions to medical services for the aged, and to cut medical care costs, there are some things that I would like to mention.

It is interesting to note that the Medi-Cal budgeted in 1967–68, $159,500,000 for physicians' services. But they actually paid out only $122,100,000.

I would also like to state that over the overall health care cost dollar in the Medi-Cal program, the physician's fees amount to just 19 to 20 percent of the entire health care cost dollar. But it is that extra day in the acute hospital that we must not allow to be abused, because this is where the cost of this program centers.

Doctors need legal and administrative regulations to enable them to apply sound medical judgment consonant with the economical implementation of the law in regard to extended care facilities. A difference between needed nursing home care and custodial or remedial care must be acknowledged.

Also an attempt should be made to investigate unnecessary and unjustifiable use of ambulances and ancillary services. There must be developed a better planning of hospital beds and facilities and develop new health services; that is, methods of preventive and rehabilitative medicine.

I think, too, that we should see that our voluntary health insurance plans develop provisions for payment of voluntary out-patient services, diagnostic services, and minor surgical procedures themselves.

The final inquiry stems from the possibility of congressional cutbacks in the title 19 program. As you know, the medical profession supports the principle of government providing financial assistance to persons not able to provide for their own health care. Title 19, the medicaid law, is based on this principle.

I therefore strongly oppose proposed cutbacks in the present program as a deterrent to the provision of health care for this needy class of people. I think this response speaks for itself.

May I again thank you for the privilege of allowing me to present these remarks, and at this time, with your permission, I would like to call upon Dr. Shapiro, if he has any comment to make particularly in regard to migratory labor.

Senator RANDOLPH. Do you want questions, Mr. Chairman, that would refer to the testimony of Dr. Todd?

Senator WILLIAMS. I think we would. I think we ought to, if you have questions, I think we ought to address them to Dr. Todd before his associate speaks.

Senator RANDOLPH. Thank you very much, Mr. Chairman. You speak of the deviant doctor in California or elsewhere.

Now, I am wondering if you, for the record, would say that this is a very small percentage of the medical profession in California, or say, otherwise, and say what steps are being taken that you have indicated to keep this a small segment.

Dr. TODD. Thank you. I am glad to have this opportunity.

In the earlier presentation that was made, a question was asked as to how many doctors participate in our California Medi-Cal program, to begin with. As I stated earlier, we have some 24,000 members of the California Medical Association, and I am happy to say that with the program that is now in operation we have over 18,000 of those doctors participating in the Medi-Cal program—much in contrast to previous testimony that was given.

I have the documented figures in front of me. I said 18,250 out of 24,000. Now we recognize that there are some of these individuals who are deviant practitioners. We, as a medical profession association, feel that we have an obligation to protect the public and public funds. And deviant physicians are those who we simply will not tolerate.

Through our peer review committee activities we are able to pick up a number of these men whose practices are far from the usual. These are turned over to the bureau——

Senator WILLIAMS. What do you call that bureau?

Dr. TODD. The office of health care services.

Senator WILLIAMS. No, no. Who reviews it?

Dr. TODD. Who reviews it? The deviant doctors?

Senator WILLIAMS. The peer—what?

Dr. TODD. These are made—oh, the peer review?

PROTECTION AGAINST DEVIANT PHYSICIANS

These are made first by California Blue Shield—that is, the carrier. These in turn then are turned over to the peer review committees of the county medical societies. If they find that claims are unjustified—that there are excessive practices—that there is overutilization of services themselves, the physician is called in and talked to in this regard by his own peers.

After this is done, a warning is given. If he does not heed the warning and does not follow the suggestions, he then is notified that he has—his name has been presented before the Office of Health Care Services of the State administration.

And they in turn then have the obligation of submitting his to the attorney general.

Senator RANDOLPH. Doctor, I wish to pursue what the chairman has said. You say this is the procedure, and I commend you.

Now, how many persons, to your knowledge, have been called before those peers and had discussions of their malpractice? This is important to the committee.

Dr. TODD. Yes, it is. It is a function that varies entirely with each one of the county medical societies. In Los Angeles County itself, our largest county, and of course the largest county medical association in the country, has been very active in this activity, and a number of physicians—a proportionate number of physicians—have been called in and had this discussion with them.

I can tell you, specifically, that of the physicians alone, some nine or 10 physicians have been reported to the office of health care services, and in turn, turned over for review by the attorney general's office.

Senator RANDOLPH. Thank you, Dr. Todd. I think that the record should indicate that not only would the medical profession, as you have indicated, be very desirous of checking these practices, which are not consonant with good medical ethics, but I think here also I would like to speak from personal knowledge.

I think that the voluntary health insurance programs have helped to ferret out some of these people. I think the Blue Shield needs a word here today for their efforts; would you agree?

Dr. TODD. I certainly would. I think they have had a tremendous task. I wonder if you gentlemen can envision the receipt of 100,000 claims per day? This is a tremendous task that they are faced with. The computers—they have six computers during this operation here for this alone—this is a tremendous job, and there obviously have been some errors in the State.

But I think we are making progress in this activity, because I want to sincerely say to you that the majority of doctors practicing medicine are interested in making this program work.

Senator RANDOLPH. May I pursue one or two other questions, Mr. Chairman?

You have spoken, doctor, of ignorance and psychological reasons why perhaps programs have not been as effective as they might have been.

Now, where does education come in, and how can education be used, and perhaps in what way can the Congress, without laying down a straitjacketed guideline, are there criteria the Congress itself, through agency administration, can bring into being to aid this effort?

Dr. TODD. Yes. Dr. Shapiro would like to answer that, if you would. He is the chairman of our Community Health Commission of the State Medical Association.

STATEMENT OF MARVIN J. SHAPIRO, COUNCIL MEMBER, CALIFORNIA MEDICAL ASSOCIATION

Dr. SHAPIRO. Senator, I think that reference was made earlier to this cannery workers multiphasic screening program. I think what we have learned from that illustrates this particular problem very well.

The cannery workers program last year surveyed several thousand people. When they got quantitative results, they found that 48 percent of these people had no doctor to whom the results could be sent, which

of course raises another problem in the area of multiphasic screening—being different from that of the Kaiser program, where they already have a doctor.

California Medical Association was brought into it by the trust in an attempt to see to it that the patients on whom abnormal findings were detected were referred to doctors who would follow up and see that they were properly taken care of.

We worked very actively with the trust on this.

One of the big problems, however, has been that no matter how vigorously the recommendations are made to the people, on whom abnormal findings are detected, we can't get them to go to the doctor. And it doesn't do much good to get the abnormal findings if we can't get the followup.

I think this is the sort of thing that the doctor is alluding to, and certainly that we must educate the people of the necessity of followup. It has to be a constructive program.

Senator RANDOLPH. Thank you, Mr. Chairman. That's all the questions that I have.

Senator WILLIAMS. Thank you very much.

Did you have any other——

Dr. SHAPIRO. Nothing that need take the time of the committee, I am sure.

Senator RANDOLPH. Your testimony was very informative and helpful, I am sure, to our committee.

Dr. TODD. Thank you. It is a pleasure to be here.

Senator WILLIAMS. I was very encouraged by your statement, Dr. Todd. I have had a feeling that the medical association was very slow in coming to these positions—the particular programs of medicare and Medi-Cal, but evidently the acceptance is there.

Dr. TODD. We are trying to work with it, and you will find that doctors are participating with the program.

Senator WILLIAMS. Thank you. Very good, thank you very much.

Is Mr. Carbray here? The chairman of the senior citizens activity committee of this county—and I think you know something about the AFL–CIO; don't you?

Mr. CARBRAY. I have a feeling that I do, Mr. Chairman.

Senator WILLIAMS. You have Mr. Davidson and Mr. Hartley with you?

Mr. CARBRAY. That is correct. Rob and Louie; would you come up here?

STATEMENT OF JAMES CARBRAY, CHAIRMAN, SENIOR CITIZENS ACTIVITIES COMMITTEE

Mr. CARBRAY. If I may, Mr. Chairman, may I express the appreciation of the Los Angeles County Federation of Labor and also the appreciation of the National Council of Senior Citizens, on my own behalf, for this invitation.

However, as you will note from the agenda, I am speaking today for the Federation of Labor of Los Angeles County. Immediately following my rather brief testimony, I would respectfully suggest that you hear a very brief statement from Mr. Davidson and Mr. Hartley.

And now, taking the lead from Senator Randolph to say something objective once in a while about the things that come to our attention,

I would like to extend our thanks to you, Senator Williams, for the presentation of S. 4115, recently in the U.S. Senate, which calls for the establishment of an Institute for Retirement Income.

I think that this is long overdue, considering the fact that we live in a rather youth-oriented society, and that poverty, where it lies, hurts the seniors to a greater degree, because of his inability to work, than it does the junior. And this I am most appreciative for.

Now, I want to preface this with a comment regarding the general statement of Dr. Todd. I don't want to construe that what I am about to say in the form of testimony is derogatory or a reflection on all the people within the medical profession or all the people who are responsible for administering hospitals. I think Dr. Todd touched on the fact that there are some scoundrels probably in both areas.

But those of us in the federation of labor, and those of us in the senior citizens organizations are aware that by and large a major portion of our doctors and our hospitals are dedicated and sincere.

Deluge of Complaints About Costs

Since the advent of medicare and Medi-Cal, union officials and officers of senior citizens organizations have been deluged by complaints of increased hospital costs and doctors' fees. These increases were reflected in a social security bulletin, as I recall, dated July 1, 1967, which is after 1 year of medicare experience, and as I recall, this report showed an increase of approximately 22 percent in daily hospital charges and just over 5 percent in doctors' fees on a national average basis.

Several studies by responsible researchers have been conducted since 1966, one such study having been made by University of California at Los Angeles, which involved some 75 or more—it seems to me the correct figure is 77—hospitals in the Los Angeles area.

The study showed an average daily hospital charge of $74 during the first quarter of 1967, according to hospital officials; but the hospitals who replied to the study questionnaires showed an average daily charge of in excess of $86.50 for the first 6 months of 1967.

Let's compare this with the Blue Cross daily average of $75 for the last half of 1966. You show a daily increase of $11.50.

During the time of this study, which was the study quoted, during 1966–67, discussions were held with health plan administrators, government officials and insurance company representatives specifically regarding doctors' fees which indicated some increases in fees of 50 percent, and considerable gouging in routine office visit fees for medicare patients.

The UCLA study discloses that information provided by representatives of Blue Cross, Occidental Life, and California Physicians Service to the Benefit Plan Administrators formed the basis for the following statements made to the UCLA representative.

(*a*) Thousands of medicare and Medi-Cal claims submitted are being held up and investigated because of suspected excessive charges on overutilization. The same applies in some respect to prescription drugs.

(*b*) A few individual doctors may be receiving, from the services alone, in excess of $100,000 a year.

(*c*) On the basis of claims submitted, one doctor apparently was seeing over 200 patients a day—an average of one every 2 minutes.

(*d*) Some claims are being paid on the basis of $9 to $12 a visit on the California Medical Association relative value study. Such claims were unusual prior to medicare and $5.50 to $6.50 per unit generally considered the reasonable customary charge in Los Angeles County.

Claims reviewed—this is all during these studies—disclosed the following:

(1) One doctor charged each of his medicare repeat patients after July 1, 1966, for his first visit on the basis of a complete history and physical even though it was just another routine visit. This provides for an allowance of 1½ to 2½ times what he should have been allowed.

This doctor was therefore paid from $20 to $35 for a routine visit.

One doctor raised his routine visit charge, treating the same patient for the same condition from $5 to $6 per unit to $8 or $10 per unit.

Routine office visit charges for medicare patients of $15 to $20 were paid to one doctor.

One doctor, using an automated laboratory for blood work, was paid $140 for tests which probably were billed to him at less than $5.

Cost of Prescription Drugs

Directly related to the health care costs of the elderly is the cost of drugs, and in particular prescription drugs. The concern of the elderly is reflected in the complaints received both by labor organizations and senior citizens' organizations and it is quite significant that where drugs can be purchased under the generic name the savings are substantial, which accounts for the demands of responsible senior citizens' organizations that prescription drugs be covered by medicare, thereby allowing the Federal Government to purchase drugs under their generic name through the means of competitive bids.

Senator Williams. Did you hear Dr. Todd's testimony?

Mr. Carbray. Yes, I did.

Senator Williams. It seems to me that he said there was a surveillance system in the medical profession——

Mr. Carbray. That's right.

Senator Williams (continuing). That brings these scalpers or gougers to heel.

Mr. Carbray. That is right, Senator, and that is why I prefaced my testimony with the statement that I did, because I do have respect for Dr. Todd, not only for his qualifications, but for his reputation as a real humanitarian in the field of medicine.

Senator Williams. Thank you.

Mr. Carbray. This sampling reveals the need for a comprehensive study in detail of both hospital costs and charges, should some hospitals refuse to cooperate, appropriate steps should be taken to assure disclosure of all records, even if by legislation if necessary, for we must bear in mind that many hospitals are operating under the banner of nonprofit ventures.

Senator Williams. Well, we have a double nexus with the Federal Government and hospitals. Not many of them have benefited under

Hill-Burton under that application, and of course medicare as the other leverage for Federal attention.

Mr. CARBRAY. Now, we feel that a similar comprehensive study should be made of doctors' fees; for during the past 2 years the press, and other news media, have reported many instances of excessive fees, and almost unbelievable increases in doctors' income since the advent of medicare and Medi-Cal.

Numerous samplings this year, during 1968, indicate hospital charges are averaging nearly $100 daily. This would indicate the upward trend continues.

RECOMMENDATIONS

The current deductibles in the medicare program are in reality an economic roadblock to health services for millions of elderly in the low-income bracket and we feel they should be eliminated.

Compounding this injustice in California is the fact—and I might say that this is also true in many other States—I think 34 other States—that recipients of State old age assistance suffer a reduction in their State assistance checks in an amount comparable to the increase in Social Security benefits as the result of vetoes by the Governor in 1967 and 1968 of legislation which would have eliminated this injustice.

Prior testimony before this committee by officers of the National Council of Senior Citizens calls for appropriate amendments to the medicare program which would remove such deterrents to health services to the needy. The Los Angeles County Federation of Labor concurs in these amendments. In many instances the billing procedures of hospitals and doctors are suspect due to failure to provide a duplicate itemized bill for services rendered to the medicare patient.

In the absence of such proof of services rendered, how can the carrier, or the Secretary of Health, Education, and Welfare, combat the abuses that are alleged?

May I suggest uniform billing standards as a means of combating such abuses? And it would seem to me that this would also help the program of the peers committee that Dr. Todd made reference to in this State.

I might supplement this with one thought that I just learned of yesterday that, in some instances, I am informed that some hospitals and some doctors likewise, have a code method of making bills—I haven't seen one, I heard of it yesterday—which even though a copy is given to the recipient of medicare, he doesn't really know what it means.

And it would seem to me that it is very simple for a physician or for a hospital to present that patient—that recipient of the medicare—with the type of statement that would properly reflect the type of service that has been rendered to him.

I think this would be a constructive way of obviously, in my opinion at least, of eliminating some of the possibilities of skullduggery on the part of those who are unethical.

And again I want to say, I know it is a minority, not a majority, of the profession that we can say this about.

Thank you, Mr. Chairman.

Senator WILLIAMS. We appreciate your appearance very much.

(Subsequent to the hearing, Senator Williams asked the following questions in a letter to Mr. Carbray:)

1. You called for a comprehensive study in detail of both hospital costs and charges and additional legislation if necessary to assure disclosure of all records. May we have additional discussion of subjects that would be considered in such a comprehensive study, and suggestions for major provisions of the legislation you mentioned?
2. Do you have any additional information on the "code method of making bills" mentioned in your testimony?
3. What in your opinion will be the effects of the newly-announced 10 percent increase in deductibles and coinsurance for Medicare?

(The following reply was received:)

NOVEMBER 18, 1968.

Dear Senator WILLIAMS:

* * * * * * *

(1) I am sure you agree with me that in the absence of complete and detailed records of hospital and nursing home operations a wholly comprehensive study of service and related costs is not possible. My reference to the need for legislative amendments is based on the refusal of hospitals, nursing homes and doctors to make such records available. I feel it is necessary that legislation be enacted which (a) requires the keeping of detailed records or services rendered, and related costs. (b) Make such records available on request for inspection by, an authorized representative of, the appropriate Federal Agency, the appropriate State Agency, and/or the authorized carrier. These requirements should be a condition of Certification by the Department of Health, Education and Welfare; for all hospitals and nursing homes wishing to participate in the Medicare Program. Similar conditions should apply to the Medicaid Program.

(2) I have no additional information on the "Code Method" of billing by doctors; but I shall continue to pursue this.

(3) The pending 10 percent increase in deductibles and coinsurance will only compound the prevailing hardship resulting from inadequate finances for the deductibles. I have had numerous protests from seniors accompanied by requests for an explanation.

Note: The recent hearing here resulting from the expose of abuses of the Medi-Cal Program by Attorney General, Thomas Lynch, lends support for the previously expressed idea that the Medicaid Program should be federalized.

Personal best wishes.

Sincerely,

JAMES CARBRAY,
Executive Board Member.

Mr. CARBRAY. Now, I would like to have Mr. Hartley and Mr. Davidson for just about a couple of minutes—each of them has one specific thing they want to relate which relates to some of the testimony in my statement.

STATEMENT OF ROBERT HARTLEY, FOR SENIOR CITIZENS ACTIVITIES COMMITTEE

Mr. HARTLEY. I have been asked to make a statement of charges as I have noticed in the past few months in my family from the hospital.

For a 3-day period in one of our Los Angeles County hospitals, a charge of $342 for 3 days' services. That doesn't include the physician's charges. That is paid elsewhere.

On a second visit within the past 3 months, an 8-day stay—and I will explain it this way—when I checked out I asked the attendant what the charges were for the full 8 days.

She told me that it was only made out for 6 days.

I said, "May I have the charges that you have on your book here?"

Six-hundred-and-thirty-some-odd dollars for 6 days. And that doesn't include a physician's charges.

Now, over and above this second charge, an anesthesiologist charge of $90 for his services for the operation.

An assistant doctor—surgeon—his charge was $60.

In the past, I will say 4 years—5 years, I will make it—I was in the hospital in the Middle West. The charges that came through on my Blue Cross statement, as the hospital charge per day, was about $35 per day.

The charges as produced by the present hospital visit means a very substantial increase, and if we are not covered by prepaid medical care, the senior citizen who is on a static income—he is on a pension in social security—it is impossible for him to absorb these increases.

LEGISLATIVE ASSISTANCE ASKED

We of the senior citizens and of the labor unions are vitally interested in those people in our organizations that are suffering from the increased costs that they cannot cover. We would like to see some legislation in the form that would give them assistance—that would alleviate some of the abuses that they are subjected to when they have to have medical care.

I thank you, gentlemen.

Senator WILLIAMS. Thank you, sir.

Mr. CARBRAY. Mr. Davidson.

Senator RANDOLPH. So as to save time, I want to comment on the gentleman—your associate—who spoke of the hospital charge.

The figure you gave for another area of the country was $30 a day. How long ago was it—I want to make sure?

Mr. HARTLEY. That was about 5 years ago.

Senator RANDOLPH. Five years ago. And the figure you gave was for ——

Mr. HARTLEY. Kansas City, Mo.

Senator RANDOLPH. And the figure you gave for Los Angeles—8 days—although charged for 6 days, but running it out on 8 days would make it about $80 a day; is that right? You said six-hundred-and-some-dollars?

Mr. HARTLEY. But that was for 6 days, only. The remaining 2 days was not on the bill.

Senator WILLIAMS. Well now, who paid all of this money?

Mr. HARTLEY. A prepaid medical plan pays for this.

Mr. CARBRAY. A supplement to——

Mr. ORIOL. A supplement to medicare?

Senator WILLIAMS. What is medicare right now?

Mr. CARBRAY. They pay 80 percent.

Senator WILLIAMS. They pay 80 percent? And your——

Mr. CARBRAY. Eighty percent for the physician.

Mr. HARTLEY. Eighty percent for the hospital.

Senator WILLIAMS. Eighty percent for the hospital? And the balance was paid by the plan that you got into?

Mr. HARTLEY. That is correct. That is correct.

Senator RANDOLPH. Mr. Chairman, I am trying to determine what the cost was per day.

Mr. HARTLEY. The cost was over $100.

Senator RANDOLPH. I see it now. The 6- and 8-day figure—I wasn't clear.

In other words, $30, 5 years ago in Kansas City; $100 in Los Angeles County.

Mr. HARTLEY. $110, to be exact.

Senator RANDOLPH. $110?

Mr. HARTLEY. Approximately $110 on the first hospital visit—$342.

On the second hospital visit—for 6 days—630-some dollars. Now, there is a variation there, but it still runs approximately $110 per day.

Senator WILLIAMS. Why did they take 8 days and reduce it to 6 days?

Mr. HARTLEY. They didn't. Due to the fact that I am covered by a prepaid plan, I could get a release from that hospital and they didn't have their bills made up, because I didn't have to pay it. My carrier would take care of that.

But the office girl related to me that for a 6-day period, there was a charge of 600-some-odd dollars.

Senator RANDOLPH. Mr. Chairman, I find no witness from the hospital profession as such; is that correct?

Mr. ORIOL. There is nothing today.

Senator WILLIAMS. I would say go ahead and do it. I will say, if you have to return to the hospital, I wouldn't go to that hospital.

Mr. HARTLEY. That's beside the point. If those charges are proper in this area, then you are going to have to go to some hospital.

I will say this of this hospital: It is a very lovely hospital and the service is excellent. I am not griping, I might say, about what has to be paid here. Medicare and the prepaid plan pays it.

Senator WILLIAMS. You are doing a service, and I wanted to develop that you didn't pay it, because you were under medicare and also under your insurance program.

So it is a service for you to come here and talk to us.

Senator RANDOLPH. Don't misunderstand me on this point, and I don't want to lay a finger on anyone, but there is a tendency where you are not paying, or the chairman is not paying it—you are speaking about a nebulous group that pays something—and then you sock it to them, because you can't put your finger on you, or you, or you, and I think it is very important that this be developed.

Senator WILLIAMS. Well, I will say this: I know in the State where I live, the Blue Cross rates go up and up and up, and this is part of it, and you know who is in the forefront of the opposition—the AFL-CIO.

Mr. HARTLEY. I have had very good service in this hospital, and I would object to anything like that—the prices of this.

The problem I am objecting to is the raises that cannot be met by the people in my age group, people who cannot afford——

Senator WILLIAMS. That's right.

Mr. HARTLEY. Prepaid medical plans.

Senator RANDOLPH. Mr. Chairman, again I want to stop talking about this—I want it broken down so as to be definitive—the hospital

charged this. There may have been some services that I want to know about, do you understand?

Mr. HARTLEY. I do.

Senator RANDOLPH. Not just bed and board.

Mr. HARTLEY. Bed, board, and food.

Senator WILLIAMS. Many X-rays, and other——

Mr. HARTLEY. Well, the equipment that they use—laboratory tests——

Senator WILLIAMS. Oh, I mean in your case.

Mr. HARTLEY. Oh, in this case—no X-rays on this particular visit.

Senator WILLIAMS. What is your name, sir?

Mr. DAVIDSON. Louis Davidson.

STATEMENT OF LOUIS DAVIDSON, FOR THE SENIOR CITIZENS ACTIVITIES COMMITTEE, LOS ANGELES FEDERATION OF LABOR, AFL–CIO

Mr. DAVIDSON. I would like to make a preface.

Because we have complaints does not mean that the senior citizens and their unions underestimate the importance of medicare. I think there is nobody that more appreciates medicare and all its functions, even with its difficulties, as much as the senior citizens do.

However, I would like to make a couple of points which will serve to substantiate what the previous speaker spoke of—and many of the other complaints.

People living on a standard like mine—income, say, about $200 a month—because of the deductibles and because of the additional costs for doctors are, in a certain way, prevented from utilizing medicare benefits.

And I will substantiate by saying this: I have recently almost entirely lost my hearing. A certain very important and very good doctor, in his profession, was recommended to me.

He examined me in his clinic, and he helped me a great deal. He somewhat restored my hearing.

His charge was $25 for the examination, for which medicare does not pay, and $40 for the service, which also has to be paid by me because the first $50 of treatment is not paid by medicare, and has to be paid by me. That's $50 deductible.

The recommendation of the doctor was to operate. He thought—and he is a very good doctor—that he could put my hearing in good condition.

After I left his office I went to make an appointment for the recommended operation. The charge was to be $650 for the operation and $50 for his assistant—which came to $700.

Incidentally, a friend of mine was operated on by the same doctor in 1959, and was charged $250. If I had arranged for the operation, I would have been required to pay the 20 percent plus the $50 deductible. I would have had to pay $100 for admission to the hospital—which means several hundred dollars.

People in my income bracket couldn't afford that kind of money, and therefore I had to give it up.

DEDUCTIBLES BAR TREATMENT

I know of three more cases. People who are suffering with their sicknesses but they cannot go through with the operation because the deductibles and all of this are just more than they can manage.

Dr. Todd made a very good point when he said that there are a great number of participants in the medicare program—but there are also a number who don't participate, in Los Angeles particularly.

The people who provide the necessary services charge an awful lot, and some of the senior citizens don't have a pocketful of money.

Even in regard to those people who do participate, I have a couple of complaints—particularly one woman that I know of—who goes to a certain doctor for many years, who has not overcharged.

He participates, but when she goes in for the next appointment, the nurse, who is the secretary of the doctor, makes her feel so bad that she, instead of taking the bill from the doctor and sending it to medicare, she just takes out the last dollar that she has to live on and pays the doctor.

One more point I would like to make, and that is in connection with Medi-Cal, which Speaker Unruh spoke for: It is true that California is one of the States that participates in medicaid. The top income of one single person has to be $167 a month. I come originally from—I am a neighbor of yours, Senator, from New York—where it is quite different.

And something else: I have a complaint that a certain person—particularly—who has recently gone in to apply for Medi-Cal—her income is $107 a month. She was unfortunate in that her husband left her an insurance policy of $1,500.

After an hour and a half of interrogation by the clerk, they found that she was not entitled to Medi-Cal—even though she only gets an income of $107—because she has $1,500 in cash.

Furthermore, according to the law, there is supposed to be an allotment, first of all, of some of the money that is in the bank for living—supplementing this $107, and also she is entitled to $700 funeral service. That has not been taken into consideration.

It may not always be handled in the same way. Not all interrogators may be the same. But I say that those things happen that discourage dignified people from—even if they cannot get along—to apply for this service.

Thank you very much.

Senator WILLIAMS. That comes from your personal experience?

Mr. DAVIDSON. That's right.

Senator WILLIAMS. That is why we are here—to try to find out what is happening. Our mission is to try to improve situations that should be improved.

Mr. DAVIDSON. That is why I am very happy to come here, because I know that you are very much interested in solving this problem.

Senator WILLIAMS. Thank you very much, gentlemen. You have been most helpful.

It is now 1:26 p.m. We will have one more witness before we recess, and Mr. Robert Thomas is available right now.

STATEMENT OF ROBERT THOMAS, VICE PRESIDENT, BLUE CROSS OF SOUTHERN CALIFORNIA

Mr. THOMAS. Mr. Chairman, and Senator Randolph, and gentlemen, I am Robert J. Thomas, vice president of Blue Cross of Southern California, with the responsibility for professional and governmental relationships.

It is my pleasure this morning to make, really, a short report on our performance as intermediaries under title 19, which is, as you know, known as Medi-Cal in this State.

In the interest of time and your recess, my remarks here this morning will just be informal.

California's Assembly bill No. 5, which was the enabling legislation to permit implementation of title 19 in this State, was enacted in the fall of 1965 in a manner which permitted the State to take advantage of the existing resources of private enterprise in the administration of health care benefits under this program.

By resources I mean our facilities, our equipment, our staff, our systems, and particularly our experience and experitse in this field.

For example, the organization which I represent has been in the business of health prepayment for more than 30 years. I have a history of having been a hospital administrator for more than 18 years.

In any event, I am pleased to report that in response to requests from State officials, from the medical profession, and from the health field in general, Blue Cross of Northern California, Blue Cross of Southern California, and California Blue Shield, joined together and submitted what turned out to be a successful bid for us to serve as intermediaries under this program on a no-profit, no-loss basis.

Senator WILLIAMS. Is there an advantage there, do you think, instead of the State handling the whole thing itself?

Mr. THOMAS. I think there is, Senator, particularly because of our long experience in the field of health and administration of health benefits.

Because of our close association with institutional providers of care, in my case, and in California Blue Shield's relationship with physicians, we are known to them—we know the ins and outs of the business.

We know the good and bad operators, as it were, and I think in most instances, certainly from the providers' standpoint, they want a buffer between the government and their own activity.

We provide that, and we are, I think, regarded as a part of the health team.

So I think we do provide a service that could not be provided normally through the existing government channels.

Senator WILLIAMS. And has this matter substantially increased costs in Blue Cross—whatever you want to call it—premiums?

Mr. THOMAS. Rates.

Senator WILLIAMS. Has it made a substantial increase?

Mr. THOMAS. Our rate increases have gone hand in hand with the overall increases in the cost of care which we have heard referred to here this morning.

Obviously our rates are set on an actuarial basis, and as costs go up, our rates must go up to cover them.

Senator WILLIAMS. And those rates have to be approved by a department of State government?

Mr. THOMAS. Yes. Although we are a nonprofit corporation, we are still subject to the regulations of the State insurance commissioner—and those rates are approved by him.

Senator WILLIAMS. As a conclusion on that point, you are in favor of the intermediary, rather than pure government handling the whole program?

Mr. THOMAS. Well, not only am I in favor of it, because we are administering the program, but I know I speak for the professions and the different provider organizations with whom we deal and whom we represent.

Senator WILLIAMS. How did you become intermediary? Did you have to compete on a fitting basis with insurance companies, for example?

Mr. THOMAS. Yes, In this State the intermediary role was let on the basis of bid, and evaluation of bids.

Senator WILLIAMS. Check. Right.

Mr. THOMAS. And even though we joined with California Blue Shield in this bid, I think Dr. Malcolm Todd has spoken quite succinctly about their role.

RELATIONSHIPS WITH PROVIDERS OF SERVICES

And so again in the interest of time, I will limit my remarks just to Blue Cross and its relation with the institutional providers of service, the hospitals, the nursing homes, health agencies, rehabilitation centers, free clinics, and so on.

Now, in the 30 months that this program has been under way in this State, 4,800,000 institutional claims have been paid in behalf of eligible Medi-Cal recipients.

And this amounts to a total expenditure of in excess of $730 million to date.

I am sure that before this fiscal year is out, this will surpass the $1 billion mark.

These payments have been made to more than 1,900 institutional providers in this State. About 560 hospitals, 1,200 nursing homes, 120 home health agencies and free clinics, so I think you can see that Medi-Cal, which sort of sounds like a drink for weight losers, is certainly not a slim program in this State. It is a very large and a very complicated program.

I would like to say right here, if I may, that I feel that our success as an intermediary has been due in no small measure to the rapport and certainly the very capable cooperation that we have had from the State department of health care services.

Each of us has a very important role to play in this program and I think we present an excellent example of private enterprise and government working together in concept.

I would say also, that our Blue Cross policy, since the inception of this program, has been to handle it on the same basis with the same safeguards and at the same level as we handle our own business.

Certainly to insure high quality of care in any of these programs it is necessary to verify that those persons admitted to institutions actually needed to be admitted.

And once they are admitted, we must determine that neither overutilization or underutilization of the institution's facilities, its tests or its treatments, were allowed.

And also we must check to see that the length of stay of the patient is commensurate with the severity of his illness.

I think if we are going to get the fullest economic use of the facilities we have in our community here, it is absolutely imperative that we get people out of the acute beds and into nursing homes and to home health agencies, home care programs or outpatient care, just as soon as we possibly can.

Intermediary Role

Now again, in the interest of brevity, let me just comment that as far as I can see there are really about three major functions in this intermediary role which I think we are carrying out very vigorously.

The first is to receive and process and pay institutional claims in an efficient manner.

The second is to provide assistance and counseling to providers in the field and to conduct utilization review and medical audit activities in the field to prevent abuses of the program.

And the third, of course, is to perform fiscal audits to verify that costs and charges are compatible for the services rendered.

Each of these functions which is carried out by us can be carried out on our Blue Cross business, on our medicare and our Medi-Cal programs at the same time, and with the same personnel with an appropriate sharing of the costs.

And this, of course, results in considerable economy for each of the participants in these programs.

For example, in the area of claims processing, we receive approximately 40,000 claims a month which involve both medicare and Medi-Cal benefits.

As has been previously mentioned on the basis of the patients entitlement to medicare, many times he can't pay his coinsurance or deductible. Now, if he is eligible for medicare, then Medi-Cal pays these for him.

Because in almost all of the cases we serve as the intermediary for both medicare and Medi-Cal, we can process the claims and make payments under both programs from a single medicare form.

This, of course, is a real saving of time and paperwork—not only for us, but for hospitals and other institutions as well.

In the functions of assisting and counseling and utilization review and medical audit, we have 76 full-time field representatives. And on each visit made by these people, all three of these programs are covered.

So each program really only pays about one-third the cost of each visit that is made.

Compatible Cost Reporting Forms

And similarly, in the performance of our fiscal audit, compatible cost reporting forms have been developed so that one audit of the institution's books will suffice for all three programs—again with appropriate sharing of costs.

In this joint administration of medicare and Medi-Cal and Blue Cross, too, I believe we have an excellent mechanism for assisting in the maintenance of high quality care and in an economical manner.

For example, our administrative costs and claims processing, to date, under the Medi-Cal program, is just 77½ cents per claim. This amounts to one-half of 1 percent of the amount paid for institutional services rendered.

I think you will agree this is a mighty low administrative cost. As the charts that have been filed with your committee will show, the volume of patient care in medicare—in Medi-Cal, rather—is increasing rather dramatically.

More and more eligible people seem to be availing themselves of the Medi-Cal benefits, and each has been seen by a doctor who has determined that the patient needed institutional care.

So I think this way we can see that the program is bringing care to a great many people who apparently needed it before, but for one reason or another had not been getting it.

I think, just in summary, if I may, Senator Williams, I would say that we had many problems at the outset of this program, as can be expected, but there have been a great many improvements in the program since its beginning. A lot are in the mill right now, and coming to fruition.

I am sure we can look forward to a great many more in the very near future.

And with the pros and cons we have heard here this morning, I am pleased to tell you that, all in all, we of Blue Cross can say that we are very proud to have been a part of what we feel is a great program and which is bringing a great deal of good to a lot of people.

If you have any questions, sir, I will be glad to try and answer them.

Senator Williams. I think you have answered all of the questions that I had prepared to ask.

How many States are included in medicaid, which is your nomenclature—is Medi-Cal?

Mr. Thomas. I don't know. I can speak for this State—well, up around 40, I believe.

Senator Williams. Is that right? Blue Cross is the agent intermediary in many of these States?

Mr. Thomas. A great many. This is the case, as you well know, it is up to the individual States to decide in their programs as to which way they will be administered.

A majority have chosen to go the route of the intermediary.

Senator WILLIAMS. Mr. Thomas, I know we have to adjourn—people have been sitting here for a long time, and you are entitled to a little luncheon—we will recess now. It is 20 minutes till 2.

Senator Randolph has a schedule problem. We will be due back at 2:15. That will give you a chance to have a long, leisurely 20-minute lunch.

(Whereupon, at 1:40 p.m., the subcommittee recessed, to reconvene at 2:15 p.m., the same day.)

AFTERNOON SESSION

Senator RANDOLPH. Our hearing will resume.

Will the witnesses now please identify themselves for the record.

STATEMENT OF JUANITA C. DUDLEY, ASSISTANT REGIONAL DIRECTOR, WESTERN REGIONAL OFFICE, NATIONAL URBAN LEAGUE

Mrs. DUDLEY. Thank you. I am Juanita C. Dudley,* assistant regional director, western regional office, National Urban League.

I am particularly concerned with health in the western region—which encompasses six States in which we presently have affiliates.

I have many concerns regarding the delivering of health care to the aged.

Accompanying me today is Dr. Clarence Littlejohn, health chairman of the Los Angeles Urban League.

He will try to answer some of the five questions—along with me—that we were requested to answer.

For brevity, and because of the time, we will move very quickly through all of our questions without stopping.

Now it has been clearly established that payments under Medi-Cal to practitioners in the black and brown communities have been less than prompt and equitable. The fiscal agents, Blue Cross and Blue Shield explained that this county is divided into 16 regions and the payment scale varies in most of these regions.

The fiscal agents said that payments are rendered within a 3- to 4-week period after submission and suggested that any problems that are existent are due to negligence and irresponsibility on the part of the submitting practitioner.

My office requested Blue Shield to run a check on a specific physician's file, and it was determined that none of the problems around payment were due to his errors. This physician had not received payment for any services rendered under the Medi-Cal program for the last 6 months.

Both Blue Cross and Blue Shield have stated that seminars are being held in the communities to help the practitioners correct deficiencies emanating from incorrectly filed forms, et cetera.

---

*See app. 1, p. 724.

Speedier Processing Requested

We have asked both the State department of welfare and the fiscal agents to insure a more speedy method of processing claims as it appears that the bogging down occurs equally as much in both areas.

We would like to request that a standardized set of procedures for all medical services under both title 18 and 19 be quickly implemented in line with the procedures that are followed with respect to 18 at present.

In answer to the second question: Are medicare and Medi-Cal programs sufficient to provide the services to those people most in need of the services? If not, what suggestions do you have for improvement?

Medicare is the most significant innovation in the American Social Security system since 1935. It works especially well for most, though its major problem may be that it is contributing to a higher medical cost for the nonaged as well as the aged.

Ten percent of the aged are not eligible for social security pensions: After 1969, what happens to medical care for this percentage, which includes State and Federal Government retirees?

We would like to recommend that all 65-year-olds be included under the Medi-Cal insurance provisions of medicare, irrespective of their lack of coverage by social security.

In southern California 400,000 claims per year are made for medical care of the aged. This approximates a population of 32,000 persons per month. Blue Shield, the fiscal agent for title 19, states that they are receiving from 110,000 to 115,000 claims per day with 85,000 to 90,000 under Medi-Cal for the aged.

It would appear that Medi-Cal is being used as a secondary insurance plan for the elderly poor when medicare title 18 provisions have been exhausted. Compulsory hospitalization prior to a patient's movement into an extended care facility has filled existing hospital beds. It would appear that most of the aged poor are in need of lengthy institutional care due to inadequate home health care.

Custodial Nursing Homes

We recommend that custodial nursing homes may be the answer to costly care, relieving hospitals for immediate needs. Frequently, the aged poor are unable to pay the first day's deductible and, consequently, continue to use the emergency room of public hospitals for regular medical needs.

It has been projected that a patient entering a custodial nursing home would remain there for his life expectancy, or about 4½ years, since he would probably enter about age 82. We are urging title 18 and 19 coverage of custodial nursing care and there are obvious reasons why nursing home and extended care facilities are often unable to accept Medi-Cal (title 19) patients who are aged and poor. They are described as being less intelligent, less sophisticated, and more difficult to care for.

We would wonder if this is not based on the differential in terms of revenue between the two programs per patient. Once again, we emphasize the need for standardizing in all States payments for care under title 18 and 19.

In answer to question No. 4: "What suggestions do you have for increasing health services manpower in a densely populated, essentially urban area, or are there now such shortages of manpower?"

Health services manpower in Los Angeles County is taken from the Los Angeles County Medical Society figures which include a total of 11,964 practitioners. Attached is a chart showing the actual breakdown in numbers and the ratio per 1,000 to the population.

PHYSICIANS BY AREA OF PRACTICE, LOS ANGELES COUNTY, 1966–68

	Total number of physicians	Patient care							
			Private practice						
		Total	General practice	Internal medicine	Surgery	Other specialists	Hospital-based practice	Other professional activity	Inactive
1966	13,068	11,706	3,036	2,156	2,790	1,793	1,931	677	685
Ratio per 100,000 population	186.8	167.3	43.4	30.8	39.9	25.6	27.6	9.7	9.8
1967–68	13,369	11,964	2,982	2,207	2,865	1,856	2,059	7,022	683

Note: Total includes all non-Federal physicians. Private practice includes solo, partnership, group, or physician employed by another physician in practice involving patient care. Hospital practice includes interns, residents, fellows, and full-time physician staff.

Source: California Medical Association, Bureau of Research and Planning: Reference Book on Selected Health Manpower Data, tables 1 and 2, containing previously unpublished data provided by American Medical Association.

We estimate that there are approximately 450 Negro practitioners in Los Angeles County with a large percentage working in public health or other clinical and group settings.

Senator RANDOLPH. Just a moment, Mrs. Dudley. According to your written statement it is 350. Was there an error?

Mrs. DUDLEY. I am sorry; yes. It is 450.

We are also aware of the very small number of minorities now in attendance at the major medical schools in this county, realizing that the decrease in medical manpower will be more keenly noted within the next 3 to 5 years.

PARAMEDICAL TRAINING URGED

We urge an expansion of paramedical training in the areas of home health aides, nursing and other allied fields. We have launched a program to help secure training for returning Vietnam veterans who served ably on the battlefield as medics. We hope that Hill-Burton funds could be extended to update and reclaim many of the existing medical facilities which are being phased out of use.

Comprehensive health planning coupled with regional medical programs for heart, cancer, and stroke must look carefully at the use of an incorporation of the paramedic in their plans for extending better health care to disabled and aged at the lowest level.

Preventive multiphasic health screening at the community level appears to be an obvious solution to high medical costs as so clearly evidenced by group programs such as Kaiser Permanente Foundation of California and the HIP plan in New York. Effective delivery of

any health service can only be measured in terms of care to the patient.

When we discuss children and their health problems, we quickly look at the mortality rate of the area concerned.

When we discuss the aged, we also examine the mortality rate, yet these crude death rates do not give us a true picture of the causes and effects. We must examine them for reasons.

When the aged reach the hospital in extremis and die within a 24-hour period, we do not consider this a problem of the receiving hospital, but rather the nursing home that waited until the last moment to hospitalize the patient.

Medical schools might extend their training to provide wardbound services in nursing homes in order to prevent patients having to enter the hospital too early or too late.

Senator RANDOLPH. Mrs. Dudley, the nursing homes that waited until the last moment to hospitalize the patient—now, did the nursing home do this because of its interest in making another dollar, or was it because in the nursing home there was no one who realized the need of the patient for hospital care?

Mrs. DUDLEY. I would not wish to indict all nursing homes in terms of that statement. But I do feel very strongly that many times the patients are sent to the hospital during the middle of the night, or during periods when the doctor may not have been in the nursing home to look at the patient.

I think that most treatments are at the request of the visiting physician who goes to the nursing home to see the patient—unless there is an accident—the patient falls out of the bed and breaks an arm, which is a very obvious infirmity that can only be taken care within the boundaries of a hospital.

Senator RANDOLPH. Then you would relieve, in general, the nursing home of the responsibility?

Mrs. DUDLEY. Yes, I believe that most of the treatments are directed by the visiting physician in that nursing home.

Senator RANDOLPH. The reason I ask you that question is because you really hadn't differentiated here between the nursing home and the physician who made the examination.

Now, I am not trying to draw any comparisons—odious or otherwise.

Mrs. DUDLEY. This is why I suggested that possibly the schools of medicine might use their training physicians to do ward rounds in nursing homes as they are doing in some of the training hospitals.

Senator RANDOLPH. Thank you, Mrs. Dudley.

(Subsequent to the hearing, Senator Williams asked the following questions in a letter to Mrs. Dudley:)

1. Mrs. Dudley's statement indicates that the California State Department of Welfare was asked to "insure a more speedy method of processing claims." What was the reply to this inquiry?

2. May we have additional details on your program to help secure training for returning Vietnam veterans who served in combat as medics? Would their services be especially helpful in providing services needed by the elderly with chronic illness, perhaps in nursing homes?

3. What is the "differential in terms of revenue" nursing care reimbursement under the Medi-Cal and Medicare programs in California?

4. Has the OEO Neighborhood Health Center been of help in providing needed services in ghetto areas? If so, would you care to see an extension of such services?

(The following reply was received:)

1. Enclosed is a copy of the letter which I wrote to Spencer Williams, Director of Human Relations, State of California.* His reply was: (1) that it was too costly to establish a computer center in Southern California, and (2) plans are underway for each certified recipient to have more than one eligibility card in order to facilitate faster service.

Since our hearing before your committee, much has happened in California, relative to an investigation report of MediCal abuses by the office of the State Attorney General. I feel that as a result, changes in the processing of claims by the fiscal agent Blue Shield will be made. (See newspaper article attached.)

2. The Los Angeles Urban League has a Department of Veterans' Affairs. Meetings were held with the Director of the Veterans' Administration Hospital, Director of Para-medical training at the Lutheran Hospital and other educators in order to establish para-medical training centers for returning Vietnam veterans who had ably served as medics while on duty. State Senator Dymally, Chairman, Senate Health & Welfare Committee, introduced legislation (which is described in enclosed bill) to facilitate returning Veterans getting credit for their military training. We feel that those Veterans have a wealth of on-the-job training in para-medical care. There must be a transitional use of these men and women at a pay scale that would be inducing. I've noted that nursing homes have a high percentage of male nursing staff which is reflective of the acceptance by men of the para-medical professions.

3. Blue Shield and Blue Cross have described the "differential in terms of revenue nursing care reimbursement" as follows:

Medicare—pays for costs incurred on a cost-plus basis.

Medi-Cal—A ceiling is placed on care. California State Department of Finance allows a maximum of $14 per day. (Most facilities are paid at an average rate of $8 per day.) The fiscal intermediary sets the fee for each facility on the basis of information submitted by the facility. On January 1, 1969, all nursing home facilities will be certified under MediCal in the state; we questioned their efforts to weed out the less desirable facilities.

4. The Watts OEO Center, as well as others in the United States, are providing major health care to their communities. Barriers to acceptance of this care range from undemocratic geographic boundaries to over-subscribed emergency room use. Aged patients need immediate emergency treatment when threatening heart failure.

Community multi-service units of health care offer this needed care. I would hope that multi-phasic, multi-service centers of health are to be a way of life in the future in America. Emphasis on multi-phasic screening for preventative health must be stressed as an important adjunct to this service.

I hope that your four questions have been adequately answered. We have very definite feelings about the use of the returning veteran, and would hope that his role could be spelled out nationally in this field of health care. California has become receptive. The AMA Emergency Health Forum of 1968 was asked by me, to consider the use of the Veteran Medic also. They felt that the pay-scale for such services were much too low to induce their interest status and commensurate pay can be achieved, I think.

Senator RANDOLPH. Dr. Littlejohn will now speak to you regarding questions 1 and 3.

STATEMENT OF CLARENCE G. LITTLEJOHN, M.D., FAAP, MEMBER, BOARD OF DIRECTORS AND CHAIRMAN OF HEALTH COMMITTEE, URBAN LEAGUE OF GREATER LOS ANGELES

Dr. LITTLEJOHN. Honorable Chairman, Members of the subcommittee, I am Dr. Clarence G. Littlejohn, member of the board of directors of the Los Angeles Urban League and the health chairman of this organization.

I am practicing pediatrician and pediatrics cardiologist on the staff of several major and minor hospitals of the city. I am a volunteer pro-

*See app. 1, p. 724.

fessor at the USC School of Medicine. I am also involved in the black congress of the medical association of the medical society and the Los Angeles County Medical Association.

As a major organization concerned with the health and welfare of our community and our Nation, we are pleased to participate in this hearing, hoping that by such deliberations the impending crisis in health care of the poor and needy will be averted.

The Medi-Cal program as presently administered actually promotes the exodus of medical resources from the ghetto. More and more health care vendors are becoming disgusted with the program and phasing it out as an economic hazard. More and more recipients, frustrated in their attempts to obtain health care near their homes, have returned to the county corridors and/or neighborhood emergency rooms for disjuncted, crisis-type medical care.

Why is this so? As a black physician, a product of the ghetto and as chairman of the Health Committee of Greater Los Angeles Urban League, I have been intimately involved in health care of our community and discussions of the same. The above observation continues to prevail in spite of the numerous efforts of the health care vendors of the black and brown communities, individually, and in groups, locally and in Sacramento, to rectify the inequities in the program so that they might continue to take care of their people. Considerable sacrifices of time and money have been made by these vendors with only minimal progress.

Dr. Francisco Barbera was in the audience prior to the lunch break. He is a representative of the Mexican-American community. He left a little document I would like to present to you.

His business was that of attending other business meetings, the result of which is to help subsidize his medical practice.

The observations made herewith are based upon individual and group interviews and conferences with scores of physicians, dentists, pharmacists, other health care vendors, and Medi-Cal recipients. The long delays in payment, nonpayment of many justified services, harassment of vendors, geographic discrimination in payment schedules and the demeaning superscrutiny of claims of ghetto doctors—with the "all those doctors in the ghetto are cheating, giving bad medicine, and making too much money" attitude—are all contributing to the rapid reduction of health care services.

Many health care vendors feel that those in charge are purposely again decimating the poor and needy by forcing them to barter their dignity for health care in crowded clinics and county corridors—particularly in Los Angeles—often many miles away and receiving such care all too frequently in a demeaning, discourteous manner.

Who suffers? The community. The recipient. The vendor is greatly inconvenienced, but he can move out and become employed elsewhere.

Health care among the disadvantaged approaches "pre-Watts" days. One of the lessons learned, hopefully, from the Watts conflagration was that a large segment of the population of civilized Los Angeles had been sorely neglected—particularly healthwise—but could and would not be forever neglected.

When the State administration announced its cuts, considerable confusion, unrest and apprehension permeated the area. This feeling is again becoming more and more evident as more and more Medi-Cal recipients are frustrated in their attempts to obtain medical services.

Emergency rooms are having difficulty referring these patients for followup care to health care vendors in their respective communities. To many vendors, the Medi-Cal program is just too hazardous, economically.

Ghetto Physicians Hard-Hit

Ghetto physicians and other vendors are hardest hit, but intimidation and fear of reprisals prevent many from speaking out. Some have practices consisting of over 95 percent welfare recipients. Most have had to hire more personnel just to handle the Medi-Cal paperwork.

In spite of unfulfilled promise after promise on the part of CPS, many vendors have continued to empathize with the underprivileged, continuing their health care services.

Many have exhausted their savings, have gone on to borrow thousands of dollars to make payroll and other expenses and/or lost their credit ratings, due to nonpayment or long-delayed payment of Medi-Cal claims.

Entire clinics have closed up. Many pharmacists have closed and others are on the verge. Near-foreclosure on homes have occurred as well as actual repossession of doctors' office equipment. Banks have refused loans on accounts receivable from Medi-Cal due to inability to ascertain dates—and amounts—of payment.

An economic lid is placed on the ghetto. This ceiling restricts the quality of employees, the adequacy of working conditions, the desirability of the physical structure of the office or establishment, and frequently the quality of service rendered.

The unpredictability of payment—both time and amount—precludes any planning, even short-range planning for health care facilities by private concerns. In such a blighted area, private enterprise should be encouraged, not discouraged. As vendors of services leave the area, they are not being replaced. More health care personnel become unemployed.

The economic ceiling on the ghetto was recently endorsed by a county supervisor who was quoted by the Los Angeles Times as saying that private doctors should earn no more than $11,000 to $14,000 from taking care of county welfare cases.

Computing this on a 40-hour week—most doctors work in excess of 50 hours a week—this is maximally $8 per hour, less than plumbers' fees and considerably less than attorneys' fees. Inequitable substandard fees imposed on the ghetto suggest a continuing desire to keep the ghetto poor.

Rape of the ghetto of medical services is becoming increasingly evident as more and more vendors of health care are leaving the area. Many are locating on the periphery of the ghetto and are reducing their Medi-Cal participation as rapidly as their private practice increases. Others are moving to the periphery in order to increase the amount of Medi-Cal payments and decrease delays in the receipt of such payments.

Some are seeing recipients only on certain days or at certain times during the day. Some are outright refusing to see recipients. Continuity of medical care is becoming nonexistent. Community hospitals are having increased difficulty obtaining consultants in upgrading

medical care at the community level and with Los Angeles so spread out, this is profoundly tragic.

Moonlighting Physicians

Moonlighting in Watts and east Los Angeles is becoming more prevalent and it is as evil as the absentee landlord system. All too frequently, the moonlighting physician is not available more than one-half to 1 day per week for followup, and emergency rooms, or the few doctors left in the ghetto are asked to perform this service.

The moonlighting vendor is frequently from an area with a higher unit—fee for service—rating by the Medi-Cal program and, of course, bills from his office—so located.

Denial of equal job opportunity is inherent in these inequitable and probably illegal disparities.

Discriminatory and severe reviews of claims of major providers of services to the poor frequently cause interminable delays in payments and denial of payments for substantiated services. Many cuts and deletions appear capricious, arbitrary, and certainly discriminatory.

For example: two comparably trained physicians billing for comparable services on patients in the same hospital side by side in the same room may receive different fees dependent upon the location of their billing office in Los Angeles County.

Frequently, in the same batch of claims returned to vendors, there may be three or more different fees for the same item or service number. These claims are supposedly reviewed by peers. The whimsical nature and arbitrariness of cuts, particularly of claims from ghetto physicians, suggest lack of guidelines and/or the political philosophies and prejudices creeping into the judgments of some reviewers. It also suggests that many reviewers are ill-informed and/or insensitive to the health care among people of poverty. This system must be improved.

Financial and tax incentives are being suggested as means of attracting more dedicated businesses, teachers and other needs of the ghetto. The health care vendors have not asked for nor do they expect any such incentive. The vast majority are dedicated men and women who want only equal job opportunity to help to provide equal health opportunity to those who so drastically need it.

Physicians Fees Defended

Here I would like to make a comment about the much-discussed and probably too-much-discussed fees. It was pointed out by one of the speakers that over a thousand doctors in California made $70,000 to $100,000.

Just some quick computations on that. You take the average doctor working 50 hours per week. This averages out to $12—the gross is usually about 50 percent—I mean, the net is about 50 percent of the gross. This averages about $12 to $15 per hour.

Even the doctor who makes $100,000 does not get more than $20 per hour.

Now, the county medical association—the California Medical Association—did some investigation, and these figures were published, and

it was found that many of these claims were filed by doctors who hired two or more doctors under the same vendor number. This is highly emphasized, somewhat to the discredit of these physicians.

Now, also, Dr. Todd pointed out quite clearly that less than one in 1,800 doctors had been found to be guilty of these practices. So I think the scapegoat has to stop, and I think some inequities have to stop, and some serious planning has to go into at least making the Medi-Cal program available to people who need it.

The ghetto is suffering because of these inequities, and we are asking, frankly, that special attention be given to the ghetto in the processing of claims, so that the people in the ghetto will not suffer from lack of services.

I would like to introduce Dr. Phillip Smith, who is a member of the Drew Medical Society, which is the Los Angeles wing of the national society.

Senator RANDOLPH. Yes, Doctor, we would be pleased to have you speak briefly.

STATEMENT OF DR. PHILLIP M. SMITH, VICE PRESIDENT, CHARLES R. DREW MEDICAL SOCIETY

Dr. SMITH. I only came down to substantiate the statement that Dr. Littlejohn made. The Drew Medical Society—the Los Angeles chapter of the National Society—is interested in getting medical services to the ghetto area.

As President Johnson stated at our meeting in Houston, one of the rights of people of the ghetto—of all people—is the right to adequate health.

Health services in the area cannot be given equally, and people cannot be placed in the mainstream of medicine unless we have equal opportunities for everyone involved.

In stating reasons for medicaid to the aged, there are hospitals in the Los Angeles area which will not admit medicare patients—if a black physician has this medicare patient—this patient is discriminated against. These have to be taken care of.

There are some hospitals, also, in the Los Angeles area which will not—which have a limitation—who will not admit black physicians to their staff, but yet and still, they can have a medicare patient admitted—one or two token—and this is discriminating against the physician.

We are not thinking about physicians—we are thinking about the people the physicians treat. Once you discriminate against the physician, then you don't think about him, you think about the people he is treating, and these are the people we want to put into the mainstream of medicine.

Also, as one speaker stated about the fees—it is almost as though he feels that the doctor goes out and recruits patients. You must remember that in the ghetto area the physicians are in an area where the people are indigent. They were attracted there before the bill came out—like my practice is there—and one must realize the truth at that time.

OUTSIDE MEDICAL RELIEF

They had a system at that time called the OMR—outside medical relief. These doctors donated time—which, I have a card in my pocket which says, "You will treat these patients without any profits."

Well, they had thousands of these type of cases which you were treating for $3 a visit.

At the time of medicare, all these patients were referred to medicaid patients. So you already had free patients in your practice.

It must be stated also that we are interested in care for the patient. If the doctor is working hard enough to warrant his fees—his money—then it should be given to him.

If you look at previous statements made by another person, you would feel that the cost of care is the most important. If the doctor is making $200,000 a year and giving quality care, I don't see why anyone should care.

Senator RANDOLPH. Thank you very, very much, Dr. Smith, Dr. Littlejohn, and Mrs. Dudley.

Your information you have given and your comments that you have set forth will be most carefully considered by the members of the subcommittee and the committee on aging.

I want you to know that even though we appear somewhat hurried as you gave your testimony, that will not be so when we go over what you have said, and attempt to evaluate it.

And certainly, we shall not only find it informative, but challenging, as we do our work.

Thank you very much.

Mrs. DUDLEY. Thank you.

Dr. LITTLEJOHN. Thank you.

Senator RANDOLPH. Mr. Mulder.

Mr. Mulder, you were present earlier today when the speaker of the assembly, Jesse Unruh, read his statement and made additional comment and answered questions from the members of the committee—and the colloquy—do you recall his statements?

Mr. MULDER. In general, yes, sir.

Senator RANDOLPH. Would you have any comment—rebuttal, or what would you describe from your standpoint as the errors or mistakes, inaccuracies, or whatnot, if there were any, in his statement?

Mr. MULDER. There are a few observations I would like to make for the record.

STATEMENT OF CAREL E. H. MULDER, DIRECTOR, CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES, HUMAN RELATIONS AGENCY

Mr. MULDER. My name is Carel Mulder. I am the director of the department of health care services. I am a career public servant—21 years in public welfare, and 11 years in health care.

I would like the committee members to have a few points understood about the Medi-Cal program which may have escaped you in the course of the day.

One of these is you might believe that Medi-Cal does not provide preventive services. I must tell you that Medi-Cal strongly supports preventive services—that the instructions to social workers are that people who do not have a personal physician, must be encouraged to seek such a personal physician, to undergo examination in order that any illness may be detected early and be subject to treatment when it can be treated sensibly and with a good chance of success.

The main problem with the program in the past has been the extreme haste with which it was put into operation. The fiscal intermediary testified this morning about the contract: the contract was entered into just a few weeks before the operation was to start——

Senator RANDOLPH. Am I correct in saying not only the haste, but to a certain degree the magnitude of the problem of a State like California—and I am not attempting to lead the witness—but would you say that that is a problem, as well as the haste with which you stress——

Mr. MULDER. It is, indeed. It continues to be a problem. We have made many improvements in the operation of the system.

The claims processing is going a great deal faster than it has. There has been much more emphasis on the medical audit. We now have operating in most counties very active peer review committees. Not only in the field of medicine, but for other fields as well.

MEDI-CAL COMPLEMENTARY TO MEDICARE

Another observation I would like to make is that with respect to the aged, Medi-Cal is really a complementary resource to medicare; that the majority of the care received by the aged is really medicare-financed, rather than by Medi-Cal.

The speaker this morning spoke about the problem around reimbursement for physicians and indicated that there had been a steadfast refusal on the part of the Governor to consider a fee schedule for physicians' services.

In that connection, the committee should know that the law which was enacted before Governor Reagan took office contains the requirement that payment be made on the basis of "reasonable charges" and that these reasonable charges are to be determined in relation to the individual physician's usual charge—customary within the locality—and within the prevailing charges in the locality.

Senator RANDOLPH. When was that law passed?

Mr. MULDER. It was passed in November of 1965, and became operative on March 1 of 1966.

The fee language is the same as the fee language which is in title 18, the medicare program. The legislature did have opportunity for reviewing the method of payment to physicians. Two committees gave it their attention and fee schedules were considered by legislative committees, and they did not proceed with them.

It has been our position that with, respect to a fee schedule, if it is to provide adequate payment for the average physician, this will happen: that the physicians who customarily charge below the average will immediately move up to the average, and that physicians who customarily charge above the average will become disinclined to participate in the program, if it doesn't provide them with their usual fees.

And the end result is that you pay the same, except that you pay it to fewer physicians who are predominantly, usually, charging lower. And the end result we felt would not be substantially different in terms of outlay.

Another observation with respect to some of the testimony of this morning: reference was made to utilization surveillance. Lest there be any misunderstanding, the system which Dr. Breslow, when he was director of public health, instituted in the early stages of the program still exists.

We do receive paid claims which are arranged in month of service order, and these records are reviewed to detect any pattern of care that appears to deviate from the accepted community norm.

Anything that looks deviant is referred to Blue Shield, where it is again subjected to medical audit, and then may go to the peer review committees that were described by Dr. Todd this morning.

Likewise, in our office, we receive complaints from a variety of sources, such as the licensing boards—indications that something may be wrong—and wherever professional judgment is needed to determine what went wrong and what should be done about it, we use these peer review committees.

San Joaquin Cost Review Project

In fact, in one area, the San Joaquin valley—the northern part of the valley—we are experimenting with an even deeper type of review.

As was indicated this morning, physicians services constitute only 19 or 20 percent of the medical care dollar that is paid in Medi-Cal.

On the other hand, about 75 percent of the dollars are for services which have been ordered or prescribed or recommended by physicians. Therefore, a review of the physicians billings is really not sufficient to determine if there is economical and conscientious use of the program.

In the San Joaquin project, which is operated by the foundation for medical care, records are reviewed with respect to all of the services so there is an intensive review of hospital utilization, drug prescriptions, and so on.

This offers a much greater promise for control than we have found in the past, and if this will work, and if it is not too expensive—we have to balance cost against the result—we hope to expand it to other areas.

We also want to expand the prepayment concept which is being experimented with in San Joaquin Medical Foundation as well.

It was said this morning that Governor Reagan would like to see Medi-Cal scratched. I want to assure you this is not so. The governor has observed from time to time that the Medi-Cal program is a problem which needs much tighter control, and it needs much, much improvement. We have been working toward that improvement and in cooperation with the provider organizations, we have better controls.

The legislature has been responsive in approving legislation which will enable us to exercise more controls and to require prior authorization for certain services where this is warranted, and has also given us the means in case we do run short of money to have an orderly readjustment of the services in the program.

If there are any other questions that you may have I will be glad to answer them. If I don't have the answers, we would be glad to furnish them to you in writing.

Senator RANDOLPH. Thank you, Mr. Mulder.

This committee now, I believe I will be speaking appropriately for all members, we are in nowise interested in the politics of a particular situation nor in the personalities involved in such a situation. We must, however, probe, search. This is our function. And the hearing is for that purpose as well as hearing testimony. So, when we hear the conflicting viewpoints, it is necessary that we attempt to have a presentation—even, perhaps, a rebuttal, if we wish to call it that—to keep the balance.

And I personally am not so concerned—and I say this to our audience as well as to the witness—I am not so concerned with differences. I am concerned only when people are indifferent. And that is what I want to find out—if there is a difference, yes, I have that with my colleagues who sit here at my right today. As I earlier sat here today.

We do not vote all the same on all questions, but I can say for him that he is not indifferent to this subject matter—as well as other subject matter in the Congress.

And I think, by and large, that would be said of the Members of the Senate—the body to which we belong.

And so, if we can, with a spirit of objectivity, we can have viewpoints expressed as we have here today and not allow them to go off into tangents, but to keep at least on the body of the substance of what we are talking about, then it is a service to us, frankly, when we have these different viewpoints that are expressed here today.

I would not want the viewpoints to flow from imagined problems, you understand. We, in this country, can often create crisis. I don't want to get into that—that's another subject—but we want to be very careful to deal with the substantive matters. I know our chairman feels that way, and I know all the members of the committee feel that way.

And so, I think it is constructive that we have the discussion which we have had, not only from Speaker Unruh, but from Mr. Mulder and perhaps others who are contributing to the dialog here today.

This is highly important. Yes, Congress passes legislation. The intent is written, and then often the agency or agencies involved will not administer the law as perhaps we in the Congress really intended. This has happened many times, and we have to have an oversight committee to check up and to see, "Now, is the agency carrying out the law as intended by the membership that passed it?"

And so you see why conflicts often arise in these areas. I would hope that out of this hearing, and I will be speaking for all members, particularly for our chairman, who of necessity is absent at this time, that we want the facts insofar as we can determine the facts.

And we want to move forward to correct the inequities whenever those inequities have been substantiated by fact. This is very important. I think it is an obligation.

As we go back on Capitol Hill, as we review not only the problem here in the immediate Los Angeles area, but in California.

Well, perhaps I have talked too long about this, but I want the record to reflect that there is a purpose in the committee other than to write legislation, but then, to go out into the countryside, as it were, and to see how the legislation actually, in operation, is coping with the problems—sometimes solving the problems. In other words, a commitment which is a continuing one, with the necessity always, I realize, for review and perhaps extension and refinement of the law which may have been placed on the statute books at the outset.

And I thank all those who have contributed today in this spirit in this context.

Mr. ORIOL. Were there any other comments you wanted to make at this time, Mr. Mulder?

Mr. MULDER. No; I was ready to answer any questions that the committee staff may have.

Mr. ORIOL. Did you say that Medi-Cal participants are given screening of some sort—a physical, tests—test for physical condition? Is this a requirement?

Mr. MULDER. No; I wouldn't go that far. I say that, in California, we have attempted to have in Medi-Cal a program that utilizes the mainstream of health care services, so that people, whether they are poor or rich can use this system—the available resources—the same way.

Mr. ORIOL. That is why I raised the question. I thought you were requiring this on a wide scale.

I wanted to ask whether you have the facilities to do it with.

Mr. MULDER. No; we do not require it. We strongly recommend that each person in the program have a personal physician, and if that physician believes that this should be done—some screening should be done—the program will provide that.

Mr. ORIOL. Well, when you said screening, I immediately thought of multiphasic screening on a scheduled basis.

Mr. MULDER. Well, we do not have that.

Mr. ORIOL. Do you feel there is need for more of that type of facility within California, and if so, what age groups do you think it would most benefit?

SANTA CRUZ EXPERIMENT

Mr. MULDER. Well, there was a very successful experiment in Santa Cruz County, many years ago, where applicants for old age assistance were given opportunity, at the Public Health Department, for a battery of tests the results of which would then be sent to their personal physician.

To the extent that there is manpower and that facilities are available, I would like to see that extended, indeed. The physicians in Santa Cruz found this very helpful, and it helped the aged persons who had not yet sought out a physician, to do so. With the old program, the problem was that we only paid for the treatment of illness. It did not pay, at that time, prior to 1966, for diagnostic examinations in the absence of symptoms.

Mr. ORIOL. I have another question.

If this is not properly addressed to you perhaps you could indicate that, and we will send it by mail to whomever you suggest.

The San Francisco Chronicle of October 10 carried a story about a study showing that the death rate of elderly patients went up alarmingly after they were removed—and apparently with some amount of haste—from Stockton State Mental Hospital. The study showed that the death rate was 27 percent higher than of those who stayed in the hospital. I believe this was part of the hospital population reduction program, but this sort of study raises some questions, I would think, about that project.

We will also address some questions by mail to the author of that study and will ask him some questions, too, but have you anything to discuss with us?

Mr. MULDER. No, I am not conversant with the article to which you refer. I suggest you address the question to Dr. James Lowry, the director of mental hygiene in Sacramento.

Mr. ORIOL. We will do that.

Without objection, we will enter that article in the record.

(The information follows:)

[From the San Francisco Chronicle, Oct. 10, 1968]

MENTAL HOSPITAL MOVE—STARTLING STUDY OF AGED

(By Carolyn Anspacher)

The death rate of elderly patients, abruptly removed from Stockton State Mental Hospital under orders of the State Department of Mental Hygiene has shot up alarmingly since the "Hospital Population Reduction Project" was inaugurated last January.

According to a new, and carefully controlled study of geriatric psychiatric patient transfers, the mortality rate of the most helpless who had been removed to nursing homes and convalescent hospitals ran 27 per cent higher than those allowed to remain in the familiar hospital setting.

The research project was undertaken by Eldon C. Killian, a member of the Academy of Certified Social Workers, and a psychiatric social worker at Stockton State Hospital. It is being submitted with hospital approval to "Social Work", the authoritative scientific journal of the profession.

He began his research last January when it was decided in Sacramento that the entire north area of Stockton State Hospital should be deactivated and, within the year, some 50 to 60 per cent of the slightly more than 800 geriatric patients moved out in a series of "waves". Some according to the transfer plan, were to be taken to other "less crowded" mental hospitals—Agnews, Modesto or Napa.

Some were to go to nursing homes, convalescent hospitals, boarding homes or guests homes and family care homes. And some were to be kept at Stockton in south area wards.

For his study, Killian took three separate groups. The first group totaled 71 males and 8 female geriatric patients who were transferred by chartered bus from Stockton to other state hospitals during the first three months of this year.

The second groups, 21 male and 44 female geriatric patients (40 per cent of whom were non-ambulatory) were taken by ambulances and autos to "extramural facilities"—nursing homes, convalescent hospitals and the like.

The third group, 52 men and 57 women, remained at Stockton State Hospital, but in other areas of the institution.

An equal number of geriatric patients was selected from the hospital's January 1, 1967 census and each matched to those in the 1968 study group as to age, sex, race, organic or functional diagnosis length of hospitalization and ambulatory or non-ambulatory status.

Killian, found that the mortality rate was 4.98 times higher for the experimental group transferred from Stockton to other psychiatric hospitals than for its "control group".

"The mortality jumps even more dramatically to 8.99 times higher for the experimental group transferred to other extramural facilities than for its control group," Killian noted.

"Nine out of 65 died in this group during the four month followup, as compared to 1 out of 65 in its control group."

Killian's study shows that in the second experimental group—those transferred to non-State homes and convalescent hospitals—26 out of the 65 patients were bedridden at the time and of these 26, seven died within the four-month follow up period. This was 27 per cent of the group.

Killian has concluded that the older, non-ambulatory, hospitalized geriatric patients who were transferred out of their hospital home (and some had lived at Stockton for a great portion of their lives) had a significantly higher mortality rate than the base rate of matched control patients who had not been transferred.

Killian believes that on the basis of his study, the mass unilateral transfers of old bedridden psychiatric patients from State hospitals can be seriously questioned.

"Is it possible," he asks at the conclusion of his paper, "or an individual's environment to assume so much importance, in this case for the geriatric patient, that upon sudden removal from it, his body functions may be affected by the emotional trauma, including death?"

And finally, as a footnote not included in his study, Killian added that on September 20, while the walls of his ward were being torn down around him, one elderly male patient at Stockton refused to leave. He was put into an ambulance and was dead on arrival at another area of the hospital. The death was attributed, not to grief nor shock, but to natural causes.

Mr. ORIOL. Another question coming from the San Francisco Chronicle of September 20 quoted you as saying that you agree with Governor Reagan's other earlier estimates of deficits in the Medi-Cal program. And, I understand that there was supposed to be a surplus, as of last June 30. Is there a contradiction here? if so, what is it? This is a knotty question. Perhaps you would rather do it in writing, but if you want to discuss it here for awhile, let's do that.

Mr. MULDER. Well, as I indicated, the program was started with great haste. The machinery was not perfect. There were delays in the processing of bills. There were delays in the compilation of the necessary statistical records which can be used for trending later.

The law provided that any provider of services could hold his bill for 6 months before sending it in. As a result, in the spring of 1967, we had an extremely poor body of information on which to make the projections. We did make the projections. We did the best we could. We consulted experts in the field, actuaries, who agreed that with the data we had, these estimates were not unreasonable.

Now, these estimates have turned out to be on the high side, but not as high as some people have said. Because when we found out that we were in difficulty, we took other actions as well.

GOVERNOR'S TASK FORCE

The Governor had appointed a survey task force which was contributed by private industry and in which permanent people in the medical association participated, and they made a number of recommendations as to changes that ought to be made in the medical program. These changes have been implemented and are still being implemented. The system has been improved in terms of the hardware and planning for the payment process.

Some legislation was introduced and passed which deferred certain obligations which would be due under an accrual basis, to the next

year on a modified accrual basis. And, as a result of all of this, we were able to live well within the budget.

In the current year we are within the budget.

From the better body of information we now have, it is our estimate that unless there are unforeseen contingencies, like the Long amendment—which we fortunately averted—that if these things do not happen, we will live through the year without the difficulties we have had in the past.

Mr. ORIOL. No deficit? But, will there be a surplus of any kind? I don't understand what a surplus in a program of this kind is.

Mr. MULDER. We operate on a closed-end appropriation as distinguished from the Federal medicaid program appropriation. The program is financed by Federal funds to the extent that the certified people are eligible under the Federal law and regulations. There is also local participation from counties. The local participation from counties, as I think Mr. Unruh touched upon this morning, is frozen substantially at the 64–65 level. Therefore, any increase in either the count of recipients or an increase in the utilization of the program, or an increase in the cost of the program, by and large, becomes a matter of 50 percent by the Federal Government and 50 percent by the State. And the counties do not share in this increased cost. And that's why the pressure on the General Fund in this program is much heavier in an inflationary period than the pressure of normal programs.

Mr. ORIOL. As we review the testimony, we probably will have other questions which we will submit by mail.

Mr. Skoien is with you. Mr. Skoien and Miss Russell have been very helpful on this committee as they have been in other projects, and we appreciate it. I am glad to see you.

(Subsequent to the hearing, Senator Williams asked the following questions in a letter to Mr. Mulder:)

1. I believe you were present when Mrs. Dudley, Dr. Littlejohn, and Dr. Smith gave their testimony (a copy of Mrs. Dudley's statement is enclosed.) You may remember that Mrs. Dudley said that she has written to the State Department of Welfare and the fiscal agents to assure a more speedy method of processing claims from so-called ghetto areas under Medi-Cal. Mrs. Dudley and her associates presented an alarming description of wholesale departures by physicians from such areas because of such difficulties. I would like to have your comments in response to these statements.

2. Your statement emphasized that social workers under the Medi-Cal program are instructed to encourage Medi-Cal participants to seek the services of a personal physician, with special emphasis on the need for preventive services. What information do you have as to the availability of such services, particularly in low-income areas? What preventive health services are available for the elderly under the Medi-Cal program?

3. You mentioned that physicians services constitute only about 19 to 20 percent of the Medi-Cal dollar. May we have details on expenditures for other services or care, with special reference to health care services of special importance to the elderly?

4. Have you yet decided whether the San Joaquin Medical Foundation procedures will be applied on a broader scale in California? If so, what are likely areas of use?

(The following reply was received:)

DEPARTMENT OF HEALTH CARE SERVICES,
Sacramento, Calif., November 27, 1968.

* * * * * * *

DEAR SENATOR WILLIAMS:

As my extemporaneous testimony at the hearing indicates, Governor Reagan and his Administration are not opposed to publicly financed programs to provide needed health care to individuals and families who have insufficient resources. He has taken a dim view, however, of federal legislation which pushes states into massive programs which, by their very nature, tend to increase health care costs generally. In addition, the previous Administration and the Legislature had set a far too early effective date for the program which did not permit a well planned organization and system for its administration, so that when the Governor took office he inherited a most undesirable and inefficient operation.

The fiscal controversy of 1967 was the result of insufficient planning for the gathering and use of cost data. The fact that the fiscal year was concluded within the budget was not solely because of previous overestimation but largely the result of administrative actions taken by the Administration and constructive legislation worked out on a non-partisan basis. The Speaker's statement that the Governor preferred to eliminate the medically indigent from the program is not correct. The Supreme Court, which interpreted the statute which the Governor inherited, clearly ruled that this was the only course the Administration was permitted to take. Since the Administration was unalterably opposed to this step it asked for alternate orderly means of reducing program costs; the 1968 session fortunately did agree that the Administration should have more flexibility and passed legislation to that effect.

The Committee's record already contains my correction that the Governor has not "steadfastly refused even to consider the threat of imposing a fee schedule" on physicians; the 1965 law clearly contains the provision that physicians, as distinguished from other providers of services, should be paid on the basis of their usual and customary fees.

Many of the statements made by the Speaker meet with our full agreement. We most certainly share his concern that the Congress should not retroactively and without notice reduce federal support of the state-operated assistance and health care programs Our principal effort should be directed to an improvement of the existing program, particularly in terms of controls, so that fraud, abuse, and inapproriate utilization of program benefits can be eradicated.

You have also asked that I express myself on four questions appended to your letter.

1. The witnesses were correct that payments through the fiscal intermediaries, until recently, have been quite slow. For several months, however, we have determined that the properly completed claim which raises no question regarding utilization or propriety of fee is paid within 30 working days.

The claims processing system does not distinguish between providers in so-called ghetto areas and those from other parts of the community. We do realize, of course, that a physician whose major part of the practice is composed of Medi-Cal patients has been more seriously affected by slow payments than other physicians. In cases where hardships were determined to exist the fiscal intermediary has been authorized to make interim payments.

Although we too have heard that physicians are moving from impoverished areas, we have not been able to verify this, and doubt very much if the Medi-Cal program is the real cause of any relocation of their offices.

AVAILABILITY OF PHYSICIANS' SERVICES

2. Physician participation in Medi-Cal is relatively high; almost 90% of all practicing physicians participate to some degree, although we recognize that the majority of service is still provided by relatively few physicians. The availability of physician services in poverty areas is still less than elsewhere but we have noted a marked increase in the number of physicians adjacent to such areas.

As to the manpower availability for preventive health services, we can only guess. Such preventive services as are professionally recognized as part of the community pattern of practice are payable through the Medi-Cal program. The extent that these services are actually furnished depends, therefore, upon the time and interest on the part of the individual practitioner and on the success of the admittedly limited health education activities in which the social work staff engages.

3. A distribution of the dollar expenditures by type of service is attached, both in table and in chart form. In reviewing this material it should be borne in mind that the Medi-Cal program is a supplementary resource to the aged and that the distribution does not include payments made on their behalf through the Medicare program.

4. The San Joaquin Medical Foundation approach of comprehensive review of all services furnished or generated by physicians is still under formal study. It is not possible to determine the advisability of wider application until more data has been collected and evaluated. Results of our initial evaluation are expected to become available by mid-1969. I have a strong suspicion this approach can be applied economically only if it is accompanied by the establishment of an effective EDP system for the compilation of profiles, both for patients and providers of service.

Sincerely yours,

CAREL E. H. MULDER, *Director.*

[Attachments]

TABLE 1.—AMOUNT AND PERCENT OF PAYMENTS TO ALL RECIPIENTS AND TO AGED RECIPIENTS, BY TYPE OF SERVICE, FISCAL YEAR 1967–68

Type of service	Payments				Aged recipient payments as a percent of total recipient payments
	Total recipients		Aged recipients		
	Amount	Percent	Amount	Percent	
(1)	(2)	(3)	(4)	(5)	(6)
Total, all services	[1] $582,093,798	100.0	$224,732,390	100.0	[2] 38.6
Physicians	122,554,513	21.1	22,948,004	10.2	18.7
Pharmacists	43,650,941	7.5	20,689,809	9.2	47.4
Dentists	22,891,705	3.9	4,318,531	1.9	18.9
Optometrists	5,984,803	1.0	1,895,269	.8	31.7
Chiropractors	1,094,214	.2	532,906	.2	48.7
Podiatrists	1,784,147	.3	1,127,060	.5	63.2
Home health agency	2,214,145	.4	813,344	.4	36.7
County hospitals	110,414,577	19.0	21,261,400	9.5	19.3
Other hospitals	94,008,964	16.2	9,499,288	4.2	10.1
State mental hospitals	18,338,837	3.2	13,768,531	6.1	75.1
Nursing homes	[1] 147,259,678	25.2	122,975,151	54.8	[3] 83.5
All other services	11,897,274	2.0	4,903,097	2.2	41.2

[1] Excludes $6,483,978 in nursing home adjustments retroactive to July 1966. Inclusion of this amount would increase the nursing home percent to 26.1 and reduce the other components slightly.

[2] Retroactive nursing home adjustments to aged recipients are not known. Under the assumption that they total 84 percent of the full amount, and adjustments are included in total, this would represent 39.1 percent.

[3] Inclusion of adjustment in the total payments, and 84 percent of the djustment in the aged category would not change this amount.

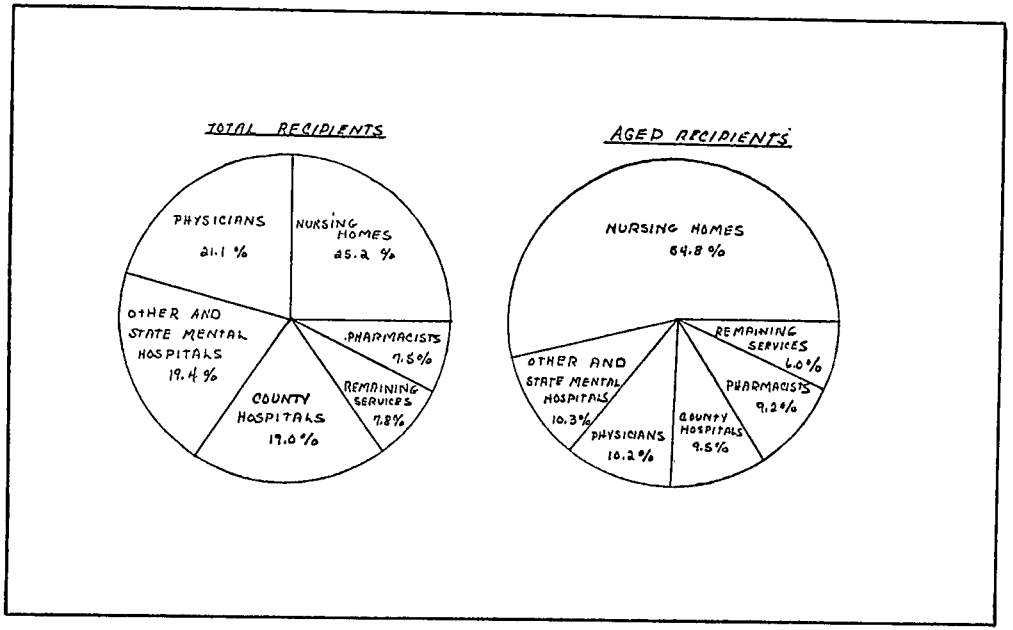
Sources: Services and Payments Report, April–June 1968, and unpublished back up data.

24-798—69—pt. 3——6

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

PROGRAM COST ESTIMATES BUREAU
REPORT 645 A 3
NOVEMBER 26, 1968

CALIFORNIA MEDICAL ASSISTANCE PROGRAM
CHART 1
PERCENT DISTRIBUTION OF PAYMENTS
BY MAJOR TYPES OF SERVICE
FISCAL YEAR 1967-68



SOURCE: TABLE I

Mr. ORIOL. Mr. Skoien.

STATEMENT OF CHARLES W. SKOIEN, JR., EXECUTIVE DIRECTOR, CALIFORNIA COMMISSION ON AGING

Mr. SKOIEN. The only thing that I am going to repeat and emphasize is not only that statement this morning by Mrs. Russell, but also re-emphasize that California is the forerunner in these programs for health care for our senior citizens. We must utilize the seniors in their own health programs, and we will mobilize—and must mobilize—and motivate the existing public and private agencies to recognize the need and then proceed.

This is being done today by the California Commission on Aging at the level of the local community.

The Reagan administration is endeavoring to provide California with a sound administrative program for the citizens of our State.

Thank you.

Mr. ORIOL. Thank you very, very much.

Our next witness is another person who has been very helpful to the committee.

Dr. Elsie Giorgi from the School of Medicine at USC. You have a time problem. I hope we haven't caused you too big a time problem.

STATEMENT OF DR. ELSIE A. GIORGI, ASSISTANT PROFESSOR, SCHOOL OF MEDICINE, UNIVERSITY OF SOUTHERN CALIFORNIA, LOS ANGELES, CALIF.

Dr. GIORGI. I don't mind if you don't. At your request, I have prepared a statement. Before I start, however, I should like to make a few comments—if I may.

Today, I have been impressed with the great interest and concern of all who have appeared here. It is obvious that there is agreement as to the need for change. I must say, however, that I have been disappointed by the emphasis on funds rather than programs. We have much evidence that funds are no guarantee of service. This was particularly true of State government representatives. Mr. Mulder, for example, spoke of preventive care services for the elderly. He spoke about such services as if they were an actuality. Something Mr. Galbraith refers to as "word—fact". Where are those services? If they are present, they are certainly invisible.

During the past 5 years, I have participated in many similar discussions. We constantly talk, exchange ideas, and plan ad infinitum—and then nothing of significance happens. I think it's time to stop talking, stop blaming, and start doing. I hope this once, it will be different. I hope this committee will see to that. For the first time, I sense a motivation for doing. For the first time, I am encouraged. That's why I'm here.

PROJECTED SHORTAGES AND COSTS

We really have no choice. We are at least 40 years behind. Unless we join forces toward the common goal of improved health care for our people, I do not think it is an exaggeration to predict that within the next 5 years, shortages will be so great, and costs so high that we

will have a black market in medicine with care extended only to those who can pay exorbitant amounts or who are agreeable to paying under the table in government funded programs.

No amount of additional funds will help. Until we design new systems; train new types of health manpower; effectively coordinate what is already there; and provide dynamic health education—those additional funds will only serve to further inflate costs without improving or providing adequate health care services. We have already seen this happen. We don't need more of the same. I think an important step would be to consider health facilities public utilities—subject to the same type of surveillance and regulation as public utilities. Why not? Health care is at least as important as our telephone and electric services. If such a system did nothing but prevent unnecessary duplication down the line—we would be well on our way to curtailing costs. This does not necessarily imply socialized medicine or government medicine. It would merely provide a much needed systems approach which the medical sector seems unable or unwilling to undertake. It is time for them to stop resisting new knowledge.

I appreciate your invitation to appear before your subcommittee on Health of the Elderly, with particular reference to the costs and delivery of health services to older Americans. I would like it clearly understood that my remarks are my own, and not to be interpreted as representative of any institution or organization with which I am affiliated.

Total Health

At the outset, let me say that I find it impossible to confine my presentation to the elderly, since the health care of any age group really starts from birth or even before that. Man is inseparable not only from his physical and psychosocial environment, but also from his genetic inheritance. Total health involves careful attention to all of these in an integrated continuing and coordinated program. Neglect at any stage of growth and development requires increasingly heroic measures for correction of defects in later years. Dr. Robert Kemp expressed it exceedingly well. In speaking of the care of the previously neglected aging individual, he said—Why fix eyes that no longer want to see—why fix feet that no longer want to walk? I certainly concur.

Health Care Delivery System Neglected

Equally neglected is this Nation's health care delivery system. It is now so sick and disorganized that nothing but heroic measures can possibly bring some order out of the chaos and ferment. I shall not bore you with a repetition of its inadequacies and inequities. These are already well known to you. Instead, I should like to devote this brief time to some comments on our almost hopelessly ineffective approach to correction of the defects and to some suggested alternative methods.

The current state of affairs did not happen overnight. In 1925, fully 40 years ago, the distinguished Dr. William Welch bemoaned the ever widening gap between highly advanced medical research and its clinical application. We have had no real change in medicine since the monumental Flexner studies of 1910–11. Dr. Flexner's assumption that

advanced scientific research and education would automatically result in quality care has not been borne out. What is sorely needed right now is a clinical revolution—counterpart of the scientific revolution that followed the Flexner report. I do not intend revolution in an anarchistic sense, but rather to imply rapid change, for we are at least 40 years behind.

What has brought about this sudden state of emergency? Many things, to be sure—but principally an enlightened public made aware of its right to good health, chiefly through medicare. That piece of legislation stimulated demand by providing funds and public education. It focused attention on the fact that funds do not necessarily provide services.

There are some who argue—was it wise to precipitate such a situation; to stimulate demand before services were available? Those who are concerned with quality and cost of care should not have wanted it any other way—for demand stimulates supply. If medicare accomplished nothing but this—and indeed it has done much more—it could rest on its laurels. Without its impact, we would most assuredly have continued as we were; each year losing ground progressively and paying more for less, while morbidity figures increase steadily as glaring evidence of our deficiencies—especially when compared with other nations of far less affluence and technologic skills.

Mr. ORIOL. May I interrupt, Dr. Giorgi? May I also say that demand might stimulate inflation—there are those who say that this sudden calling for services has caused too much demand for too little supply.

Dr. GIORGI. I think you are right. Demand in excess of supply inflates the cost. It always does—but it soon levels out because it outprices itself out of the market. I'm afraid that's what is currently happening to our prepaid health insurance plans. Any good which might be inherent in them is nullified when it becomes too expensive and unreasonable and untenable in costs. But there soon comes an end to that or it must go out of existence.

This Nation possesses the greatest potential for total and comprehensive health care. It boasts of the finest facilities, equipment, health manpower, and a generous national budget—all for the most part in advantageous ratio to population. What is needed is coordination of what is already there, and effective health education toward better health practices, as well as toward optimum use of existing services. Instead, we keep adding instant new programs, for the most part hastily and poorly thought out, which usually serve to further dilute our resources.

OVERDIAGNOSED AND UNDERTREATED

In medical school, we learned that diagnosis puts us well on the way to treatment and recovery when cure is possible. We have repeatedly and effectively diagnosed the ills of our health care delivery system. They are not incurable. We should be well on the way to treatment and recovery—Instead, we persist in studying them over and over again. We are overdiagnosed and undertreated.

It has become obvious that current major governmental planning funds under Public Laws 89–239, 89–749, and even the National Center for Health Service Research and Development, are being allocated predominantly to more diagnosis, to education of the medical sector, and to training of planners. It is also obvious that the term "partner-

ship for planning" intended to involve—in the words of Dr. William Stewart—"by no means only the medical sector"—and not "the same old card players around the same old table"—is rapidly doing just the opposite.

Continued subsidy of existing institutions such as medical and public health schools has not, in the past, been effective in promoting adequate or significant change. Why do we expect it to do so now? Their role as advisers, educators, and their contributions in identifying unmet needs, are most valuable, indeed—but we cannot continue to overlook the fact that such institutions are not service oriented and not activists in a true sense.

Recommended Changes

What we need is to apply what those institutions have so effectively studied and diagnosed in the past. Basically, what is needed is a reallocation of existing resources into a coordinated, unified health care delivery system—and we need it right now.

To this end, why not channel a good part of those funds to activist service groups such as associations of health professionals? Why not enlist the expertise of the medical, dental, and public health schools to assist those groups in planning services based on what is already known? Why not grant fellowships under sponsorship of educational and allied institutions to individuals who are adept at planning, and at grantsmanship—with a view to assigning them to work with such groups toward implementation of alternative health care delivery models? To be sure, we are told that such planning funds are available under section 314E of Public Law 89–749—but to my knowledge, they are not very visible and those who might put such funds to use are just not good at drawing up proposals. I have no objection to educational institutions continuing their studies and their teaching of planners. I would just like to see them extend into the community and help other groups design service programs—both are of equal importance—and what better way to train planners than in the framework of service.

Why not have them also make contact with future doctors and dentists, at the medical school and residency training level, encouraging them to understand and consider participation in new approaches to delivery of health care services?

All of these would distribute funds and enhance participation at the service level—far more effective than continued study and planning at the institutional level, virtually in splendid isolation from current and future health practitioners.

I am being repeatedly requested by medical students, by medical residents in their last year of training, by practicing physicians, by large consumer groups such as Union-Management, and more recently by large scale proprietary hospital ownership groups and city planners involved in the design of new communities—to assist them in evolving and implementing comprehensive health care models.

The medical profession and organized medicine groups are publicly expressing interest in change. The practice of medicine is becoming increasingly difficult and emotionally unrewarding because of demands made upon it by the very complexities and multiple problems of daily

living, as well as by the increasing amount of administrative and managerial tasks imposed by very necessary government standards and health insurance regulations. It has become impossible for the physician to go it alone and to be it all. The time for change was never so propitious. Activism is needed as it never was before.

Alternative Health Care Delivery Proposal

I have taken the liberty of appending to this paper, a suggested alternative health care delivery model, together with a recommended definition of roles for the various sectors involved in health care, including public, private, and philanthropy groups.* These comprised a proposal submitted by me to a private group interested in funding a Community Health Planning Foundation. We are still discussing this possibility.

There is no doubt that governmental action of the same kind could also effectively promote the development of such services. These papers are too long to permit reading here.

Briefly, the plan describes the creation of a unified health care delivery system, centering about comprehensive ambulatory diagnostic and care centers—called Health Care Facilities—pooling ancillary, paramedical, managerial, and administrative services, simultaneously permitting the one doctor/one patient relationship. It provides free and rapid transfer between the various components of the system and defines the role of each. These include the community—cottage—hospital, medical center, and extended care facilities and programs.

All services are supervised by the managing physician, coordinated by the health care team, and expedited by the family health agents. The latter is a new career—a peer related, informed advocate of the family. The plan coordinates existing services and is adapted at the individual community level—adding services only as the need for such addition is clearly demonstrated. It establishes effective quality and optimum utilization surveillance through a team approach. It is expected that savings in cost will result from the pooling and more sensible use of those parts of health care which are the most costly—namely: ancillary, administrative, managerial, and institutional.

The plan is offered as an alternative method. There is little doubt that the elderly would benefit greatly from it—perhaps more than any other group, since it permits easy availability and accesibility of all services through a single access, and also provides the means whereby they may be put more closely in touch with existing health services. Another service which is greatly needed by the elderly in urban areas, especially those that are relatively and absolutely homebound, is the meals-on-wheels concept. We should have more of this.

Family Health Agent

The family health agent would be of great value in providing the elderly with information concerning their entitlement relative to governmental and other benefit programs. This type of medical manpower, together with other physical and emotional rehabilitation personnel

*See app. 1, pp. 727–734.

provided through the health core facility are of special importance to the elderly as well as to other groups with multiple problems. The OEO neighborhood health centers have clearly demonstrated this.

The elderly are very much like the ghetto dwellers. They live in a segregated ghetto of their own—too often in a single room furnished apartment, suffering from retirement rot with nothing but time on their hands. At that stage, their problems are largely nonmedical.

It is not unrealistic to consider the use of the health core facility as a vehicle for training of the unemployed at all ages, not only as health agents, but as professional assistants of all types. The elderly would benefit greatly from this. They could be trained toward the second job in the pre- or post-retirement years. This would circumvent the destructiveness attendant on their loss of work role as well as permit additional income at a time when they need both very badly. We need such new careers in all the human services—especially in medicine as well as other undermanned fields. This, too, involves the principle of improved allocation of resources. Do we really have a severe shortage of professional manpower or are we merely senselessly misusing our highly skilled groups?

The proposed model, strategically located geographically, would permit availability to all age, ethnic, race, and economic sectors, which would be far better psychologically than systems requiring further segregation of any one of those groups—which is often demoralizing of itself.

Comprehensive health care systems are absolutely essential if we are to promote preventive care. We really have no choice. We must concentrate our efforts in the pregeriatric years, or very soon we will face the prospect of geriatrics virtually absorbing the practice of medicine.

Summary

In summary, then, I am making a plea for more activism and less study; for new cardplayers; for government and/or private encouragement and facilitation of improved health care delivery models, not only for the geriatric patient, but for all ages; for better coordination of existing programs, rather than addition of new ones; for a consortium approach with a clearer definition of roles; and for greater involvement and participation at the actual service level: I have also proposed a new model which, in my experience as a practitioner, as well as a health care programer, seems to have some universality and replicability.

I hope this very busy committee will find it possible to examine and consider it. Your critique will be most valuable to me.

I could not possibly end this presentation without thanking you for permitting me to come. I expect to learn a great deal. I hope my remarks will offer some contribution to the solution rather than to the problem.

Mr. Oriol. Didn't you say at a conference earlier this year that physicians spent only about 25 percent of their time in direct patient care?

Dr. Giorgi. Yes; it has been estimated that physicians spend about 25 to 35 percent of their time in direct patient care. The rest of their time is spent in doing chores that could well be done by others—chores that do not require their highly specialized skills.

Duplication of Equipment and Personnel

Another factor in costs and shortages is that of unnecessary duplication. Dr. Littlejohn stated that overhead expenses in a doctor's office is about 50 percent. No wonder. Each doctor's office has a full component of expensive and scarce equipment and personnel which they use only part time. Such equipment and personnel should be used full time. The real culprit in exorbitant costs is duplication down the line—from the doctor's office to the hospital and other facilities for institutional care.

At this point, I would rather not talk about cost per se—I would prefer to talk about care quantitatively and qualitatively. Improved health for all our people must of necessity prove to be less costly in the end. And that improved care will not be effectuated only through financial quantitative commitment. It must come through commitment to much needed change. It will require heroic measures—but it can and must be done. It will not be easy but it may well be easier than our current antiquated, cumbersome system of senseless duplication, fragmentation, and almost complete disregard of consumer perspective and dynamic health education.

Thank you very much.

Mr. Oriol. Dr. Giorgi, you can be sure that your proposed new model will receive a great deal of attention. I find myself with many questions which we can't go into in detail right now, but we would like to get more discussion on it.

Is any work going on at the national center for health service research and development along the lines you are recommending?

Dr. Giorgi. I will tell you—you know, the Scheuer amendment with new careers is working on this. They haven't done enough in the health field. I would like to see this applied——

Mr. Oriol. Could this be a specific recommendation?

Dr. Giorgi. I would like it to be, and you could make it in connection with the aged, teaching them the second job.

Mr. Oriol. Well, some of the questions that we will throw at you after having read your proposal in detail are: What is this model for? Is this a model for Federal action—to promote development—or is this a model for community action?

Our Federal programs, including the development of what you envision—or are they contradicting each other, perhaps, in some cases?

We will address many questions to you along that line.

Dr. Giorgi. Thank you very much.

(Subsequent to the hearing, Senator Williams asked the following questions in a letter to Dr. Giorgi:)

1. Your "Unified Health Care Delivery System"—which, as you said, would be of special usefulness to the elderly—is of great interest. Have you give any thought as to revisions in existing federal programs—or perhaps suggestions for entirely new programs—that could be helpful for establishment of such a system? Or do you envision development of this system as primarily a matter for private resources, with only supplemental incentives from the federal level?

2. You also suggested that the elderly might serve in useful "second careers" as health aides of one kind or another. In what roles could they be especially helpful?

3. Your observation that preventive care for the aged in California is "invisible" leads me to ask for your comments on what kind of services are needed but are not now provided.

4. I am not certain I understand your references to a possible "black market" for health services. Do you mean that the onset of a program such as Medi-Cal has increased demand for health services to the extent that Medi-Cal participants will be willing to pay some kind of premium to give them access to scarce health personnel? Or did you envision a more general problem?

5. You and other witnesses emphasized the need for health education, and yet I find myself wondering just how such education could reach the general public, especially the elderly. Do you have suggestions for increasing the effectiveness of educational efforts?

6. You began to discuss OEO health programs and indicated that you might have additional thoughts on that subject. Is it possible for you to give us additional discussion for our hearing record?

(The following reply was received:)

QUESTION NO. 1

My statements regarding development of a Unified Health Care Delivery System through private resources were expressed out of desperation. It is obvious that those institutions which might have been expected to be prime movers in behalf of unmet needs—namely, government (public health), profession schools, and the medical/dental professional organizations—seem powerless to perform. A conjoint effort on the part of all of these would be ideal. It is long overdue. Each of these seems blocked—perhaps because they refuse to recognize the fact that they are unable to "go it alone". They need help from other sectors. The approach is too complex for the health sector alone. A multi and interdisciplinary consortium is necessary. For this reason, I proposed a privately funded Community Health Planning Foundation as a means of providing such a consortium.

There is no reason why the same approach cannot be sponsored by government. As a matter of fact, in view of an enlightened public's indignation over the inadequacies, inequities, and exorbitant costs of health care it may soon become mandatory for government to assume leadership. We already have much evidence that a very large consumer of services—the labor movement—is becoming quite militant in this direction. The Health Care of a Nation is one of the prime responsibilities of government. In this connection, as things stand at present, government— functionally, at least—has been placed in the position of responsibility without authority—extremely untenable to say the least.

SWEDISH SYSTEM

I would like very much to see a Unified System developed through government sponsorship—primarily along the same lines as the Swedish System developed under the leadership of Dr. Arthur Engel, former Director/General of the Swedish National Board of Health, so well described in his 1968 Michael M. Davis Lecture—Planning and Spontaneity in the Development of the Swedish Health System. This could easily be done without infringement on the one patient/one doctor concept which seems to be the main basic concern of both the provider and recipient of services.

However, if government does assume leadership it should take the form of promotion of effective planning for service rather than direct ownership, direct operation, or continued funding of educational or institutional groups in isolation from service groups.

Central to the Unified Health Care Delivery System is the Health Core Facility already described. This is a single access Ambulatory Care Facility either free standing or hospital based. As such, it lends itself very well to government sponsorship along the same lines as the Hill-Burton or Hill-Harris concepts. To be most effective, this would require new legislation and a new program. This legislation should be carefully designed to include provision for all the components already mentioned in the description of the Unified Health Care Delivery System. I would like to see funding provided to associations of professionals (not just doctors) preferably on a long term, low interest loan basis, rather than on a matching funds basis. I would also like to see provision made for community participation and Federal public utility regulation as well as a more equitable plan for prepayment either directly or through health insurance fiscal agents. The "Catchment area" concept should be maintained to avoid duplication and might even be extended to include "adoption" of a contiguous community where a medical vacuum exists. The latter could become a satellite of the central Health

Core Facility. Very important, also would be the provision that optimum use be made of existing facilities and programs before new ones are added. In those areas where adequate facilities and programs already exist, funding can be directed towards their consolidation and coordination.

All of this could be detailed by the framers of the new legislation. While it is important that the legislation be quite specific, it is equally important that it be looked upon as a guideline rather than a blueprint. It should detail only the basic essentials guaranteeing optimum service; optimum use of facilities, equipment, and manpower; equitable care to all; and reasonable cost. All this must then be regionally adapted with services individually rendered, family centered, and community oriented. This is by no means "pie-in-the-sky". It has already been done in other nations—why not by ours?

I feel that only through new legislation can we achieve an overall concept. Continued additions and rebuilding on shaky foundations of old programs which have remained isolated from each other—and have failed miserably—gets us nowhere.

Equally ineffective is the senseless addition of new programs addressing themselves to a small part of the larger problem. They only serve to further fragment and to dilute all resources. A new program of this type may not necessarily require a great deal of additional funds. Since the keynote is primarily coordination of existing services, it can be partially funded through optimum use of existing funds.

It should be noted that organized medicine has already indicated approval of ambulatory care centers. I refer to Dr. Milford Rouse's statement in the November 27th, 1967 issue of the Journal of the American Medical Association. The California Medical Association has also been very interested in "promoting the art and science of medicine and the betterment of public health". In California Medicine of May, 1968, it calls for a "flexible and informed advocacy" on the part of the medical profession and envisions "individual physicians and organized medicine as a powerful and effective force for better health and better health care in this Nation". They are asking for inclusion in planning. I find this very encouraging.

Alternatives for Government Involvement

If new legislation is not feasible, alternative methods for government involvement could include the following.

1. Extension or revision of PL 89–239 (Regional Medical Program) to include implementation of a Unified System.
2. Revision of PL 89–749 (Comprehensive Planning Act) promoting a closer relationship between sections 314C and 314E so that training of planners can be done in the framework of service and involvement of practitioners of all disciplines in designing a Unified System.
3. Revision of the O.E.O. Family Neighborhood Health Center concept towards incorporation into a Unified System. It is far better when services to all groups can be rendered through common facilities. Accessibility can be arranged through strategic location of services as well as by provision of transportation when needed.

Question No. 2

The elderly are too often forced to retire at a time when they are still very capable of function. This is especially true of those who are employed in the "over manned" fields. Labor Union regulations also promote such retirement. Too often those regulations are motivated towards making room for new membership.

I would like to see us educate and train such retirees towards a "second job" in the "under manned" fields such as health aides and assistants of all types—both those already existent and new careers. These could include medical aides, laboratory assistants, X-ray technicians, home health aides, nurses' aides, social service aides, health education aides, multipurpose workers (new careers), etc. Aides in education are also desperately needed. I think the retiree should be trained prior to retirement through the mechanism of a sabbatical.

The concept of the multiphasic worker is further discussed in answer to question five. The idea of training for a "second job" in the pre-retirement years was described in the paper—The Sabbatical in Industry*—previously submitted to your committee.

*Retained in committee files.

QUESTION NO. 3

As far as I know, there is no provision for periodic health examinations. To my knowledge, such services are not reimbursable under either Titles XVIII or XIX. A program providing periodic multiphasic screening tied to a physician examination would go a long way towards preventive care. It would be even more successful if it were performed in the pre-geriatric years. In addition to detecting disease and disruption prior to the irreversible stage, such health examinations might even provide some means for surveillance and circumvention of such abuses as over-testing and excessive visits by providing a general, social, and biochemical reference audit and profile on each patient.

It would have been very feasible to make provision for this through Medicare. It is very customary to request health evaluation in conjunction with health insurance. Medicare is mediated through the mechanism of social security which is an insurance plan.

Such periodic examinations, including multiphasic screening, can decrease the time required for a complete checkup from about two hours to one-half hour or less. This will help circumvent professional manpower shortages. It has been estimated that, if every person in this country were to have an annual complete health examination under present methods; it would require about forty-five hours out of each practicing physician's week. Obviously this is not feasible. Decreasing the time to one quarter of the present required time would obviously assist this immeasurably.

The type of complete audit permitted through a well designed periodic multiphasic screening program may even provide a means for determining priorities on professional time. At the very least, this is worth testing and demonstrating. The Health Core Facility Concept provides a vehicle for such testing and demonstration.

QUESTION NO. 4

By "black market" in medicine, I meant that services will soon be so scarce and the cost so high that only those who can pay "premium" fees will be able to secure health care. I also referred to currently existing practices of "hidden" additional costs to institutionalized Medicare patients which take the form of such things as extra charges for telephones which are not requested by the patient; and extra charges for family visitor parking equally unsolicited; as well as other abuses recently reported in connection with the California Medi-Cal program. The acceptance of the patient into the facility becomes contingent on such "tributes". This and other types of "under the table" payment have a definite "black market" flavor since they involve illegal practices as well as "premium" and "tribute" payments.

QUESTION NO. 5

Some of us are frequently requested to speak to groups of elderly people. They are very avid for information concerning nutrition, medicines, and the more commonly occurring chronic illnesses such as arthritis, cancer, heart disease, stroke, diabetes, etc. There is a striking lack of knowledge as to these as well as to the proper use of health services. We will never have true "quality care" until the patient faces his doctor with adequate knowledge as to what is being told to him as well as to his entitlement. Without such knowledge, the elderly—who are constantly being told; "what do you expect at your age"—often wait until it's too late to present for care.

One of the better ways to provide such health education is through the informed advocacy of properly trained peer groups such as new career multipurpose workers—health ombudsmen. This could be a "second job" for retirees.

Many years of observing patients in clinics as well as in my own practice have taught me that a great deal of the therapy is in reality done by peer related lay groups. Repeatedly, I have observed them consulting cashiers, attendants, porters, secretaries, etc. after leaving the doctor either for additional information or for clarification of confusing orders given by the professional staff.

Multipurpose workers of this type could be used in clinics. They could also visit Homebound Medicare recipients in their homes and could conduct community teaching sessions in schools, churches, clubs, etc. There is little doubt that they could reduce the need for scarce professional services and for unnecessary medications—too often given to "get rid" of the patient. It has been correctly estimated that about 80 to 85 percent of people presenting to the physician just need someone to "talk to".

The Health Care Facility Concept can well be used as a training Laboratory for all types of health career assistant and associate personnel. It can also be used as a vehicle for dynamic health education. The elderly are admirably suited to such careers by reason of their experiences, empathy and their great need to feel useful and wanted. Proper training can orient such multipurpose workers towards the direction of optimum self-sufficiency for their clients.

QUESTION NO. 6

My experience with O.E.C. health programs results from very active participation in the design and implementation of the Southcentral Multipurpose Health Services Center; a U.S.C. sponsored, O.E.O. funded Neighborhood Health Center in the community of Watts, Los Angeles. It is very difficult to discuss such health centers purely from the medical care standpoint. They were part of the larger parcel—The War on Poverty.

The intent of the Family Neighborhood Health Centers was to make use of health services as a wedge to correction of other inadequacies and inequities experienced by the disadvantaged such as poor education, poor housing, unemployment, etc. They promoted a total health concept in its broadest sense which, though admirable, inevitaably resulted in the introduction of numerous variables—each of which posed a threat to existing institutions, resulting in constant harassment from many sources, and repeated compromises which were too often paralyzing and disruptive.

Like other O.E.O. programs, the Family Neighborhood Health Centers were supposed to reduce the powerlessness of the poor. The impression was that they, rather than the establishment, were to be in command. This became impossible of achievement since the funding of the Health Centers was awarded to the establishment, and quite naturally the disadvantaged equated power with money.

The term "maximal feasible participation" was never clearly defined which produced an inordinate amount of conflict in the design and operation of so highly technical and complex a structure as a large health center in which areas of competence are of great significance. Consumer perspective and participation is very necessary in all service programs. However, when this became confused with actual operation of the facility, chaos often resulted and threatened the proposed partnership.

Many problems were also inherent in the need for "year to year" funding. There were constant deadlines to meet in the way of reporting and re-budgeting. All of this interfered with smooth operation. Even more significant was the quite ridiculous assumption that professionals would leave either a good job with security or established practices to assume full time work with a program that could not guarantee employment beyond the one year term of the grant. The result was inevitable. Too many of these health centers either employ part time professionals or are understaffed—thus sacrificing the concept of continuity of care. A sense of the temporary was pervasive; certainly not conducive to feelings of security or stabliity.

Many of the clinics are free standing. Without guarantee of admission to the hospital, there is always the element of rejection by the hospital admitting physician. Attempts at true coordination with existing services and programs, even those funded by O.E.O., were constantly thwarted due to such things as differing philosophies and criteria for acceptance as well as manpower, budget, and space shortages on the part of other agencies and institutions. All of this greatly interfered with both continuity of care and implementation of the total health concept.

The inevitable result was further frustration and distrust on the part of the people who felt betrayed by promises unkept in the failure to achieve the goals of better health, better jobs, and better education.

In spite of all this, there is a definite danger of further frustration and distrust should these health centers be discontinued. However, before they proliferate further, I would think it mandatory to have a complete evaluation as to their efficiency, per capita operational costs, etc. I do not believe this has been done to date.

I do not think that O.E.O. Health Programs—as they are now designed—can effect coordination and unification of health care services—both of which are sorely needed. As a matter of fact, should they continue to expand beore proper evaluation, the end result may well be a shift of inequities through further dilution of funds and resources.

At the same time, I wish it clearly understood that I approve of the basic philosophy of the total health concept, and the War on Poverty, and the use of health care with relation to both. The concepts of consumer perspective and participation; health care teams; dynamic health education; peer related multipurpose workers as informed family advocates—all of these are of proven value not only to the poor but to all of us. There is no reason why these cannot be incorporated into a coordinated and Unified System rather than through creation of plans which enforce rigid geographic and economic eligibility standards, and are stll in reality "medicine for the poor".

We are indebted to O.E.O. for its energetic approach toward promotion of these concepts. It is now time to move on to a broader and more complete plan—one which addresses itself to the total problem of better health and health care to all with the least amount of threat to existing institutions. This can be accomplished if we are mindful of the fact that truly successful planning usually carries with it that which is good from the past; is pertinent to the present; and has some meaning for the future.

At this point in time, with relation to health care services, I feel that experience has taught us that the perference of both recipients and providers of services leans heavily toward a one to one relationship in connection with the very "personal" services. Comprehensiveness, and reasonable cost as well as the other factors described can still be achieved through pooling of the less "personal" aspects of health care such as clinical tests, other special para-medical and ancillary services, and the administrative and managerial components—all of which traditionally lend themselves much more readily to grouping.

Mr. ORIOL. Our next witness is Mr. Cass Alvin, representing the council for health plan alternatives.

If Senator Williams were here, he would greet you as a fellow steelworker.

Mr. ALVIN. Yes. Thank you.

STATEMENT OF CASS ALVIN, EDUCATION COORDINATOR, UNITED STEELWORKERS OF AMERICA

Mr. ALVIN. My name is Cass Alvin, and I am representing the California Council for Health Plan Alternatives, which is comprised of trade unions in California, both AFL and CIO, as well as the independents and the State and regional bodies.

This is a problem of time where I am unable to make a formal presentation on behalf of the council.

We will, with your committee's permission, Mr. Chairman, submit the council's views at a later time, and we will continue to do so as we work together, unraveling some of the mysteries of the rising costs of health services, and we will submit from time to time some of the ideas and suggestions we have for improving the efficiency of health care services and its quality.

I would like to confine my remarks to a few observations.

I would like to say first of all that following Dr. Gorgi is not a very easy job. I think she touches just about all the observations that can possibly be made. She is one of the consultants to our council on health planning alternatives, and we value her imagination and creativity in this field.

The California Council for Health Plan Alternatives grew out of the need of trade unions for a coordinated effort in tackling the problem of how best can we provide our members quality medical care at the lowest possible price.

Our experience in this field was at first limited. We bargained for a few cents. We went to a vendor, an insurance carrier, who would

indemnify our members to some extent for the cost associated with hospital and surgery.

Over the years we have gone back annually to our employers, shook their pockets, stacked more money on the table, enlarging to a small degree the coverage of the insurers' plan, adding new and sometimes questionable benefits only to return again to take more money in lieu of wages, and turning it over in a lump sum premium to an insurance intermediary.

Health Plan Alternatives Committee

With but few notable exceptions, like the Kaiser plan, that was the only way open to us. And that is all that is open to us presently—that is, until we started our work with California Health Plan Alternatives committee.

What we in fact, are doing is what you in Government are doing about the dollars that are going to the health care for the aged. You and we in labor, as the consuming groups apparently are yet unable to make an impression on most of the medical establishment which needs to know the thinking of the consumer.

We are the representatives of the people who pay the bill.

We in labor grow weary of chasing the dog's tail, finding ourselves in this whirl of putting more money into our plans and not making any appreciable headway.

We can't get out because as yet there is no alternative for our members.

The prepaid union negotiated medical plans in the State of California amount annually to about a quarter of a billion dollars—this is a lot of money. We are the largest single consumer of health plans in the private sector.

We have been trying to get at the root causes of some of the rising costs and looking for standards by which we can improve the quality of medical care. We don't think you can separate quality from the cost.

It matters very little to a person who can't afford a medical plan what the quality or costs are. If the cost gets so prohibitive that you can't obtain medical care, then quality is of little value. We think the two have to go together.

We think we have found, up to now, some alternatives to some of the rising costs. What complicates our problem and complicates the problem of your committee is that it is almost impossible to get available data, or even a rationale for the rising medical and hospital costs from those who have the figures but who are reluctant to release them.

No secret was ever guarded as carefully as the figures behind the fantastic escalation of medical costs—the hospital and doctor costs. I suspect this will continue to be the case until those who pay the bill —the consumers, we in the labor unions and you in government— insist on some kind of an accountability from the purveyors of medical services, and that the data upon which they base their cost assumptions are exposed to public scrutiny.

Position of Labor Unions

California labor unions, by now experienced in the inflationary phase of the State medicare program, are not accepting the recommendation by the California Medical Association and the Blue Shield that the 60 percentile basis for charges for medical procedures be raised to the 90 percentile level.

This proposed change would tend to bring all the medical costs up to the 90 percentile, and would bring about an automatic escalation. If there is any remaining money in the Medi-Cal program, once this change is instituted, the surplus would be wiped out and the increased costs will have to be made up by going again to the legislature for more money.

We were told this was necessary to keep more doctors interested in handling medicare patients. Incidentally, it was said that there were 18,000 doctors in California involved in the Medi-Cal practice. What wasn't stated was how many of those doctors charge fees over and above what is provided under the medicare and the Medi-Cal programs.

We in the Council object to this proposal made by the California Medical Association. For what use your committee could make of our testimony, and to all parties concerned in this State, I would like to submit our thinking on this matter as a matter of record to your committee.

You may ask what costs of medical and medicare have to do with the medical costs and delivery of health care of all others. Our experience in trade union prepaid medical expense plans, convinces us that it is all a part of the same ball of wax. It cannot be separated.

Every movement, every development in the medical care field has a relation to the other.

When medicare became operational, for instance, millions of aged people, who before could not afford medical services, saw hope and took their illness to the same establishment that serves all the others, including trade union members who were covered by prepaid medical plans, and all others in the community deriving health care services from the same establishment.

Something is bound to happen. You start paying more for the same or even paying more for less. Sometimes you get services you don't need, and you pay more for them. We don't think this will stop unless something is done, until we regulate by consumer pressures the price rates of medical care or until we find alternative ways—some new systems of delivering medical care not only for the aged but for all the people.

It is like the old jar of jam. Unless there is some control over it, an awful lot of well-intentioned people find themselves all covered with the stuff. This will keep going on as long as this jar continues to be refilled and no controls put over it.

I don't say this as a pointed charge against any segment of the medical establishment. We have, as has been earlier indicated, some cooperation from the California Medical Association, and much to the credit of our committee, I think we are doing what you are doing with

these committee hearings; starting to have a dialog with the medical establishment.

We are, for the first time, talking with the people who deliver the medical care services to our people.

Talking with intermediaries I think is a waste of time. While we appreciate the insurance companies and other intermediaries—they have got their little playpens. They have taken a lot of health plan negotiators out to lunches, but we just don't think we have had any success with them.

We don't think they can effectively change the method of delivery of medical care services or in any way control the price. We think they are really a part of the entire system, and no changes are likely to come from them at all.

The economic forces being what they are, I don't think the equation will ever change unless there are consumer pressures. What we need is more and more competition in this field of medical care.

I am a member of the hospital advisory board, and I am appalled at the gross inefficiencies that go into our hospitals. Even the purchasing of the necessary paraphernalia for hospitals indicates that there must be some kind of a fungus growing which allows costs to rise without any checks or controls.

One example, for instance, we have an employer under contract with our union who makes bicycles. But in addition to making bicycles, he makes wheelchairs.

Now, the same kinds of skills—making bicycles—go into making wheelchairs. About the same kind of material goes into a wheelchair as goes into a bicycle, and yet the hospital pays about 10 times as much for a wheelchair as a consumer pays for a well-made bicycle.

Actually, the amount of material and labor that go into making bicycles and a wheelchair are almost identical.

It seems that no one seems to care about the cost that goes into hospitals. No one apparently cares about such items of cost so long as someone else is paying the bills. In the health care business there are not the kinds of pressures we find in the rest of the marketplace.

"Piecemeal" Health Programs

We ought to look at the health of the whole community. We may be exceedingly wasteful by just fashioning our system to serve a particular segment.

What we are doing at present is having medicine for the rich, medicine for the poor, for the old, for the young, for the black, for the white, for the rural community, for the urban center. I think we must start thinking about medicine as something to be delivered on a communitywide basis, so that we don't have the segregation problems—we don't have rich people involved in one kind of medical care and the poor in another kind—the black in one, the white in another.

It is understandable why this occurs. Many times Government programs come about in a piecemeal fashion, and we all hope that once such programs are started, they will serve as a foot in the door for the rest of the community.

We have been doing this, in part, for years, one foot at a time in the door—and I suggest that this is more than just a two-legged problem.

It is really more even than a centipede. Maybe we should start getting all of the feet at one time.

For instance, what we do for the infant and the children in health care will have a lot to do with what they will require as aging citizens or the kind of care they received during their working years.

The kinds of health care that we are able to provide people in the middle span of their lives likewise will affect the health of the older citizen.

We see today a tragic paradox in the problem of the unemployed. While there are shortages of certain technicians, nurses, and other health service personnel, it seems that in the area of human needs, these human services, there is an unwillingness by the private sector to spend a buck.

The public sector is of course afraid of the cost pressure of taxes. So we are left here with people who are able and willing to provide human services, and because there is no proper organization in this area the abilities of these people are not being utilized.

My observation is that we are, for instance, willing to spend more money and more time in training the seeing eye dog to lead a blind person around than we are willing to spend on some individual who could take the hand of an older person and provide him the kind of human services required.

Teamsters Multiphasic Screening Program

In the California Health Plan Alternatives Council, we are very much impressed with the successful program of multiphasic screening used by the Teamsters and the other unions in the food processing industry. About 20,000 workers are pressed every year through a mobile system of well-equipped vans.

We have evidence of how thousands not only receive annual check-ups without cost, and with minimal inconvenience. A number of people, because of this early detection, became well, and in many, many cases had their lives saved.

There are certainly many ways that such a type of an examination—detection of ailments—can be helpful with the health care of the aging.

This idea should be explored further. Not to be in conflict with what was said at this hearing about preventive medicine, I still have to see any sort of a multiphasic screening or any other type of preventive medicine program in the State of California for the aged.

It is not enough to say that you ought to have a family doctor. What was learned from the multiphasic screening in the food processing industry is that about 60 percent of those people don't have a family doctor. The family doctor is a yellow page of a telephone directory.

Just telling them they should have a family doctor is not a form of preventive medicine. Certainly everyone should—it is like telling a person, "You ought to be well and not require medical services."

Observation indicates that the aged are not really, in many cases, receiving medical care but are housed in places that provide little more than custodial care.

Many of these people may be just lonely, and not sick, as Dr. Giorgi indicated. While this is probably prevalent in other age brackets, this

may be peculiar to the aged. It may require new professions and vocations, schooled to fill some of the kinds of needs that the aged require, other than just medical care.

Elderly as Power Bloc

My last word, if you will permit me—I am talking to a group of Senators—with about 10 percent of our population of 65 or over, I feel confident that some solutions will be found not only in the area of cost of medical care, but also in the quality of medical care. The large number of elderly people is a definite power bloc, and in this day and age when we group people into color power blocs, we call it the aging "grey power".

And since 65 comes after 21, I need not remind anybody here of the pressures that this power can exert, or what change of direction it can make in our society—even in our medical establishment.

The California Health Plan Alternatives Committee wants to use its voice to help in this problem, not only because we are in a sort of symbiotic relationship with other groups wanting to improve our system of health, but also because we are also all aging together.

Mr. Oriol. I would like to thank you very much for that statement.

I know you didn't have time in this statement to give a full description of what the Council on Health Plan Alternatives is, but we will get that in a letter statement.

But basically what this group is doing is making sure that current members of unions—is it limited to union members?

Mr. Alvin. Yes

Mr. Oriol (continuing.) Are covered adequately by health plans, and in doing that, you discovered certain things in the delivery of services that you would like to see improved.

So that by the time this present group that you are working for now themselves become elderly, why, by having taken care of themselves at an earlier period of time, in a way they are contributing to the resolving of some of these problems concerned with the elderly.

Mr. Alvin. Also, in addition to that, many of our plans now include not only coverage for the active employees, but for the employees upon retirement. We are concerned certainly with our aging population and their health needs.

There is another important point on this, and that is that many of our plans provided medical services and health care services to retired people. When medicare care came into being, some of our members were already covered by union negotiated plans. Now who is going to pay the bill? Of course, the employers and unions—just as any other groups—choose to transfer the cost on to the Government, and this has been done in many cases. It has been a saving in many ways to our negotiated plans. Some of these costs to our plans now are borne by medicare.

On the other hand, however, we know that putting 10 percent of our population on medicare has an inflationary pressure on existing plans, so that in one way, we have benefited a little costwise but in another way have found the inflationary cost effects of medicare.

Mr. ORIOL. We want to develop that in questions to be addressed to the committee. You will submit for the record this Memorandum on Health Plan Alternatives?*

Mr. ALVIN. Yes, I will submit it.

Mr. ORIOL. I would like to acknowledge that Congressman Alphonso Bell is in the audience. If he has any time now, and wishes to address the committee——

Mr. BELL. Thank you, Mr. Chairman. I have nothing to address to the committee at this time. Thank you.

Mr. ORIOL. And now I would like to call Mr. Donald Gormly, president of the California Association of Nursing Homes, Sanitariums, Rest Homes and Homes for the Aged, Inc.

I see Mr. Burch of the American Nursing Homes Association. Perhaps you would like to accompany Mr. Gormly.

Mr. Gormly, your appearance springs from discussions we had with the ANHA. I am glad to see you here.

Mr. GORMLY. Yes. Additionally I have Mr. Clinton Jones from the California Nursing Homes Association.

We shortened our title. Our official title is——

Mr. ORIOL. Is it longer than this?

Mr. GORMLY. Well, in conversation we call it the California Nursing Homes Association.

STATEMENT OF DONALD GORMLY, PRESIDENT, CALIFORNIA ASSOCIATION OF NURSING HOMES, SANITARIUMS, REST HOMES, AND HOMES FOR THE AGED, INC.

Mr. GORMLY. Mr. Chairman, members of the special committee, my name is Donald Gormly. I am President of the California Nursing Homes Association. I am also a regional vice president of the American Nursing Home Association—representing region VIII, the Western States—and in that capacity I serve on the executive board of the national body.

On behalf of the California State Association and the American Nursing Home Association we wish to extend our appreciation and thanks to Chairman Williams, Senator Moss, Senator Randolph, and other members of the committee for the leadership you have demonstrated and the concern you have expressed for the elderly, and for your efforts in strengthening the medical care programs for the aged. We wish also to express our appreciation for the cooperation extended by this committee in the past.

We stand ready to continue or cooperation in the effort to achieve our common goal: to make a better life for our senior citizens by providing quality health services to them.

Mr. ORIOL. Mr. Gormly, if I may interrupt. You mentioned Senator Moss—and that is Moss of Utah, and he had hoped to be here today, especially because he is chairman of our Subcommittee on Long Term Care.

You can be sure a copy of your statement will be sent to him.

*See app. 1, p. 734.

Mr. GORMLY. We will appreciate that. Thank you.

Mr. Chairman, we as providers of health services in California comprise an organization of 1,300 private facilities, with approximately 55,000 medical care beds. All are licensed by the State; mostly as nursing and convalescent homes, and some as mental hygiene long term care facilities.

Virtually all of these institutions—both proprietary and tax-exempt—currently provide services to patients under the title 19 program, known in this State as Medi-Cal, and to which I shall hereinafter refer.

Of equal interest is the fact that over half of these facilities—over 700 in number—are title 18 medicare-certified, thus forming by far the largest State group of extended care facilities—ECF's—in the Nation.

In addition, our California membership includes hundreds of residential care homes and institutions—all of them licensed. I mention this group particularly because of its increasing importance and potential as this committee weighs the advisability of defining various levels of aged and needy patient care to meet more exactly the needs of the individual elderly and convalescent ill.

I might add that our State association is dedicated first and foremost to the constant betterment of patient care. As a demonstration of this, a primary requirement of membership for each facility is State licensure, and the meeting of State-set standards of care. Conversely, loss of licensure terminates membership.

In the light of our prime interest in the patient, then, I will respond briefly to the suggested question: What has been the effect of the medicare and Medi-Cal programs upon the kind of services provided by our member institutions—and what recommendations do we have for further legislative or policy change?

MEDI-CAL AND MEDICARE STANDARDS

In general, there seems little doubt that the two programs have resulted in higher standards throughout California. In fact, the newly required title 19 Medi-Cal or skilled nursing home standards are nearly approaching Title 18 medicare standards in terms of costs.

Our California association has just completed a cross section study of 309 facilities to find there is now only 44 cents difference per patient day between a Medi-Cal skilled nursing home and a free-standing ECF. On the average, then, Medi-Cal standards are catching up costwise with medicare.

Mr. ORIOL. May I ask why you so pointedly say "costwise?" What other comparisons might be made?

Mr. GORMLY. Well, the standards of the title 19 program have been elevated, and they have, in fact, come up almost to the medicare standards, and this in effect raised the cost—standardwise they have to——

Mr. ORIOL. So that cost follows standards?

Mr. GORMLY. Yes, they are going down the same road.

The basic reason for this growing similarity is easy to identify: it is the increasing nurse staffing requirement—the major cost item in today's nursing and convalescent home. Nevertheless, the delivery of good quality nursing care in these Medi-Cal institutions constitutes

government's biggest bargain in health care for the elderly and needy—at a time when general hospital care costs are soaring toward the hundred-dollar mark per patient day.

Mr. Chairman, despite the foregoing analysis favoring improved patient care standards overall, we are confronted with many obstacles in our efforts to deliver services efficiently and economically.

California providers are not unique in this regard because standards and regulations are promulgated at the Federal level but implemented at the State level—often with inconsistent, rigid, and inflexible interpretations.

Further, we in California nursing homes live with the necessity of pleasing several governmental masters. Federal HEW sets skilled nursing home standards as a title 19 requirement. The State department of public health has separate licensure standards in many ways in difference with the Federal program.

The department of health care services administers title 19 standards, adding its own inspired regulations and interpretations. And last, but by no means least, the State department of finance—unconcerned with patient care standards—unilaterally sets the budget.

Mr. ORIOL. That department of health care services—that's the State department of health care services; is it?

Mr. GORMLY. Yes. These are State agencies I am talking about.

Thus our facilities have been and continue to be caught and squeezed between demands for higher and higher standards, while denied just recompense for providing care to our elderly.

In the interest of time, Mr. Chairman, we would like to conclude with brief references to three specific problem areas, by way of responding to the question in your opening statement: "Are present medicare and Medi-Cal policies intensifying old problems in the organization of health services or causing entirely new problems?"

SPELL OF ILLNESS

Mr. Chairman, the American Nursing Home Association has had a longstanding controversy with the Social Security Administration concerning definition of a "spell of illness" for purposes of determining covered and noncovered benefits under title 18. I will not take up the committee's time now, but with your permission submit for the record excerpts from association testimony before the Senate Finance Committee on H.R. 12080—1967 amendments to the Social Security Act, which discussed this issue in detail.* We feel this is a good example where an existing policy denies the elderly benefits which Congress intended them to have.

RETROACTIVE DENIAL OF BENEFITS BY INTERMEDIARIES

Another area of concern to both nursing homes and the beneficiaries is the retroactive denial of benefits after beneficiaries have been certified for services. This is the result of social security guidelines being interpreted by fiscal intermediaries in a manner offering no flexibility. In effect, the intermediary overrides the utilization review commit-

*See app. 1, p. 739.

tee's decision. Not only is this a form of practicing medicine but it is an injustice to the patient needing medical care and to his family, often unable to pay for services already provided in good faith by the facility, but suddenly "uncovered services."

In this connection, I have personally received this reaction from several of the Western State associations making up region VIII of which I am vice president. Their responses to the subject matter before this committee are still coming in. I want to assure you, Mr. Chairman, that the reports on medicare and title 19 in Arizona, Nevada, Oregon, Washington, Idaho, Utah, and Hawaii will be filed with your committee within the specified time limit.

Concluding our comments on retroactive denial of benefits, this situation which has continued for almost a year shows hope of clearing up. Some longstanding denials are now being authorized to be paid under instructions issued September 23 by Director Thomas M. Tierney of the Bureau of Health Insurance.

While we are gratified at this progress, we feel that present policies continue to hamper the programs for the elderly.

Mr. ORIOL. Mr. Gormly, if I may interrupt?

For one, we will be happy to receive those reports.

For another, I see Mr. Mulder is still here, and we are interested in full discussion, so if he has any comments to make at the end of this discussion, perhaps you would care to remain?

Mr. GORMLY. Fine.

Perhaps I might elaborate and ad lib a little bit here on this retroactive denial. What has really happened is that the care has been provided the patient under title 18, the billing submitted to the fiscal intermediary, and the patient has gone home thinking his bill has been paid, and that he was covered under an insurance program.

And then payment was not made for the care going back 6 months.

Mr. ORIOL. And it is the individual himself who becomes responsible for ultimate payment?

Mr. GORMLY. Well, the recipient of medicare—the beneficiary of medicare—assumes that he has an insurance program covering his illness, and all of a sudden by some decision made by some—not necessarily a medical staff—he is not covered under the program.

Mr. ORIOL. Who is ultimately responsible for paying that bill?

Mr. GORMLY. The patient—if he signs a financial responsibility.

In other words, if he signs a financial responsibility statement saying he was responsible for his debt, regardless of governmental coverage or any other insurance coverage, then he would be responsible.

But trying to go back 6 months and tell a patient, "I am sorry, your benefits didn't come through"—maybe the patient died—maybe he has moved. The point is, many times you can't recover the cost.

Mr. ORIOL. So the nursing homes are bearing some financial loss because of this?

Mr. GORMLY. In Kansas City there were over $300,000 in claims disallowed—and arbitrarily disallowed.

Mr. ORIOL. And how were those claims paid?

Mr. GORMLY. They were not paid.

Mr. ORIOL. In other words, the nursing home——

Mr. GORMLY. They couldn't find the patient.

Mr. ORIOL. They could not collect? We have received reports from elsewhere on this very problem, and we are very interested in it.

Mr. GORMLY. Yes, very well.

PROPOSED CHAPTER 9 OF PROVIDER REIMBURSEMENT MANUAL

Finally, we would like briefly to mention the difficulties with which owners of ECF's and skilled nursing homes will be confronted under a proposed draft of chapter 9 of the Provider Reimbusement Manual now being considered by SSA. We were asked, along with other organizations, to submit comments.

Frankly, Mr. Chairman, we find the proposed draft objectionable, and moreover we feel that SSA is asserting authority that Congress did not intend it to have. As stated in our comments submitted to SSA:

> Our primary objection * * * is that it is invalid and in violation of Section 1801 of the Act. Section 1801 provides in part that "Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control * * * over the compensation of any officer or employee of any institution, agency or person providing health services * * *" Nothing could be clearer than the fact that the Social Security Administration is attempting to regulate in an area from which it has been conclusively foreclosed by Congress.

Since time is of the essence, Mr. Chairman, we wish only to cite this as another example of legislating by regulations, and/or guidelines, which will impair the smooth operation of needed programs of elderly patient care.

In concluding, we wish to express our appreciation for this opportunity to present comments on the effects of medicare and Medi-Cal.

I would particularly like to put in the record the California Association's gratitude for the cooperation and assistance received from Mrs. Mercia Leton Kahn—Regional representative for the Western States of the Social Security Administration—in developing title 18's program in ECF's here in the Far West.

Similarly, the State Department of Public Health of California, and the Department of Health Care Services have been most helpful and cooperative, in their acting capacities as arms of the Federal Government on behalf of both the medicare and Medi-Cal programs.

To us, our mutual relationships in bettering elderly patient care is a fine example of government and the private sector working together in a common cause * * * which is the same noble cause that brings us all here today.

Mr. ORIOL. Thank you very much, Mr. Gormly.

I might add that we are impressed by the evidence of the very responsible position taken by the American Nursing Homes Association in its statement. The Nursing Homes Association's statement on matters that are of concern to the Federal Government because of the high level of assistance and support it gives.

So we really thank you.

Do any other members——

Mr. GORMLY. If we may have another minute, I would like to give an example of what happens in this "spell of illness" thing.

Unless you are familiar with it, or unless you prefer me to submit it for the record.

Mr. ORIOL. Well, we are getting—we are late—we are not just getting late. It might be better to submit it for the record.

A written question that we will submit to you in writing is: How the intermediate care facility requirement under the 1967 amendment is affecting you here in California.

In Washington they are very concerned about it, and we want to known how it is affecting you.

Mr. GORMLY. We have filed—I believe—objections to the definition as published in the Federal Register, because we feel that intermediate care is a care concept that should encompass from the title 19 standards going down through licensed residential care facilities, because we don't think that the intermediate care patient is a static thing—that he remains in one spot.

He will move from slot to slot. Maybe he will require nursing care 2 weeks and then be able to go into a residential care facility providing another type of program.

And that is our main difference with the concept of intermediate care as published in the Federal Register.

Mr. ORIOL. Thank you.

Mr. Mulder, did you have anything you wanted to discuss at this point?

Mr. MULDER. No. The points that Mr. Gormly discussed were primarily points to do with medicare.

Mr. ORIOL. Thank you. Thank you very much.

Mr. GORMLY. Thank you.

(Subsequent to the hearing, Senator Williams asked the following questions in a letter to Mr. Gormly:)

1. What are the most common reasons given for retroactive denial of nursing home benefits? We would like to have the reports from individual states for our hearing record. Have any improvements in the situation occurred since Director Tierney's directive of September 23?

2. What will be the likely effects of establishment of the "Intermediate care" category in California? Will redefinition of state categories be necessary?

(The following reply was received:)

1. The common reason given for retroactive denial of Medicare nursing home benefits in California as well as other states is that the patient is not qualified to receive such services. This declaration made by the fiscal intermediary thus overrules completely the physician's medical decision.

Director Tierney's instructions have lately begun to improve the situation.

2. The likely effect of establishing "Intermediate Care" in California would be to give official sanction to a continuing deficient level of skilled nursing home care, thru by-passing the higher Title XIX standards already pending implementation in 1969.

Pressure from agencies concerned with Medi-Cal costs would tend to result in moving patients "down" from Medi-Cal to Intermediate Care: the only practical difference being a reduction in professional nursing coverage from "around the clock" to day shift only. Already some 250 small nursing homes are expected to be de-certified from Medi-Cal in 1969 because of this very "difference," i.e., they cannot meet the higher standards of patient care.

There is also considerable question as to how many Medicare and Medi-Cal certified facilities would seek to provide Intermediate Care for the same though transferred-downward patients at a lower reimbursement rate when they must be fully staffed and tooled up to the higher standards.

The California State Association's position on Intermediate Care, based upon the H.E.W. guidelines requiring RN and LVN daytime staffing is that "the quality of patient care would be seriously jeopardized by such a program and accordingly is incompatible with the State Association's standing policy advocating higher standards of patient care in nursing homes."

In addition, California possesses several thousand licensed Residential Care facilities which, under proposed implementation of the Chappie Bill (AB 389—'68 Legislature) appear to offer a more appropriate type of "Intermediate Care" through a combination of board-and-room and other special services purchased and arranged to better fit the needs of public assistance recipients not needing skilled nursing home care. It is possible that this latter approach may additionally prove more economical to government than Intermediate Care per se.

Mr. ORIOL. And now I would like to call Dr. Austin B. Chinn.

It is a real pleasure to do so for many reasons. Dr. Chinn is very helpful in the discussion and early work on the preventicare bill, and was the consultant to this subcommittee on the health of the elderly in the first—in the two hearings that we conducted earlier.

It is good to see you again, Doctor.

Dr. CHINN. Thank you.

Mr. ORIOL. We wanted to make you a "wrap-up" witness, Dr. Chinn.

STATEMENT OF AUSTIN B. CHINN, M.D., PROFESSOR OF MEDICINE AND DIRECTOR, REHABILITATION RESEARCH AND TRAINING CENTER, UNIVERSITY OF SOUTHERN CALIFORNIA

Dr. CHINN. All right. If you will bear with me.

The hour is very late, of course. I don't want to take any more time than is absolutely necessary.

What I have to say in attempting to summarize this very full day would be presumptuous on my part in a full context. However, I can make a few remarks regarding points which struck me during the hearings as germane to the issues you have.

Many aspects of medicare and medicaid have been presented here. Some of them favorable, and some of them critical. To attempt to comment on all these would be, really, out of order, I think.

Dr. Todd commented on the aspects of surveillance which is being provided by organized medicine relative to the medicaid program. And you, of course, have those remarks in the record.

Dr. Littlejohn, I think, made some cogent remarks about some of the serious effects that medicaid is having upon medical care, particularly in the ghetto areas.

He said that actually, health services are leaving the ghetto areas as a result of medicaid. This, I think, is a very serious charge, particularly since the people in the ghetto areas need medical care and health services more than people anywhere.

We all know that the incidence of disease in the population of deprived people is infinitely higher than it is in any other group in the United States. To witness removal of those health services that do exist seems to me to be a very, very serious thing.

Dr. Giorgi gave us a sweeping survey of the entire health situation. I wouldn't really feel it appropriate for me to comment on what she said.

A couple of things that Dr. Breslow said I would like to mention. He talked about the quality of medical care in this country and the need for quality control and the influence of medicare and medicaid on quality control.

One of his thoughts which I would like to emphasize, has to do with the remarks he made about preventive health services. In this context,

I think it is accurate to say that there has been in this country, in the past 25 years or more, a vast increase in medical knowledge and skill.

The problem has been really to deliver the fruits of this knowledge and skill to the people of the Nation.

A factor influencing the delivery of this knowledge is of course the increase in the population, particularly the increase in the very young and the very old. The urbanization of the population has also been an influential factor and has been a direct impediment to the delivery of health services.

The shortage of health manpower has been a distinct impediment. There have also been social and economic forces which have impeded the delivery of these fruits of knowledge and skill to the people.

Included among these are attitudes and understanding on the part of people about health services. Distances from health services, particularly when old people had to travel, are involved with transportation difficulties, are also problems that are relative to this.

The organization of health services and the attitudes of people of the health professions with respect to older people have sometimes been impediments to the delivery of services.

Poverty, it goes without saying, has been an enormous influence on the delivery of health services.

In the stimulation and support of the delivery of care, however, we have the normal humanitarian instincts that exist in the minds of people in this Nation.

These civilized and humanitarian instincts have, of course, predominated with respect to most of us and counter the other influences which tend to impede.

Also, a promising increase in health plan power and a promising evolution of different kinds of manpower, such as the doctor assistant and the nursing assistant, is emerging. A better use of manpower is undoubtedly coming about and there are promising organizational changes, such as the establishment of better institutions as here in California. For example, the Long Beach General Hospital, which is devoted entirely to the care of elderly people is an excellent institution, and that kind of thing, I think, is emerging.

We are also having better kinds of health services such as home care, home-health services, and ambulatory services, all of which leads toward the development of better utilization of this knowledge that I was talking about earlier.

The Void: Inaction on Prevention

But it seems to me, the most important void in all of this—which Dr. Breslow touched upon and also Dr. Giorgi and has been referred many times here today, is the prevention of illness.

This, it seems to me, of necessity has to be approached realistically in this country sometime within the near future.

Most attention to illness and disease in this Nation has been directed to the immediate treatment of the sick—with hospitalization, nursing care, medicare, and such other measures necessary to bring about a cure.

Historically, however, the greatest progress in health in the world has been made on the one hand by the primary prevention of disease as the acute infectious diseases—smallpox, typhoid fever, diphtheria,

and so forth—brought about by immunization, sanitation, and quarantine, and on the other hand the identification of disease in its early or presymptomatic stage. Those two principles have influenced the health of the world more than any other influences that have been known since the dawn of mankind.

When I talk about the identification of disease in its early or primary or presymptomatic stage, we have as graphic illustrations of this the diseases of tuberculosis and syphilis.

Both of these of course are chronic infectious diseases and their control has been largely brought about by their identification while in a nonsymptomatic stage. The identification of pulmonary tuberculosis in its earliest stage—where it is only a minor shadow on an X-ray film is in marked contrast to an advanced stage of the disease, with cavitation, and other evidence of widespread disease.

The medical contrast between those two situations is graphic beyond belief as is the contrast in cost of their management.

The same thing is true of the other chronic disease that I named, syphilis. The identification of this disease by simple blood test as contrasted to its symptomatic stage with nervous system or cardiovascular system involvement is strikingly different.

The contrast between management of the chronic infectious diseases in their early nonsymptomatic stages with their management in symptomatic stages is graphic. There is no reason why the chronic, noninfectious diseases may not fall into similar categories of management.

The same principles of early identification of noninfectious chronic diseases are as vital and as applicable as the early identification of the chronic infectious diseases.

Such diseases as hypertension, coronary artery disease, glaucoma, cancer of the uterine cervix and breast, and mouth, pulmonary emphysema, and a host of others can all be identified in an early or presymptomatic stage. The technology is available, and there is no reason why it cannot be applied.

These hearings have been directed toward the principle of cost. It seems to me that if we are thinking of increasing cost of medical care, as it presently exists, we can think only in terms of building, increasing numbers of hospital beds, of educating increasing numbers of physicians, nurses, and other professional people and of increasing efforts directed to the care of the already sick.

We will thus have increasing costs of hospital beds—and these other services for the sick for the foreseeable future. Where do we wind up? The Nation is increasing at the rate of millions of people every decade, and all that we can expect is to increase the number of beds and doctors and professional people to take care of them.

The cost, on the other hand, of early identification of these diseases, which are filling the hospitals, causing morbidity, and mortality must be looked at in comparison.

Cost "Miniscule" in Relation to Benefits

I think that the cost of this, though substantial initially in the effort to find the disease, and in the event the disease is found, to move the individual into the receipt of health care, is minuscule compared to the management of that same individual months or years later follow-

ing the development of an advanced stage of the disease with the prospect of long periods of hospitalization, or other institutionalization, physician services, nursing services, and on and on and on.

It seems to me, Mr. Chairman, that we are at the point wherein we must face the issue of whether we want to do what we are doing now, or whether we are willing to sponsor the support and development of this type of health service as we did with biomedical research some 25 years ago.

I would like to remind you that for all practical purposes, biomedical research was in its infant stages immediately after the Second World War. I think the Cancer Institute had its origin before the war, and maybe the Heart Institute, but the effort was really in its infancy.

Out of this has grown a stupendous body of knowledge in 25 years. But it would never have come about if we had sat back and done what we were doing in the late 1930's and early 1940's.

Today, we are at the same stage, essentially, with respect to this segment of health services that we were 25 years ago with respect to biomedical research. I would urge the committee to consider what steps it might take with respect to these humanitarian and the social and economic interests.

Thank you.

Mr. ORIOL. Doctor, we thank you. I think it is apparent to the few hardy survivors here yet remaining why we asked Dr. Chinn to give us not only testimony but wisdom and a vision of what we hope will be the future.

I have many questions, and some of them will find their way to you in the form of the mail, but one question I would like to try out on you now: There has been much discussion today about how you cannot separate health care for the elderly from health care for all. It is regarded as part of the total health system. But in terms of organization, the attention given to health services for the elderly at the Federal level—is there some advantage to having a unit of government at a very high level devoted to the health care of the elderly? And I say that knowing full well that you are the former chief of the Adult Health and Aging Branch of the Public Health Service, but in view of the rising numbers of the elderly, in view of the increased attention being given to health costs simply because we now have medicare, do we not get similar benefits if we use the kind of quality health services given to the elderly as one way of raising the quality of services for all?

Dr. CHINN. I think it is, as has been said here today, that medicare has not only done a great deal for the older person, but has done a great deal for medicine and medical care in this Nation as a whole.

HEALTH PROBLEMS OF OLDER PEOPLE

As you well know, the health problems of older people are quantitatively infinitely greater than they are for any other age group. Qualitatively, one might argue about whether they are different, but quantitatively they are different, and there are many more complexities relative to these health problems.

I don't consider physical health problems alone: I am also talking about social health problems and mental health problems. All of these things interdigitate with respect to the influence of one area upon another.

It seems to me that quantitatively if we are looking for the greatest health problems that exist in the Nation, one can profitably look toward the elderly population. If we can solve these problems or can come even close to solving them, or develop mechanisms for solving them—then this cannot help but have a large impact on the rest of the population.

I would be the first to say that the health problems of elderly people—whether they be physical, mental, or social—do not necessarily begin when they are 65—when an individual gets to be 65. They begin in younger years, certainly, in the fifth and sixth decades of life, or maybe even in the third or fourth decades. Therefore, the problems as we know them in elderly people are qualitatively not peculiar to older people but there are more of them. I would endorse emphatically the fact that if one can focus down upon them, the impact of this upon the health of the Nation as a whole would certainly be profound.

Mr. ORIOL. Another question I wanted to raise:

The Kaiser Permanente—or Kaiser Foundation health multiphasic screening program has been mentioned here quite often today. I think it is important for the record that we note that the persons receiving this screening are members of a prepaid group health plan.

When we talk of widespread multiphasic health screening, possibly along the lines suggested by the Preventicare—or more specifically along the lines that are now at work in three or four pilot health screening programs, which were initiated, I believe, while you were with the Public Health Service—with all those, you are dealing with a group that is not organized into a prepaid package. How can you hope to get widespread participation? What are the difficulties here?

PUBLIC ACCEPTANCE OF PREVENTICARE

Dr. CHINN. Well, I don't think that all of the difficulties are known. And this is, I think, one of the reasons that the four prototypes that you mentioned, which are now in operation in communities, will serve to disclose a great many of the problems that are inherent in an open-ended community program. The lack of close physician participation and the lack of proper understanding of many people who would be coming to such a screening operation present real problems.

Factors about the delivery of the information and the followup and utilization of the information—all of these factors, I think, are unknown. However, I would say this: It took a great many years, many centuries, as a matter of fact, before the value of hospitals came to be recognized as something other than "death houses."

Prior to and including the 17th century, and indeed into the 18th century, one didn't go to a hospital to get well, one went to die. And it took 150 to 200 years before people learned to go to hospitals to get well. Formerly it wasn't recognized as a place to help the sick individual; it was a place to which to remove the dying person from society and hide him away.

This is an exaggerated statement, of course, but it seems to me that what we are talking about here today may require a long period of acceptance. But once it has been shown to the public that the identification of disease before it is symptomatic has proven its value, we won't have more trouble with public acceptance.

As it stands now, the public hardly accepts any preventive health measures. People won't stop smoking—people won't stop overeating—people won't stop drinking excessively—so when one says this thing will soon be clasped to the breast of the general public, it is sheer nonsense.

But the fact of the matter is that there never has been any health measure that I know of, which has been accepted, nor should it be until it has been proved to be of value. I think this is essentially where we are today.

Mr. ORIOL. It was said earlier today that it is the same old cardplayers around the same old table in the terms of people or groups of people involved in our health effort.

Do you think old cardplayers can learn new tricks? Do you feel the same sort of concern that was expressed earlier?

Dr. CHINN. I do not necessarily; I am old, and am still learning new tricks. I see no reason to think that everybody else can't.

I think that the health professions are on the verge of learning new tricks.

I would like to say a word about the ferment that is going on in medical education today. Medical educators are aware of this card table and these tricks—old tricks. They are doing something, really, very intensively about it. There is an enormous amount of activity going on toward the revision of medical curriculums, revising educational programs to fit into and to be in accord with the tempo of the times.

And I think that all these educators are not necessarily young. Some of them are rather advanced in years—such as myself.

So I think they can learn new tricks. I think there is a climate here today that has no parallel since the Flexner report of 1912.

CHANGES IN MEDICAL EDUCATION

I think that the whole system of medical education is about to undergo a radical revision and to try new approaches to what it is supposed to be doing.

What kind of man or woman is supposed to be turned out of a medical school? What are they going to do after they leave medical school?

Mr. ORIOL. You mentioned the Flexner report just then, and that set the stage beautifully for this question:

Within recent months an attempt was made to establish a presidentially appointed Commission—we will call it Health Maintenance and Disease Prevention—the idea being on that high level, much as the Commission that produced the heart, stroke, and cancer legislation—this Commission produced a report so comprehensive, so overwhelming, that it would set the stage for every kind of action you described in terms of disease prevention.

Do you think that this Commission is a good way to begin, or would you rather see an action program begun to make the point dramatic cally, or do you think it might be a combination of both?

Dr. CHINN. I think it should be a combination of both. I don't see how you can really have one without the other.

The Commission study would be worthless unless it could be implemented—whatever its recommendations were.

At the same time, I think you have isolated islands of activity going on without a national image. It will also take decades to get this idea across to the public.

I think that the two in concert would be the proper answer to this, and I would endorse it enthusiastically.

Mr. ORIOL. Do you have any questions?

Well, I would like to thank you, Dr. Chinn, especially for your contribution as well as all the other witnesses, in absentia, for a really good record which will give the subcommittee much to work with in the months ahead.

I would also like to correct an outstanding deficiency of the day by introducing Mr. Shalon Ralph, the professional member of the committee. This is his first hearing.

Mr. Ralph was retired until he joined the committee recently.

I also wish to introduce to you Mrs. Slinkard, our chief clerk.

And once again, thanks to all.

(Whereupon, at 5:15 p.m., the subcommittee adjourned, subject to the call of the Chair.)

APPENDIXES

APPENDIX 1

ADDITIONAL INFORMATION OR EXHIBITS FROM WITNESSES

ITEM 1: EXHIBITS RELATED TO STATEMENT OF DR. MALCOLM C. TODD,* PRESIDENT, CALIFORNIA MEDICAL ASSOCIATION

EXHIBIT A. CALIFORNIA HOSPITAL ASSOCIATION—CALIFORNIA MEDICAL ASSOCIATION

PROCEDURES FOR REVIEW OF EFFECTIVE UTILIZATION OF HOSPITAL SERVICES

(Adopted by Office of Health Care Services, June 12, 1968)

Aim

To provide Medi-Cal with a system of safeguards in the utilization of hospital services; and to assist hospitals to maintain and strengthen standards of care.

Need

Providers of health services have a responsibility for assuring that the public interest is being served in the delivery of hospital services for persons covered by the Medi-Cal program.

Quality is the most important component to effective hospital service. Standards of quality can be best judged by professional peers, functioning expressly to review patterns of hospital practice.

Methods

In cooperation with the California Hospital Association and the California Medical Association and under the provisions of their agreements as the contracting carriers with the State of California, Hospital Service of California and Hospital Service of Southern California will organize and implement the following procedures for reviewing irregular patterns of practices by hospitals participating in the Medi-Cal program:

1. Screening for irregularity

In the conduct of its customary and routine procedures, provider claims for service are reviewed by the contracting carrier for conformity to prevailing standards of practice and Medi-Cal regulations. This work is performed by staff with proven skills for discerning presumptive irregularity. All questionable claims are referred to a special unit of the contracting carrier's organization where specially-trained staff carry out further analyses.

2. Detecting irregularity

When there is reasonable question about the justification of a series of claims, contracting carrier staff collects information needed for clarification. If, after this further evaluation which frequently involves field data collection and direct contact with the provider, questions about suspect patterns are not satisfied, the provider institution is placed under special review. A record of the provider's pattern of practices is developed. Should the record reasonably convince the contracting carrier about provider irregularity and subsequent efforts with the provider fail to correct detected patterns, the contracting carrier, with notice

*See statement, p. 846.

24-798—69—pt. 3——8

to the Office of Health Care Services, shall ask for the establishment of a peer panel to review the problem.

3. Referring for peer review

(*a*) *Panel designation.*—Upon request from the contracting carrier, the designated officer of the California Hospital Association and the designated officer of the California Medical Association will appoint appropriate persons from among their respective memberships who agree to function as peer review panelists. Each panel shall consist of at least two hospital administrators and two physicians with a chairman designated by mutual agreement of the respective designated officers. Panel members will serve without compensation but shall receive from the contracting carriers reasonable reimbursement for travel and living expenses. The contracting carrier will serve as staff and attend all meetings of the panel.

(*b*) *Referral to committee.*—The contracting carrier shall make a written report to the panel, informing them of the nature of the matter to be considered, summary of data collected, and history of efforts to resolve issues presented. At the time of referral, the contracting carrier shall advise the panel members that their findings and recommendations will be reported to the Office of Health Care Services. One of the primary aims in activating a peer review panel is to counsel providers on ways for correcting patterns and irregularities and for improving their services and economic practices, regardless of sources of payment.

(*c*) *Notice of hearing.*—The provider shall be given written notice of any meeting at which the peer review panel will receive evidence on the matter submitted. This notice shall be given by the panel no less than 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 information needed for identification. 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. The contracting carrier will provide the panel with the facts in support of any alleged irregularities.

(*d*) *Attendance by the provider.*—The provider shall be entitled to attend any panel meeting while evidence regarding him is received. The provider shall have the right to see any documentary material received by the panel. 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 panel. 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 panel determines that his participation would be of assistance to the panel. These hearings shall be informal and the rules of courtroom evidence do not apply. Failure of the provider, without reasonable excuse, to attend scheduled meetings shall not preclude the panel from carrying out its proceedings.

(*e*) *Written record.*—A summary record shall be prepared in any case where the panel recommends action limiting or denying future or continued participation in the Medi-Cal program, including recommendations for imposition of requirements. In such cases, the record shall:

(1) Indicate the date of any hearings and the persons in attendance;
(2) Contain or summarize all testimony;
(3) Include all documentary evidence received;
(4) Describe any other evidence received;
(5) Contain the findings and recommendations of the panel, indicating the vote on each finding and recommendation;
(6) Include copies of notices to the provider.

(*f*) *Findings.*—In such cases, the panel shall make specific findings on those issues which have clear and convincing proof in support of any recommendation made. Causes for suspension are enumerated in Medi-Cal Regulations, Sec. 51455(b) of Title 22, California Administrative Code, 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. All actions of the panel shall be by vote of the majority.

(*g*) *Recommendations.*—The panel shall make a written recommendation as to action to be taken. In any case where the recommendation would impose conditions on future payments or participation, the panel shall indicate how and when the recommendation should be implemented.

(*h*) *Notice of decision.*—The provider shall be mailed a copy of the panel's findings and recommendations upon issuance, and he shall be advised in writing as to appeal.

(*i*) *Rehearing.*—The chairman or a majority of the panel may grant a rehearing when it appears that the provider offers substantial new evidence which he could not reasonably have offered at the hearing, or when it appears that the panel has acted in error.

(*j*) *Report to the Office of Health Care Services.*—It will be the responsibility of the contracting carrier to forward the record of the panel, including findings and recommendations, to the Office of Health Care Services and to California Blue Shield. The Office of Health Care Services will initiate appropriate action, with appropriate notification to the provider. The chairman of the panel or a member designated by the chairman will be available and will be present and participate in any hearings conducted by the Office of Health Care Services.

Evaluation of the system

After a year's experience, the California Hospital Association and the California Medical Association, working closely with the Office of Health Care Services, will examine the effectiveness of the peer review method and report their conclusion to the Secretary of Human Relations for the State of California.

EXHIBIT B. THE INTERMEDIARY FUNCTIONING OF THE TITLE 19 PROGRAM IN CALIFORNIA WITH RESPECT TO INSTITUTIONAL CARE

HISTORICAL BACKGROUND

When the U.S. Congress enacted legislation creating Medicare, it declared its intent to take full advantage of the experience of private organizations to fulfill the program's goals.

Thus, Medicare adopted methods—such as calculating benefits in terms of days of care; paying for service through cost reimbursement and involving providers of health care services in the professional review and control of quantity and quality of care—all of which were pioneered originally by Blue Cross—the country's largest prepayment system.

The California Legislature in passage of A.B.5, December 17, 1965, to set up Medi-Cal under Title 19 (Medicaid), also turned to the private sector. Blue Cross in both Northern and Southern California and California Blue Shield were selected for their respective responsibilities as fiscal intermediaries. The selection was made on February 19, 1966, just nine days before the effective date of Medi-Cal, March 1, 1966.

The knowledge and experience of these three private, nonprofit corporations, in professional health benefits management, their available facilities and their trained personnel were primary factors in getting the program underway in the short time from notification of selection to "start-up" time.

EARLY PROBLEMS

The short lead-time made it difficult for the State Government to adequately describe the Medi-Cal requirements in advance to the providers or the public. As Medi-Cal began, many administrative details had not been worked out. In the early weeks there were often clarifications, interpretations and actual changes in regulations. All such changes were communicated, interpreted, and fed into the system by Blue Cross on a day-to-day basis.

A FOSTERING RELATIONSHIP

A major factor in the ability of the fiscal intermediaries to perform has been the excellent guidance and cooperative support given by the Department of Health Care Services of the California Health and Welfare Agency. The program's success might have been considerably diminished without the capable assistance provided by this agency of the California Government with its obvious awareness of the affected public's health care needs.

Medi-Cal is in fact an excellent example of how well such a program can operate when policy guidelines are laid down by a government agency and carried out operationally by a private organization. It is a prime example of

government and the private sector of our society working together in the public interest.

BLUE CROSS GOALS

It may help here to outline the Blue Cross goals in its fiscal intermediary role under Title 19. These are:

1. To handle, process and pay claims and to pay them on the same basis as in all other sectors of Blue Cross operations;
2. To interpret correctly and carry-out governmental objectives to the satisfaction of both the government and the contracting parties;
3. To recognize problems and areas of potential problems in providing services and to communicate such knowledge to the government as needed. This, of course, requires Blue Cross to represent two parties—the providers—hospitals, nursing homes, extended care facilities, rehabilitation centers, home health agencies, and others—which offer the institutional services, and the government, which provides the benefits to the ultimate recipient, the public.
4. To assist the providers of the service—the institutions concerned—to operate in an optimal manner in all specific and collateral services rendered.
5. Finally, in the administration of the program, to make Blue Cross responsive in seeing that the public's right to good health is recognized and respected.

These goals are consistent with the services Blue Cross provides to the public and to the institutions with which it works. They are also consistent with Blue Cross' major corporate goal, which is to provide all segments of the population with the means of obtaining the highest quality of medical care in the most effective and economical manner with continued dedication to the preservation of the voluntary health care system.

WHAT BLUE CROSS PROVIDES

The State Government was able to take maximum advantage of Blue Cross' capabilities and unique services. These include:

1. *Experience* in private, prepaid health care programs, particularly in those providing service benefits;
2. *Existing facilities* with related equipment and trained personnel;
3. *Experience* in cost-related reimbursement programs;
4. *Long-established relations* with providers of covered services;
5. *Experience with the coordination* needed for the requirements of both Medi-Cal and Medicare;
6. *Long history of cooperation* with Blue Shield (physician prepayment agency similar to Blue Cross' role in providing prepaid hospital care);
7. Control mechanisms, i.e. fiscal claims and utilization of review procedures and systems.

Blue Cross helps to safeguard the tax dollars of the public. It does this in the course of its normal procedures in its review and audit activities. There are two broad categories of this activity:

The first is preventive and is covered by carefully detailed individual billing instructions with on-the-scene visits to smooth out eligibility and processing problems and also various group educational programs, institutes and seminars.

The second could be called correctional, i.e., the creation of safeguards against abuse and follow-up regarding appropriateness of activities in connection with the Medi-Cal program, through audits and utilization reviews.

These two categories of activity are carried out by the seventy-six Blue Cross field people who routinely and regularly visit all hospitals, nursing homes, home health agencies, and other providers. These are trained representatives who are specialists in professional relations utilization review and reimbursement. Their primary purpose is to help the facilities concerned comply with the operational requirements of Medi-Cal.

It is clear, however, that in the process of doing this they create a network of communications and a clearing-house for interpretation and cross-reference which helps prevent and/or correct potential abuses under Title 19.

There are 566 acute care facilities, 1,215 nursing homes, and 122 home health agencies and free-standing clinics, for a total of 1,903 providers in California. These are furnished information regarding the Medi-Cal program through Blue Cross bulletins, workshops, routine and special visits, provider visits to the inter-

mediaries' office, telephone communications, individual letters, and participation by the intermediaries in regional and State provider association meetings.

Since the inception of Medi-Cal, March 1, 1966, Blue Cross has an increasingly intensive utilization review and audit program to safeguard against abuses while at the same time assuring that eligible recipients receive optimal health care.

BLUE CROSS—MEDI-CAL'S "CLEARINGHOUSE"

Medi-Cal is a vast program as the later charts on performance show. In support of Medi-Cal, Blue Cross acts—as does Blue Shield in its particular field—as a "clearinghouse" in behalf of the State of California to:

1. Receive bills for services rendered to eligible people, determine compliance with regulations and approve for payment those bills that meet the requirements of law and regulation, including those that apply to the appropriateness of costs and charges.
2. Maintain all necessary records and furnish the State all necessary information and reports.
3. Provide liaison and coordination with providers and groups, organizations, committees representing them, or other interested parties.
4. Apply safeguards against unnecessary utilization, abuse and fraud.

REIMBURSEMENT

Blue Cross' experience in cost-related reimbursement is unequalled. Blue Cross has a staff of accountants trained in hospital accounting fully qualified to review financial statements, determine allowable cost and apply a reimbursement formula.

Since the State initially adopted a formula similar to the one Blue Cross of Southern California uses, Blue Cross was able to provide an existing staff of experts.

Understandably, confusion could develop if a single provider, for example, was subject to audit by Blue Cross for its business; by another Medicare intermediary for Medicare claims; and by a state agency for Medi-Cal. As it is, *in most instances, a single audit suffices.* The hospital can supply its cost figures to Blue Cross, and Blue Cross can determine payment for all.

RELATIONS WITH PROVIDERS

An important advantage of Blue Cross' administration of the Medi-Cal program is its long-term favorable relationship to hospitals. Actually, the hospitals, along with the general public, have a voice in the policy and operations of Blue Cross through board membership. Blue Cross is sponsored and supported by hospitals; Blue Cross works closely with recognized hospital organizations; the contractual relationship between hospitals and Blue Cross is yet another bond between the providers of institutional care and the fiscal intermediary in the Medical program. The hospitals and the general public are accustomed to working with Blue Cross.

Evidence of provider preference for Blue Cross can be found in the fact that 92% of all Medicare participating hospitals in California selected Blue Cross as intermediary under that program. So did 60% of extended care facilities and almost all home health agencies. While selection by provider is not permitted under Medi-Cal, it can be assumed that there would be essentially the same ratio of preference for Blue Cross.

This provider rapport works to the advantage of the Medi-Cal program in other ways. Blue Cross field representatives, who regularly visit hospitals and other providers, help train personnel in administrative practices involving Medi-Cal. They also serve to answer questions and solve problems that might arise, in advance.

Hospitals prefer to work with Blue Cross, rather than directly with government. Blue Cross understands hospital problems and manages an equitable balance of provider and state interests in administering Medi-Cal.

COORDINATION BETWEEN MEDI-CAL AND MEDICARE

Many Californians are covered by both Medicare and Medi-Cal. In such cases, the provider—where Blue Cross is the intermediary—may submit one claim on the Medicare form and refer to coverage under Medi-Cal. The Medicare claim

form is processed and amounts payable under both programs are determined. Payment is thus made by the same organization but from separate funds.

These dual claims currrently run almost 40,000 per month. Since in the great majority of cases Blue Cross administers both programs, coordination is easily accomplished, and speedily. Were another organization to administer Medi-Cal, delays and most probably confusion might develop in coordinating the benefits payable under the two programs.

COOPERATION WITH BLUE SHIELD AND OTHER INTERMEDIARIES

Blue Cross enjoys cordial working relationships with Blue Shield and other intermediaries.

As an example of how this is helpful to Medi-Cal (and Medicare) administration, both Blue Shield and insurance companies request information about hospital care through Blue Cross. This system reduces the number of people who approach hospitals to review confidential medical records. It is customary for hospital personnel who know Blue Cross personnel to allow them ready access to necessary information.

CONTROL MECHANISMS

Blue Cross processes claims professionally—that is, with an eye to services which could be *inconsistent* with the diagnosis and charges not in line with similar hospitals.

This same service is performed for Medi-Cal. The system requires trained personnel and cooperation from the providers.

The procedure

1. Claims are reviewed for benefits or exclusions, for medical necessity and for appropriate charges;
2. Claims requiring medical evaluation are sent to the Medical Audit & Review Section;
3. This section, staffed by experienced medical auditors, reviews the claim. It is approved and returned for processing and payment, or is referred for further check;
4. When indicated, an investigator is sent to the facility to obtain copies of patient records. These records are reviewed by a physician who is a Blue Cross medical advisor in instances where a physician's judgment concerning the medical aspects is required;
5. A claim, rejected for medical reasons, is returned to the provider with an explanation by the physician;
6. Should a questionable pattern of care develop, the facility's claims are audited. The provider is invited to discuss questionable claims. If a problem is still not solved, the provider meets with the Peer Committee of the California Hospital Association for final examination and resolution.

The Professional Relations Department also has responsibility for Blue Cross' activities in utilization review. As required under Medicare, utilization review is being installed in most hospitals to apply to all patients. In this sensitive area, Blue Cross' professional assistance and counsel is readily accepted because of its long experience and close relationship with providers.

SUMMARY

To summarize—since March 1, 1966, Blue Cross has worked with 1,903 providers, and paid 4,010,945 claims, totalling $730,367,036.

Over the past thirty months, significant improvements in performance have been achieved through the informational, utilization review and audit procedures and collateral educational and support operations.

Medi-Cal has come through its early problems of changes in regulations and policies, the complexities and resultant delays in determining eligibilities and the cross-relation with Medicare in determining eligibility and usage under that program.

In its intermediary role between the providers and eligible beneficiaries and under the fostering policy guidance of the Department of Health Care Services, Blue Cross has seen the program become an efficient contributor to the health care of the people of California.

Blue Cross welcomes the projected plan for systems analysis of administration of Medi-Cal and will join the Department of Social Welfare, the Department of

Health Care Services, and all other interested institutions and departments in working for its success.

The success of Medi-Cal thus far is only a beginning to the benefits to be enjoyed by the people of California from title 19. In its fiscal intermediary responsibility under this program, Blue Cross is dedicated to the equitable provision of good health care services for all the people of California as one more example of private enterprise working with government for the common weal.

The following tables provide some indicators for Blue Cross' performance of its intermediary role under Title 19, Medi-Cal. They cover the number of claims processed, the benefits paid, review activity, field activity and administrative costs:

BLUE CROSS PERFORMANCE—STATEWIDE

TABLE 1.—CLAIMS VOLUME AND AMOUNTS PAID (FIRST 12 MONTHS), MAR. 1, 1966, THROUGH FEB. 28, 1967

Vendor	Number of claims paid	Amount paid
Home Health agencies	61,955	$1,370,046
County hospitals	386,961	49,781,403
Noncounty hospitals	523,482	74,448,835
Nursing homes	401,506	108,811,671
Total	1,373,904	$234,411,955

TABLE 2.—CLAIMS VOLUME AND AMOUNTS PAID (SECOND 12 MONTHS), MAR. 1, 1967, THROUGH FEB. 29, 1968

Vendor	Number of claims paid	Amount paid
Home health agencies	97,697	$2,223,413
County hospitals	693,976	89,374,248
Noncounty hospitals	791,774	91,746,966
Nursing homes	555,246	135,554,083
Total	2,138,693	318,898,710

TABLE 3.—CLAIMS VOLUME AND AMOUNTS PAID (FIRST 6 MONTHS OF 1968–69)

MAR. 1 1968, THROUGH AUG. 31, 1968

Vendor	Number of claims paid	Amount paid
Home health agencies	30,272	$1,310,992
County hospitals	557,662	38,888,149
Noncounty hospitals	477,242	54,754,842
Nursing homes	285,942	82,102,388
Total	1,351,118	177,056,371

TABLE 4.—CLAIMS VOLUME AND AMOUNTS PAID (TOTAL PERIOD), MAR. 1, 1966, THROUGH AUG. 31, 1968

Vendor	Number of claims paid	Amount paid
Home health agencies	189,924	$4,904,451
County hospitals	1,638,599	178,043,800
Noncounty hospitals	1,792,498	220,950,643
Nursing homes	1,242,694	326,468,142
Total	4,863,715	730,367,036

TABLE 5.—PROVIDERS COMMUNICATIONS CONTACTS MAR 1, 1966, THROUGH AUG. 31, 1968

Visits to providers facilities	10,357
Workshops (average attendance 95 persons)	75
Bulletins	113

TABLE 6.—BLUE CROSS ADMINISTRATIVE COSTS (STATEWIDE), MAR. 1, 1966, THROUGH AUG. 31, 1968

Total number of paid claims	4,863,715
Administrative costs	$3,762,932
Administrative cost per claim	$0.774

	Amount	Percent of total expenditure
Paid claims	$730,367,036	99.5
Administrative cost	3,762,932	.5
Total expenditure	734,129,968	100.0

ITEM 2: EXHIBITS RELATED TO STATEMENT OF JUANITA C. DUDLEY,* ASSISTANT REGIONAL DIRECTOR, WESTERN REGIONAL OFFICE, NATIONAL URBAN LEAGUE

EXHIBIT A. LETTER TO DIRECTOR OF HUMAN RELATIONS AGENCY, STATE OF CALIFORNIA

MAY 6, 1968.

DEAR MR. WILLIAMS: Recently many of the Negro Professionals offering services to Medi-Cal recipients have brought to our attention two extreme hardships being imposed upon them by the slowness of services given by the Blue Shield Company. Upon discussing this with the Los Angeles office of Blue Shield it was suggested that their services would be greatly improved if two innovative changes were made, these are:

(1) Establishment of a Southern California Computer Center to process this region's claims;

(2) Adoption, state wide, of the San Bernardino Plan, which involves each recipient having 5 eligibility cards being given to them each month for use by practitioners to enable the elimination, in time, of the processing of eligibility by Blue Shield.

As these two innovations are feasible, we would strongly urge the adoption of same. Blue Shield states, that, as of today, they are processing January and February applications for payment which indicates a hardship on the practitioners.

It was most rewarding having an opportunity to talk with you personally during lunch at the Human Relations Commission Luncheon meeting in Sacramento last week.

Sincerely,

JUANITA CARROLL DUDLEY,
Assistant Regional Director, Health and Welfare.

EXHIBIT B. NEWSPAPER ARTICLE CONCERNING REPORT ON MEDI-CAL PROGRAM BY CALIFORNIA DEPARTMENT OF JUSTICE**

LYNCH CHARGES MEDI-CAL FRAUD

SACRAMENTO.—Nursing homes, drugstores and other parts of the medical establishment are robbing the state's Medi-Cal program of at least $8 million and probably more every year, Atty. Gen. Thomas C. Lynch has charged.

His Department of Justice said a nine-month investigation into abuses of the $800 million program showed Medi-Cal was riddled with kickbacks, phony claims, "overserviced" patients and other "illegal and unethical activities."

A 75-page report charged that physicians, dentists, druggists, optometrists, hospitals, nursing homes and others paid with Medi-Cal funds cheated the taxpayers out of about 1 per cent of the program's budget.

*See statement, p. 666.
**See full report, app. 4, pp. 812–836.

Lynch's chief deputy, Charles O'Brien, told a news conference that the temptation to abuse Medi-Cal was made easier by a vast bureaucracy operated by both the state and its fiscal intermediaries, Blue Cross and Blue Shield.

The report identified no bilkers and called for no indictments. O'Brien said the attorney general could not prosecute because records were too inadequate to make a case.

"The best prosecutor in the world would be hard-pressed to use these records," he said.

State human relations secretary Spencer Williams demanded that specific cases of fraud be identified and prosecuted.

O'Brien acknowledged that while there might have been some deliberate "overutilization" by medi-care recipients, nearly all the abuses were by the medical profession.

"One of the worst ironies in the world is that when we are talking about law and order and increasing penalties for liquor store holdups, that striped tie, buttoned-down crimes goes unpunished," he said.

About 1.5 million poor Californians receive free medical care under the program, financed by state, federal and local governments. Blue Cross and Blue Shield funnel the money from the state and the medical suppliers.

But O'Brien charged "the private sector has not handled it (Medi-Cal funds) the way the private sector handles its own funds." He said the intermediaries were paid on a cost-plus basis "so there is no incentive for improvement."

He also asserted the state had no effective enforcement program "to discover, investigate and defer" frauders.

Professional and other organizations criticized the report as "generalized" and "vague." They demanded proof of such claims as:

Druggists charge the state three times as much for the same medication as they charge the public.

Some nursing homes require "under the table" payments from patients to secure admission while others accept kickbacks from vendors in exchange for business.

Doctors, dentists, optometrists and other professional falsified claims for treatment that was never performed or for treatment that was unnecessary.

In one case, an optometrist sought state authorization for an expensive pair of sunglasses for a blind patient.

Some nursing homes pocketed for their own use state funds for incidental patient expenses.

O'Brien said the Justice Department is investigating the possibility that organized crime had infiltrated the nursing home business, but that evidence so far has not indicated it is extensive.

Williams said the state has not and "will not tolerate fraudulent misuse of Medi-Cal funds by those who receive or provide services."

He said he requested a meeting with Lynch's staff, "to secure specific cases of fraud and abuse which were uncovered." He added, 'we will continue to insist on prosecution in any case where there is evidence of wrongdoing."

EXHIBIT C. LETTER FROM ROBERT H. WEST, VETERANS AFFAIRS COORDINATOR, TO ADVISORY BOARD MEMBERS

JUNE 8, 1968.

DEAR VETERANS AFFAIRS ADVISORY BOARD MEMBER: On Tuesday, June 18, Senate Bill 1263, sponsored by Urban League Veterans Affairs, will be heard before the Education Committee in Sacramento. This bill is an effort to recognize the college equivalency of armed forces technical training and service. Specifically, this bill, introduced by Mervyn Dymally, will allow 15 semester units for each year in the service as a medical technologist or laboratory technician up to 60 units or equivalent to two years of college work.

This college credit will encourage veterans to take advantage of GI Bill education and earn their degrees as medical technologists. Another beneficial feature of this legislation is to alleviate the shortage of trained medical technologists presently plaguing the world of medicine.

Senate Bill 1263 is a real breakthrough of the archaic bonds in our educational system. This recognition of armed services education is long overdue and can be a pilot legislation for federal efforts in this vital area.

This effort to solve the joint problems of veteran unemployment and unmet medical needs is but one of the enterprising, innovational ventures of your Urban League.

Please call me with any constructive comments on the subject of this bill. I might add that the outlook is extremely optimistic—at this time there is no opposition.

Sincerely,

RICHARD H. WEST,
Veterans Affairs Coordinator.

EXHIBIT D. LEGISLATION INTRODUCED, CALIFORNIA LEGISLATURE, DESIGNED TO PROVIDE AN EDUCATIONAL EQUIVALENCE TO VETERANS WITH CERTAIN KINDS OF TRAINING; SENATE BILL 1263

CALIFORNIA LEGISLATURE,
SENATE COMMITTEE ON SOCIAL WELFARE,
Sacramento, Calif., June 5, 1968.

MR. RICHARD WEST,
Urban League,
Los Angeles, Calif.

DEAR DICK: As you are aware, I have introduced legislation in the current legislative session which is designed to provide an educational equivalence to veterans with certain kinds of training. Specifically, the measure is Senate Bill 1263, and it pertains to veterans who have had training and experience as clinical technicians in the armed forces of the United States.

We believe this legislation is in line with the recent efforts called for by President Johnson to assist veterans in the transition from the military to the civilian sector of life. Further, we are sure that the valuable and worthwhile experience these men have gained could be of immeasurable worth to the needs of the communities of our state.

In view of these factors, I am willing to devote the full resources of my office to seek the passage of Senate Bill 1263. Any assistance you can provide toward that end will be greatly appreciated.

Sincerely,

MERVYN M. DYMALLY.

[Enclosure]

SENATE BILL NO. 1263 *

CHAPTER —

An act to amend Section 1261 of the Business and Professions Code, relating to clinical laboratory technology.

The people of the State of California do enact as follows:

SECTION 1. Section 1261 of the Business and Professions Code is amended to read:

1261. The board shall issue a clinical laboratory technologist's license to each person found by it to be properly qualified and it shall hold written, oral, or practical examinations to aid it in judging the qualification of applicants. The examinations for license to work in a clinical laboratory as a technologist shall cover the fields of biochemistry, hematology, and microbiology, except that the examination for a special clinical laboratory technologist's license shall be concerned only with the subject or subjects in which the license is to be issued. The minimum prerequisites for entrance into the examination shall be one of the following:

(a) Graduation from a college or university maintaining standards equivalent as determined by the department, to those institutions accredited by the Western Association of Schools and Colleges or an essentially equivalent accrediting agency with a baccalaureate and a major in clinical laboratory technique, the last year of which course shall have been primarily clinical laboratory procedure; provided, however, that if the curriculum did not include practical clinical laboratory work, six months as a clinical laboratory technologist trainee or the equi-

*Passed Senate, July 5, 1968; passed Assembly, July 29, 1968.

valent as determined by the department in a clinical laboratory approved by the department shall be required; or

(b) Grdauation from a college or university maintaining standards equivalent, as determined by the department, to those institutions accredited by the Western Association of Schools and Colleges, or an essentially equivalent accrediting agency, with a baccalaureate and a major in one of the biological sciences or essential equivalent as may be determined by the department plue one year as a clinical laboratory technologist trainee or the equivalent as determined by the department in a clinical laboratory approved by the department. One year of practical experience in a public health laboratory may be accepted if such experience or if unversity or college courses included practical work in clinical biochemistry and hematology; or

(c) A minimum of three years of experience as a clinical laboratory technologist trainee or the equivalent as determined by the department doing clinical laboratory work embracing the various fields of clinical laboratory activity in a clinical laboratory approved by the department and 60 semester hours or equivalent quarter hours of university or college work in which are included the following courses, or essential equivalent as may be determined by the department; general inorganic chemistry—8; quantitative analysis—3; basic biological science—8; bacteriology—4. Additional college or university work which includes courses in the fundamental sciences may be substituted for two of the three years of experience in the ratio of 30 semester hours or equivalent quarter hours for each year of experience; provided, however, that individuals seeking admission to the examination on or after January 1, 1965, shall meet the prerequisites specified in subdivisions (a) or (b) of this section, or the prerequisities as set forth by the Council of Medical Education and Hospitals of the American Medical Association and the Board of Registry of Medical Technologists of the American Society of Clinical Pathologists, and the American Society of Medical Technologists, or equivalent accreditation body approved by the Department of Public Health, provided, however, that the total or combined time of college or university work and practical training and experience in an approved clinical laboratory be not less than five years or as specified in subdivision (a).

Experience as a clinical technician in any branch of the armed forces of the United States may be considered equivalent to the experience as a clinical laboratory technologist trainee, if such experience as a technician is approved by the board. Each year of training and experience as a clinical technician in such armed forces shall be equivalent to 15 semester hours, which shall be credited to the minimum number of hours required to qualify for registration as a clinical laboratory technologist trainee. The semester hours acquired in this manner shall not be in organic chemistry, quantitative analysis, basis biological science, and bacteriology, unless these courses have been completed at a college, university, or institution maintaining standards equivalent, as determined by the department, to those institutions accredited by the Western College Association or an essentially equivalent accrediting agency. The maximum number of hours granted shall not exceed 60 semester hours or its equivalent.

* * * * * * *

ITEM 3: EXHIBITS RELATED TO DR. ELSIE A. GIORGI'S STATEMENT*

EXHIBIT A. PROPOSAL FOR A COMMUNITY HEALTH PLANNING FOUNDATION

I. THE NEED

For a very long time in Medicine, we know much better than we do. The gap between technology and its clinical application becomes ever wider in spite of a very generous National budget. Our great potential for comprehensive care is dissipated through duplication and lack of coordination. Addition of numerous isolated, poorly thought out programs, have only served to escalate costs and add to the chaos and ferment.

What is needed is a new health care delivery model, which makes optimum use of what is already there, through coordination and unification, and simultaneously promotes dynamic health education towards improved health practices and proper use of health care services.

Advanced medical science has succeeded in the virtual eradication of a hard core of disease predominantly responsive to antimicrobial therapy and surgical

*See statement, p. 686.

extirpation. What is left are the degenerative, neoplastic, metabolic, and emotional disruptions—all very possibly linked in causation—for which there are no cures. Thus mortality figures improve, while morbidity increases.

The inseparability of man from his genetic inheritance and his total environment; and the need to treat all if we are to produce optimum function and total health—is becoming increasingly mandatory as the diseases of stress become more and more predominant.

Total health planning of this order, requires a degree of technologic competence, not within the scope of an isolated medical sector, trained mainly in the biologic. It requires a broad scoped multi and interdisciplinary-consortium approach.

An enlightened public—recipient of health care services—demands change. Harried providers of services are ready for it. Large consumers such as labor-management, government and industry threaten outright planning, ownership, and direct rendering of services. The Congress has mandated change and has recommended regional adaptation and partnership planning. The time was never so propitious. There is a great need to define and relegate the role of all involved and concerned if we are to plan most effectively.

Figure I depicts a suggested relegation of roles:

FIGURE I.—*Sponsorship—Relegation of roles*

PHASES	SPONSORSHIP
Planning by (interdisciplinary consortium)	Philanthropy (or Government): a health care planning foundation.
Demonstration—Innovation	Government (Public health), other public and private health agencies.
Implementation	Association of Practitioners in consultation with Health Care Planning Institute.
Financial support	Investment groups.
Initial outlays (loans)	Large consumers: Government. Union-management. Industry. Cooperatives.
Continuing support	Individual and large consumers: Self-paid and/or health insurance.
Research and education	Government (public health): Philanthropy, schools.

II. THE PURPOSE

It is proposed that the consortium approach to planning be implemented through a non-profit Community Health Planning Foundation, sponsored by philanthropy. There is much precedent for this. Historically, the most significant changes in medicine have been promoted by institutions outside the existing structure. Striking examples are the Flexner report of 1910–1911, supported by the Carnegie Foundation, and the sweeping innovations in education and research, influenced by that report as well as the Rockefeller Foundation.

This is particularly necessary at this point in time, as it becomes increasingly obvious that the current policy makers seem unable or unwilling to take the initiative. Restrictions imposed on government public health units, force them, for the most part, into consultative and fiscal roles. The rigidity of the academic world and its poor motivation towards outright community service, have perpetuated its interest predominantly in scientific research and education. Organized medicine seems unable to overcome the inertia of "tradition."

Philanthropy seems to be the only vehicle flexible and financially strong enough to undertake this gigantic and much needed task. It is unimpeded by conflict of interests. It can attract the best minds in the country—those with broad scoped knowledge, experience, and creativity whose feet are on the ground, but not in cement.

III. THE FOUNDATION AT WORK

The Foundation will have a three pronged approach—service, research, and education—all very closely interrelated. Figures II and III depict this graphically:

FIGURE II.—*Community Health Planning Foundation (Multi- and Interdisciplinary Consortium)*

Research:
- Epidemiology.
- Prevention.
- Ekistics, Urban Ecology, Community Development.
- Medical Economics.
- Systems Engineering.
- Computer Analysis, Record Keeping, Information storage and Retrieval.
- Optimum sue of Laboratory Procedures—Preventive, Curative, Predictive.

Education:
- Public.
- Professional.
- Para Professional, including new careers.

Service: Planning for comprehensive health care delivery models (biomedical complex—see fig. III).

Biomedical complex: Provides vehicle for service, research, and education.

FIGURE III.—*The biomedical complex*

1. Centers around a single access Ambulatory Care Diagnostic and Treatment Center, rendering pooled paramedical, ancillary, managerial, administrative, and secretarial, at reasonable cost. (Health Care Facility—fixed and/or mobile, depending on population density—to include multiphasic screening.)
2. All services rendered through the personal, (managing) physician, assisted by a Health Care Team, permitting optimum utilization and quality surveillance. Combines best features of solo practice ("one doctor/one patient") with those of group practice (pooling of his personalized services).
3. Expedition of services by "Family Health Agents"—peer related and a new health career—supervised and trained by the Health Care Team. (A Medical Ombudsman—informed family advocate.)
4. Closely related to all institutions—Community ("cottage") Hospitals; extended and domiciliary care facilities and programs; Medical Center; and education and research. The principle is that of rendering frequently used services locally and less frequently used, more highly specialized and technologic services, through centers—treating the "right patient in the right place at the right time" with free and prompt transfer.

Alternative, improved health care delivery models—regionally adapted—will comprise the laboratory for all components. The model to be demonstrated first is a Biomedical Complex, centering around the Health Core Facility Concept. It is described briefly in the Appendix and its accompanying Figures. This model has been chosen because it seems to have a significant measure of universality and replicability. It permits demonstration, research, and education in the framework of service where they rightfully belong if we are to avoid a continued widening gap between them. Each Health Core Facility will serve about 100,000 people, which is numerically very significant.

Figure II indicates the proposed areas of major concern to be addressed. The factor of sheer numbers—the population explosion—demands a systems engineering approach. The highly successful attack against man's formerly predominant enemy—the world of microbes—has shifted emphasis to the physical and chemical world around him—the atmosphere of pollution, crowding, noise and competition for status and recognition.

There is a great need to apply the same type of scientific excellence, so successful against infective and communicable disease, to a study of the edidemiology of our current major offenders—degenerative, metabolic, neoplastic and emotional disruptions.

A wider laboratory must be created—one involving the greater mass of our people and the more common pathology—if we are to effectively study, combat and prevent the more frequently occurring diseases rather than just the rare and the exotic. Medical Care is only one factor in the broad gamut involved in Comprehensive and Total Health Care. It can, however, lend itself very well as an opening wedge to all the others.

Centralized computer analysis, data storage and retrieval, and optimum use of laboratory procedures, may well eventually provide us with information permitting determination of priorities for professional time as well as guidelines for prediction of disease—valuable tools towards circumvention of manpower shortages and true prevention and prompt restoration to function.

The close interrelationship of the component parts of the Biomedical Complex, permits analysis of the patient from diagnosis to therapy. One of the areas to be explored can include the assembly of consultant expertise in the various medical specialities and sub-specialties, towards the goal of determining the minimal requirements from diagnosis to therapy relative to the more common illnesses (at least 85%). This will serve to insure optimum prevention, treatment and quality of care. It will also be a valuable instrument in determining "reasonable costs" for those illnesses, and can be used as guidelines for reimbursement through prepaid government and other health insurance programs.

Another area of interest will be the creation of a branching type questionnaire, permitting complete data gathering simulating physician history taking. This can then be done either by non-professional personnel or by automated devices—freeing the physician's time considerably, simultaneously permitting a better and more sensible allocation of labor resources.

The Biomedical Complex can become a very valuable field laboratory for education at all levels, and for creation of new careers designed towards use of non-professionals to perform those parts of the daily tasks now done repeatedly by professionals—not requiring their skills. This is also a very important means of improved allocation of manpower resources.

Other projects will undoubtedly be undertaken as the need for them becomes apparent.

The table of Organization for the Foundation will be decided upon as soon as possible. It should be kept in mind however, that since Medical Care is only a part of the entire gamut of Total Health Care Services, the medical sector should not predominate. Indeed, since the main emphasis will be on improved allocation of resources and the effect of man's genetic and physical environment on his total wellbeing, the non-medical expertise sector must play a very prominent role, at least equal to that of the medical sector. Continued education of the staff on an inter and intra-departmental basis is essential.

A Board of Directors will assist the staff in policy making and program planning. Their participation must be meaningful and not merely tokenism.

Publications of findings will be as frequent as feasible in order to disseminate information as well as to promote the institution of similar programs by others.

The Foundation will be non-profit. However, within these limits, it can still apply for grant awards, and can charge consultation fees whenever feasible.

IV. RELATIONSHIP OF PROGRAMS TO EXISTING SERVICES AND INSTITUTIONS

Every attempt should be made to prevent duplication. Services will be added only when those existing in the community are inadequate or inefficient. Every effort will be directed towards meaningful affiliation with existing facilities and programs.

It is proposed that the Foundation be free standing, in order to circumvent the rigidity which is too often associated with the academic world. Preferably, the relationship with professional schools and other institutions, will be through affiliation of its staff, rather than of the Foundation.

V. ADVANTAGES

There is little doubt that well organized, broad scoped planning of this type, will be of great benefit to both consumers and providers of services. The general public will benefit through improved, quality oriented services. Large consumers such as labor-management, industry, and Government, will benefit greatly through improved quality and lowered costs. The Foundation can serve as a valuable resource to these large consumer groups, as well as to indigent groups in deprived areas, and others such as Geriatric Residence plans, who are constantly in need of consultation for health care planning and who currently have no one to turn to.

As usual, there may well be some who will feel economically threatened. However, these should be very few, since the proposed plan preserves the concepts of "one patient/one doctor," and free enterprise. Preliminary discussions indicate acceptance and approval of the medical sector, including professional schools, private practitioners, organized medicine and labor-management. The planned approach is not disruptive. It carries with it the better components of the past, is pertinent to the present, and has meaning for the future.

VI. PHASES

Phase I (6 months) :
Recruitment of key staff (executive level).
Writing a budget.
Designing of internal organization, including table of organization and working committees.
Selection of consultants.
Selection of board
Phase II (6 months) :
Designing of health core facility.
Assembling of association of physicians.
Establishing relationships towards creation of biomedical complex.
Phase III (6 months to 1 year) :
Implementation of health core facility
Enrollment of patients (through the association of physicians), to include large consumer groups.
Phase IV (continuing—starting after second year) : Designing research and demonstration projects by staff and by invitation of others (grants to be accepted whenever feasible).
Phase V (after all components functioning) : Teaching and education, including new careers.

It should be noted that service will be rendered within two years at the latest. Publications will be encouraged throughout all phases. There should be careful documentation of the process as well as content of the data related to service, education and research.

VII. FUNDING

A sizable basic permanent fund will have to be maintained if we are to attract the best people. Additional funds will come from consultation fees and grant awards. The Foundation will maintain a non-profit status throughout, but will serve profit as well as non-profit groups.

Some thought should be given to starting with "seeding" on planning funds required to complete Phase I, in order to establish a larger and more permanent budget.

VIII. CONCLUSION

As far as we know, there is no precedent for a Health Care Planning Foundation such as we envision. If such an institute were formed, it could set a precedent for establishing innovative health care delivery models and new associative and assistive health careers, designed towards improved quality and lowered costs of care, through circumvention of the duplication, fragmentation, shortages, and inequities which currently exist. In reality, it might well precipitate a much needed clinical revolution, counterpart of the scientific revolution promoted by the Flexner report of 1910–1911.

As justification, we need only remember that we are at least fifty years behind in our health care delivery system, as pointed out by the renowned Dr. William Welch in 1926, when he bemoaned the widening gap between scientific advances and their clinical application. There has really been no major change since Dr. Flexner's monumental work in 1911. His expectations that quality care would be a natural concommitant of scientific and educational excellence, have not been fulfilled.

It is hoped that philanthropy will again supply the resources and become the unifying force towards implementation of a scientific and systematic approach to the rapidly deteriorating Health Care of our Nation, and thus preserve its heritage for excellence and humanism.

EXHIBIT B. A UNIFIED HEALTH CARE DELIVERY SYSTEM

[Excerpted from address by Dr. Giorgi to the Southern California Hospital Council]

IX. APPENDIX

A true challenge to an effective, acceptable Health Care Delivery Model is to preserve the very important concept of "one patient-one doctor", simultaneously permitting comprehensiveness and quality care at reasonable cost. For successful care, there must be a personal "managing" physician who sees the patient

through each door. No matter how many consultants he uses—no matter how many ancillary and paramedical services he orders, the ultimate responsibility, continuity, and final decision rest with him. His services can be greatly augmented by collaboration with a multidiscipline coordinating and expediting team, freeing him for that part of his work which requires his more highly specialized skills.

Medical Costs

Contrary to popular notion, those "bad" doctors are responsible for only about one-quarter of the total costs. This, in spite of the fact that their services are the most frequently used by far. I do not intend this as a defense of physicians. Certainly, all costs, including doctors' fees need to be evaluated. However, it is far better that costs for so highly personalized services be improved by means of better use of professional time as well as by reduction of overhead resulting from sub-optimal use and duplication of personnel and equipment in each physician's office.

It is also obvious that, if reduction in costs is to be significant, it must be concentrated around the larger segment of that cost, the remaining 75%. Here, too, duplication and sub-optimal use are very significant factors—but here, they lend themselves much more readily to pooling and the concurrent savings resulting therefrom.

Hospital costs are the most astronomical of all (over 30%) and are becoming increasingly worse. The unexplained wide cost variations in hospitals of the same category certainly bear scrutiny. According to a report of the President's National Advisory Commission on Health Manpower—these differences are as high as 100%. There is also a need to more clearly define the role of all institutions—the community hospital, the medical center, and the extended care facility. Not every hospital should be doing everything. The more frequently required, more common services should be community based and should be rendered through the smaller community hospitals, referred to under the Swedish system as the cottage hospital. The less frequently used services requiring high order skills, and highly specialized personnel and equipment should be available through the medical centers which should serve the megalopolis rather than just the smaller community. Chronic care should be delegated to extended care facilities and special out-of-institution programs. Too often all three are combined in one institution contributing to duplication and under utilization.

Most important of all, the best way to reduce institutional costs is to keep people out of them. Ambulatory care, diagnostic and special treatment centers would help immeasurably towards this end as would also health insurance plans permitting reimbursement for such services. It is common knowledge that high on the list of causes of hospital abuse are the doctors' use of the institution as his workshop and the senseless insurance allowances for in-hospital diagnostic services disallowed on an out-of-hospital basis.

The basic idea is that of pooling and centralization of the expensive and less frequently used services for economy and availability, and decentralization of the less expensive and more frequently used services for accessibility and personalization. This can be effected by relating the physician to a single access ambulatory care diagnostic and special treatment center which makes available to his patient all the services contained in the hospital, exclusive of the sick bed or in-hospital observation, through the writing of a simple order just as he does in the hospital. Such a center can also supply other services including managerial, administrative, secretarial, and referral. Direct patient care services will be coordinated and mediated through the Health Care Team which will also be responsible for utilization review and quality surveillance. A dynamic health education program aimed at improved health practices as well as optimum and proper utilization of services will undoubtedly affect quality of care as well as reduce costs.

This type of system avoids the pitfalls of large group practice which too often becomes depersonalized as the patient identifies with a clinic rather than a doctor. It combines the best features of solo and group practice. The mainstream concept must also be maintained. The recently conceived "neighborhood clinics" for the poor tend to perpetuate the concept of "separate but equal". This too should be avoided.

Family Health Agents

A very important part of the team will be the family health agents—a new health career, a medical ombudsman. These agents are properly trained and educated, peer related groups who will act as informed advocates of the family unit. They constitute an activist group who also serve as expediters of services.

It is conceded by most medical care experts that about 85% of people presenting at a physician's office are not biologically ill but are troubled. This is a very significant group, constituting a great drain on all services and economy. Of this 85%, it is estimated that about 15% need true psychiatric care. The remaining 70% often just need someone to talk to. The family health agent can provide the type of informed advocacy required to help them.

In reality, they take over many of the functions previously performed by the old family doctor whose great bid to fame was that he took time to listen and knew the whole family. The plain fact is that he knew that family because he lived in the neighborhood and he had time to listen because health care was far less complex. I do not agree with those who advocate his return. The cost would be too great. It would involve the tremendous loss involved in depriving patients of the great value of specialization. Listening and understanding family problems can very effectively be undertaken by peer related non-professionals who are often more trusted by patients. These agents will keep the professional informed of family problems he might otherwise never be aware of.

Health Care Team

Referrals to community hospitals, chronic care units, special programs, medical centers, and public and private agencies can be coordinated through the Health Care Team. Mobile Health Core Facility Units for sparsely populated areas are also very feasible. Education, training and research can also be conducted but care must be taken to exclude these costs from patient care costs. Teaching in the community hospital should be confined to personnel in final stages of training who will act as paid apprentices, thus increasing available manpower as well as providing improved emergency care.

The Health Care Team and Family Agent Concepts are innovative and their effectiveness in circumventing manpower shortages, abuse of facilities and equipment, and improving quality of care should be demonstrated at first through government grant awards.

There must be free transfer between all components of the system which in reality becomes a BIOMEDICAL COMPLEX. This is a functionally unified complex and not necessarily geographically unified.

It is very realistic to expect that such a system will permit the physician to supervise the care of more than twice as many patients as he does under the present systems, thus not only circumventing shortages but also lowering costs.

Pooling of services, optimum utilization of all components, coordination, and team quality surveillance should improve quality and lower costs. Thus it might be possible to continue the fee for service concept and still maintain reasonable costs. Certainly, this plan is the more popular with providers of serivces and even to the recipients who often object to prepayment for services they may never use. The fee for service plan has undoubted value in the form of incentives to the provider and circumvention of abuse by the recipient. An all inclusive prepaid plan can produce a situation whereby the well finance the frequently and chronically ill which is certainly undesirable. Another possibility is physician fee for service with prepayment for all other services. Whatever plan is adopted, effective safeguards over quantity and quality of care are exerted through the Health Care Team. Also, if associations of physicians have a vested interest in the Health Core Facility, it is obvious they will protect its optimum utilization and operation.

Patient Preferences

There is a great need to study patient preferences. This has never been done to my knowledge. We never seek their perspectives—which is a bad mistake. We always assume that what we think is good for them is what they want. I wonder if prepayment is such a good idea in a country such as ours, where a pay-as-you-go policy—free enterprise—is so cherished. I wonder too, if stressing the need for prepayment—in case illness strikes—does not in reality orient our people towards illness rather than health. Too often, I have seen patients view their health insurance as a precious passport to the hospital. Is it then health insurance or sick insurance?

Perhaps a combination, providing prepayment for catastrophic and frequent or prolonged illness with reasonable exemption for family per year is more desirable. The type of payment is far from decided. There are so many individual preferences that flexibility is certainly necessary.

* * * * * * *

The real challenge is to insure availability of quality oriented care to all, no matter which reimbursement system is applied. Decreased cost, effected through pooling, coordination and optimum use of facilities, equipment and manpower, could just as readily be applied to the fee for service plan as it could to prepaid plans. This would have the added incentive of circumventing abuse by both consumers and providers, as well as insuring that consumers will for the most part, pay only for services rendered to them. Prepayment could then be applied only to long-term and catastrophic illness. This would adequately protect families from such events, and could be secured at a more reasonable rate. Such a system would very likely be more acceptable to all involved than is the present multi-faceted and complicated health insurance and other prepaid plan systems, which too often succeed only in subsidizing the medical industry, the insurance companies and the prepaid groups, causing further inflation of health care costs.

ITEM 4: EXHIBIT RELATED TO STATEMENT OF MR. CASS ALVIN,* EDUCATION COORDINATOR, UNITED STEELWORKERS OF AMERICA

EXHIBIT A. MEMORANDUM ON HEALTH PLAN ALTERNATIVES

OCTOBER 4, 1968.

To: California Council for Health Plan Alternatives: members of the Council and Advisory Committee Members; California Labor Federation: Thomas Pitts, Mike Peevey; Central Labor Councils, Metropolitan Areas; Other union officials and health care specialists concerned about the MediCal Program.
From: Bruce Poyer, member, Health Review and Program Council.
Re: September 25th meeting of the Council.

(Note: Copies of this report are being sent to California Health Welfare Department officials, other HRPC members, CMA officials, and administrators of major negotiated health programs in California. Comments or suggestions (or criticisms) on any matter raised herein will be appreciated.)

The key agenda item for September 25, which was on the advance agenda, was: "Presentation of California Blue Shield method of determining reasonable charges for physicians' services on the basis of profiles."

Spokesmen for CBS, the fiscal intermediary, gave a thorough and detailed explanation of the entire, complex, profile business, and described their procedures in processing MediCal claims, in keeping track of physicians' fees, and in reviewing questionable costs and practices.

The agenda item which was not described in advance, and which related only indirectly to the CBS appearance, was the California Medical Association's request, appearance, and argument for higher fees to be paid to doctors for services performed under MediCal. In contrast to the detailed procedural description presented by CBS, the CMA spokesmen gave no data and developed no economic rationale to support their argument for higher fees. They relied primarily on the simple threat that continuation of present limits on fees would soon cause California physicians to be unwilling to participate in the MediCal program.

The present formula sets maximum physician fees at the 60th percentile of the level of physicians' charges in effect January 1, 1967. Physicians' charges are determined by procedures, as defined in the CMA Relative Value Studies, and by different areas of the state. Price control "at the 60th percentile" means that at a particular price for a particular procedure in a particular area, over 60% of all claims for that procedure in that area are at or below that price. The present maximum fees under MediCal are presumably set at the 60th percentile of prices charged January 1, 1967.[1]

---

*See Statement, p. 697.

[1] There is some question about where the maximum fees are actually set. The following is from the legislative analysts report on Governor Reagan's budget request of last November, with particular reference to the appropriation requested for physicians' fees under the MediCal program:

"It is difficult to understand the meaning of all of these assumed program limitations. We have never been able to obtain a clear explanation of the reported rollback of physicians fees to January 1, 1967, and the related application of the sixtieth percentile maximum fee. This is because the actual administration of the fee system has been by contract with California Physicians' Service. We do not believe that in fact physicians fees are being approved at the level of those fees which were charged by individual physicians at January 1, 1967, and if this is the case, then all assumptions as to increases in physicians charges should be reexamined to see how far physicians have in fact been able to increase fees since January 1, 1967, and what this means as to increases for the next few years."

The CMA proposal was to move this "percentile control" to the 90th percentile of current charges, rather than charges in effect January 1, 1967, and to redefine the interpretation of the percentile control point. Under the redefinition, for a procedure like an office visit or a tonsillectomy, the maximum fee MediCal would pay for a particular area would be (a) that fee which is at the 90th percentile of all claims under California Blue Shield plans in that area for that procedure (this is the "area profile," as used previously); or (b) that fee which is at the 90th percentile of all fees charged by all the doctors in that area for that procedure (this is the "individual physicians' fee profile," now to be introduced). Whichever fee is higher, (a) or (b), would prevail as the maximum fee that could be charged to a MediCal patient. In no case would the maximum fee ever be below the 90th percentile on both profiles. In some cases, if the (a) profile established a price higher than the (b) profile, or vice versa, the actual control point could fall as high as the 98th percentile on both profiles.[2]

In discussion of the CMA proposal, the following points were raised:

(1) The State Department of Health and Welfare estimates the cost of the revision requested by CMA to be "in the neighborhood" of 5 to 7 million a year. This would be over and above the 5% increase in physicians' fees which was already budgeted in appropriations for this fiscal year. Questions raised at the September 25 meeting established that the 5–7 million estimate is obviously

[2] In a paper describing the mechanics of its full service program, California Blue Shield has itself given the most concise explanation of the development of its "profiles:"

"From an 'area profile' of charges, with the 'top of the range' established by means of a conversion factor applicable to broad bands of service reflected in the Relative Value Studies, the evolution has been to 'procedure profiles by area.' The latter establishes a range of charges for each procedure (service). Thus, a charge is screened against a procedure profile to establish that it is customary for that specific service in the geographic area.

"Now in its final state of development is the 'Individual Physician Charge History.' This is a refinement from an 'area profile by type of service' to an individual physician's usual charge history for a specific procedure (service). Thus, a charge is screened, first, against the physician's charge history to determine that it is his usual charge, then it is screened against the area range of charges to verify that it is within the customary range of charges for a similar service, and, therefore, considered 'reasonable.' . . ."

In the same paper, CBS also gave a better illustration than it gave to the HRPC of how the two profiles would be put together in the determination of "Top of the Range:"

Example 1: Procedure 1234

Physician's charge history	Number of physicians	Cumulative percent of physicians	Number of claims	Cumulative percent of claims
$35.00	47	34.6	216	37.0
$40.00	51	72.1	249	79.8
$45.00	18	85.4	61	90.2
$50.00*	11	93.4	24	94.3
$75.00	9	100.0	34	100.0

*Top of the Range.

Example 2: Procedure 2345

Physician's charge history	Number of physicians	Cumulative percent of physicians	Number of claims	Cumulative percent of claims
$75.00	18	10.5	49	5.6
$85.00	47	38.0	193	27.5
$100.00	58	71.9	257	56.6
$110.00	35	92.4	263	86.5
$120.00*	10	98.2	101	98.0
$150.00	3	100.0	12	100.0

*Top of the Range.

In Example 1, at $45—90.2 percent of the claims were included. However, only 85.3 per cent of the physicians were included. Therefore, to establish the range to include at least 90 per cent of physicians, the next charge of $50 was selected as the top of the range. This represented the charges of 93.4 per cent of the physicians and 94.3 per cent of the claims.

In Example 2, at $110—92.4 per cent of the physicians were included. However, only 86.5 per cent of the claims were included. Therefore, to establish the range of at least 90 per cent of the claims, the next charge of $120 was selected as the top of the range. This represented the charges of 98.2 per cent of the physicians and 98.0 per cent of the claims.

very loose. No data was submitted to support the estimate, nor did it appear that any reliable data was available.

The control point on physicians' fees was moved back from the 90th to the 60th percentile, in September, 1967. The Office of Health Care Services later (May, 1968, reestimates) determined that this reduced expenditures for physicians' services by 10 million in fiscal 1967–1968. and by a projected 12 million for fiscal 1968–1969. The financial impact of the proposed upward revision would be greater than the impact of the last downward revision, for two reasons: (a) there would no longer be a freeze on fees at their January 1, 1967 level, and fees are obviously much higher now; (b) the use of the individual profile system permits maximum fees beyond the old 90th percentile maximum level.

(2) California Blue Shield the fiscal intermediary, indicates that complete "top of the range" fee data, by areas, using both the individual physicians' profiles and the area profiles, is available only from January 1, 1968.

This means, in effect, that CBS either does not have, or will not disclose, any "base data" that can be used to determine what usual and customary fee charges were in the various areas, except data as of January 1, 1968. Nearly two years of inflationary impact of the MediCal and Medicare programs is therefore now to be built into the January 1, 1968 determination of "top of the range" (or 90th percentile plus). Probably, that will be the only data available as a bench mark for future determinations of how fast fee levels are rising.

The intent of the MediCal law was and is that physicians' fee levels prevailing in various community areas were to determine what MediCal paid for similar services to recipients. However, the "bench marks" on what is happening to fees in the various areas are continually pushed forward in time—by the physicians—who are the fiscal intermediaries. Thus, what is being measured is usual and customary community practice, plus all of the inflationary impact of the MediCal and Medicare programs.

In other words, in my opinion, the program is being used to advance the fee levels that are considered to be "usual and customary," which in turn results in advancing the program's fee levels. It is a very nice situation for any provider of service to be in, especially if the provider is also the fiscal intermediary, and is therefore in charge of all the data.

(3) The representatives of the medical profession quoted data to indicate an over-all increase in the "California Physican Fee Index" of about 4% a year for the past five years or so. They did not bother to produce any of the data they quoted. Their figures are probably from the Socio Economic Report of the Bureau of Research and Planning of the CMA. The March 1968 issue of this report shows the CMA physician fee index at 123.9, using June 1962 as base of 100.0. This would be a 4.34% increase per year over the 5½ year period. However, the 5½ year period used in this computation includes only 1 year and 9 months under MediCal, and 3 years and 9 months when we did not have MediCal or Medicare. Use of this period spreads most of the inflationary impact of the government programs over a longer period of time prior to the advent of the programs.

The same CMA data, using December 1964 as base, shows a 14% increase in physicians' fees to December 1967, or 4.7% a year. This 3 year period is short to establish a trend, but it sets a base period 1 year and 3 months before the government programs started, and it covers 1 year and 9 months of their operation. It thus provides more realistic barometer of what is happening now.

U.S. Department of Labor data on physicians fees in San Francisco and Los Angeles (from the BLS Cost of Living determinations) was also quoted at the September 25th meeting. This data is regularly discredited by the CMA, as being statistically unreliable. However, in the 3 year period December 1964—December 1967, BLS shows virtually the same change in physicians' fees in Los Angeles and San Francisco, as that which is recorded in the CMA data. BLS shows a 4.9% increase per year over the 3 years. CMA shows a 4.7% change each year over the 3 year period.

The basic similarity of BLS data describing the 3 year period is important not only because CMA discredits their data, but even more because BLS shows an index of physicians' fees (for Los Angeles and San Francisco) for June, 1968. CMA is silent on that subject, at least in its public disclosures.

BLS shows a remarkable jump of 11% in physicians' fees in Los Angeles and San Francisco in the six month period December 1967 to June 1968. That single jump is big enough to bring the annual rate of change in the BLS series up to 7.8% over the total 3½ year period, December 1964 (base) to June, 1968. CMA data, or that which is released publically, does not yet cover this period Decem-

ber 1967 to June, 1968. CMA representatives at the September 25 meeting refused to comment on the data reported by BLS, except to say they consider it statistically unreliable, and prefer to use their own data. Clearly, whether statistical reliability is involved or not, their own data is much better for their public relations.[3]

(4) Of course, there is a great deal more data to indicate that physicians in California are not suffering too much from inadequate fees, and some of it was also quoted at the September 25 meeting. However, the data on fees and the fine points about its interpretation obscures a more important question: why should a "control point" on maximum fees be set at the top of the usual and customary range (or at the 90th percentile or higher), rather than at some mid point in the range (such as the 60th percentile or lower)? The chief CMA spokesman was asked to comment on the following quote which summarizes this whole issue (from the report of the Governor's Survey on Efficiency and Cost Control):

"Many of the physicians who charge the higher fees practice in geographical areas where there are few Medi-Cal patients. Therefore, if some of the physicians, by reason of fees charged, find the program unacceptable and discontinue their services, it would not result in any major loss to the program. Further, the processing costs being incurred in handling claims with fees above the normal range do not appear to be justifiable."

The CMA spokesman commented only that all doctors should participate, and that fee limits should not be set so that some doctors are "cut out of the program."

There was no information from the Department of Health Care Services as to whether all of MediCal's needs for physicians could be met with maximum fees set at any particular percentile level. Presumably, the program has been getting all the physicians services required with the control point at the 60th percentile. According to CMA, the physicians with higher prices are performing the necessary services, billing at the higher levels, and then complaining when their claims are reduced by MediCal to the maximum levels which existed under the 60th percentile control. The doctors, of course, have complete freedom to refer the Medi-Cal patient (or have the administration refer him) to any physician who would accept the existing maximum. Therefore the relevant question really is: are there enough physicians charging the lower fees to meet all MediCal needs?

I have no data to suggest an answer. CBS and CMA may have such data, but if so, they probably prefer not to discuss it. It does not appear to me that the Administration is even interested in raising the basic questions, let alone demanding the data to answer them. They appear to respond only to the threat that the doctors "may not choose to participate" in the program if fees are not adjusted upward, and they appear unwilling to ask: how many would not participate? at what control points? where do they practice? how many Medi-Cal patients do they have? what are they charging? would their nonparticipation be a major loss to the program? or a net gain to the program?

---

[3] The statistical reliability question is not actually an argument. CMA prices more physicians' procedures than BLS, although the BLS sample of procedures is a good one. All of CMA's pricing is done in California, while BLS prices in San Francisco and Los Angeles and in 54 other cities in the U.S. BLS does not publish separate physicians' fee indexes by separate cities, since its pricing procedure is designed to produce a national index. However, the data for San Francisco and Los Angeles is available on request.

The BLS pricing procedure relies primarily on trained field representatives who gather data in personal interviews (giving more statistical reliability). It is my understanding that the CMA procedure relies primarily on mail questionnaires (which have considerably less statistical reliability).

The medical care component in the BLS's Consumer Price Index (of which physician's fees are a part) was previously criticized for failing to measure quality improvements adequately. To correct this, a linking procedure was developed and is now used to factor out price increases based on a new or different quality. The linking procedure is now criticized as a factor tending to understate the actual amount of medical care price increases measured by the BLS.

Research on BLS pricing of medical care components (primarily by Anne Scitovsky) has also established that pricing individual items and services results in a lower index than pricing the total illness. The "total illness" approach takes account of a number of factors not considered by either CMA or BLS, including the introduction of more complicated and costly types of treatment. (See Social Security Bulletin, July 1967, p. 15, for appropriate citations.)

The fine points about statistical procedure should not obscure the fact that CMA and BLS data show virtually the same price changes for the period December 1964 through December 1967, which is the only period that can be used for comparison. On the basis of this similarity, there is every reason to believe that the CMA index for June 1968, when it becomes publically available, will show an increase of much the same magnitude as that already shown by the BLS in its physician fee indexes for San Francisco and Los Angeles—an incredible 11% increase in fees in the six month period.

CONCLUSION

1. The HRPC recommended to the Health and Welfare Department that the January 1, 1967 freeze should be lifted, that the percentile control point should be moved from the 60th to the 90th, and that the individual physicians' fee history should be added as a criterion in the definition of the 90th percentile. The HRPC recommended moving right now to this new definition, but also recommended placing a 5% limit on the amount of fee increases that would occur under the new definition in each of the two years *following its adoption.* In this recommendation, the 5% is not a limit on the amount of fee increase that will occur immediately if the new definition is adopted. (I was the only non-governmental consumer or public representative present, and mine was the only dissenting vote. It should be noted that the Council did not have an adequate explanation of what its vote meant. It should also be noted that HRPC recommends only, and the Administration is not obliged to follow its recommendations.)

2. It is still impossible to tell how big an increase in physicians' fees would result if this recommendation is carried out. There was no indication of how many claims have been denied because they were higher than the 60th percentile of charges in effect January 1, 1967. The CMA argued that "a majority of all claims" now comes in higher than the control point allows, but they don't back up this assertion with any data whatever. If it is true, there obviously would be a big jump in fees immediately. And it will obviously be bigger than the 10–12 million a year previously estimated on the basis of last year's reduction in maximum fees permitted.

On the other hand, there is no way of knowing whether the January 1, 1967 "freeze" in fee levels was ever actually enforced (see footnote 1, which casts some doubt). If it was not enforced, then a good bit of what the doctors asked for is already being paid to them, and the recommendation of the HRPC would simply legitimize present practice. In that case, there would not be such a big jump immediately.

The Department of Health Care Services itself had no meaningful analysis of the impact of the increase, either in gross cost terms or on the question of the availablity of program services at different levels of controlled prices. Further, there was no analysis of what services might not be available to recipients as a result of a considerable increase in the amount of resources now to be allocated to physiicans for their particular services. (This is not surprising any more—the recipients and their health care problems always seem to be left out of HRPC deliberations.)

My guess is that the increase will be sizable, but the only thing I have to base this on is the hard push the CMA is apparently making to get the increase established. Their attitude at the September 25 meeting seemed to be that their program was going through regardless of the fact that relevant data was not supplied to support it, and regardless of what arguments might be made in the HRPC. In short, it has all the earmarks of the old steam roller. The best guess is that it will cost plenty, and that MediCal has only begun to pay the increase.

3. Whatever amounts are involved in additional MediCal expenditures for physicians' fees, it is obvious that there will be an immediate impact on all other physicians fees under all other programs. Administrators of major negotiated plans should advise collective bargaining representatives accordingly. The law is written so that MediCal should pay on the basis of usual and customary fee experience outside the MediCal program. But if the HRPC recommendation is carried, collective bargaining representatives can expect to negotiate increased fees for the doctors on the basis of immediae repercussions from the MediCal program—or face the unpalatable alternative of cutting back the benefit levels of their negotiated programs.

It would be extremely useful if organized labor, as the largest consumer representative in the state, could supply organized, consistent, and comprehensive data on the coverage, costs, and utilization of their programs, to throw light on the many obscurities of the MediCal program. I believe that if anyone but the doctors' own oranization now handled the responsibility of fiscal intermediary for the MediCal program (including the state of California), there would be much more data available on sensitive questions like doctors' fees, and there would be much less possibility of conflict of interest in the gathering, handling, reporting, and analyzing of all health care data involved in the MediCal program.

Is it possible, even at this late date, to introduce some coordination in the kinds of data handling procedures used in the administration of organized

labor's negotiated programs? There certainly appears to be good and sufficient reason now for some of organized labor's top policy people to start meeting with some of the administrators of the important plans to see what can be done.

4. There will be many further problems with the addition of the "individual physician fee profile" as a criterion in the determination of the percentile control point. The problems will continue whether a final control point is located at the "top of the range" (or at the 90th percentile plus), or somewhere around the middle of the range, or even at the bottom of the range.

It is my understanding that to date Blue Shield has been using its own programs to represent the "usual and customary" universe. Their programs undoubtedly constitute a very broad sample—perhaps the broadest that could be found in California. But if the reliance is on Blue Shield programs alone to establish what is usual and customary, then a vast amount of other, non-Blue Shield "usual and customary" experience is left out of the calculation. Have labor's negotiated programs ever been asked to give CBS or the state any information on their physician charge profiles? Probably not, and the whole mainstream of medical practice under negotiated health care programs has probably been left out of the determination, to date, of what usual and customary actually is.

Presumably, the use of an individual physician fee profile as a criterion in determining the maximum fee level for MediCal claims, will bring into consideration that "other, non-Blue Shield" experience. It will also bring into consideration a host of new problems in gathering and interpreting data on physician's fees.

To mention only one such problem, the fiscal intermediary will have to keep track of the entire range of each individual physician's fees for each procedure, as charged to all kinds of different, non-governmental, group and individual purchasers. Presumably, this information will be gathered from all physicians who participate in the MediCal program by mail questionnaire. Of course, the respondents will know, when they get the questionnaire, that their answers are going into the determination of the price MediCal will pay for similar services rendered to recipients. What kind of ojectivity, either in the gathering or in the interpretation of the fee data, will be possible in this situation?

At every turn, the MediCal program is still confronted with the need for objective data and information, which is still not being supplied to the program.

At every turn, the program is still getting answers to its problems which are primarily in terms of the special interests of the providers of services.

ITEM 5: EXHIBIT RELATED TO STATEMENT OF MR. DONALD GORMLY,* PRESIDENT. CALIFORNIA ASSOCIATION OF NURSING HOMES, SANITARIUMS, REST HOMES, AND HOMES FOR THE AGED, INC.

EXHIBIT A. EXCERPTS FROM ASSOCIATION TESTIMONY BEFORE SENATE FINANCE COMMITTEE ON H.R. 12080—1967 AMENDMENTS TO THE SOCIAL SECURITY ACT

STATEMENT OF DAVID R. MOSHER, REGIONAL VICE PRESIDENT, AMERICAN NURSING HOME ASSOCIATION

Mr. Chairman and Members of this committee, my name is David R. Mosher and I appear on behalf of the American Nursing Home Association. I am a nursing home administrator and the owner of two nursing homes certified as Extended Care Facilities in St. Petersburg, Florida.

Nursing homes are playing a major role in the operation of both the Title XVIII (Medicare) and Title XIX (Medicaid) programs. The role of the nursing home in both of these programs, we are convinced, will be expanded to even greater limits in the months and years ahead.

I say this because nursing homes, whether certified as Extended Care Facilities under Medicare, or operating as skilled nursing homes under Title XIX, provide a tremendous cost-saving service for government.

Those certified as ECFs are saving the Social Security Administration, the Federal Treasury and ultimately the American taxpayer, tens of millions of dollars.

---

*See statement, p. 703.

We do not know if some of these Rules and Regulations issued as State Agency Letters and Letters to Fiscal Intermediaries without regard to the Federal Administration Procedures Act and without publication of them in the Federal Register were first presented to Health Insurance Benefits Advisory Council, for we are not privy to the minutes of HIBAC. On the other hand, we do know, that many of them have been issued without prior consultation with national organizations as provided for under the Social Security Amendments of 1965 (P.L. 89-97). Let me cite a few examples:

Spell of illness

Directing your attention to the definition of a "spell of illness" presently proposed by HEW in State Agency Letter No. 65. This letter will affect state Title XIX programs by increasing the costs thereto both to the individual states and to the Federal Government while working a hardship upon the patient.

In Section 1861(a), "spell of illness" is defined as commencing with the first day a patient enters a hospital, uses his hospital and extended care benefits, and ending 60 consecutive days thereafter on which he is neither an inpatient in a hospital or an *extended care facility.*

EXTENDED CARE FACILITY

An "extended care facility" for the purposes of "spell of illness" is defined in Section 1861(j)(10) as a facility "which is primarily engaged in providing to inpatients (a) skilled nursing care and related services for patients who require medical or nursing care or (b) rehabilitation services for the rehabilitation of injured, disabled or sick persons." Congress specifically defined an "extended care facility" for the purposes of "spell of illness." Now Social Security Administration has radically altered Congress' definition.

The Social Security Administration defines "extended care facility" so as to prolong a "spell of illness" as a facility which is in charge of a licensed practical nurse (who need not be a graduate of a state approved school) with aides, orderlies or attendants on the other two shifts. Such a facility fails in the essential element that it be primarily engaged in skilled nursing care and services for patients who require medical or nursing care. State Agency Letter No. 65 adds a great deal of confusion to the health care field. More important, however, are the results which follow. This definition denies our aged people medical benefits Congress intended them to have.

THREE EXAMPLES

Let's take 3 examples. Patient A who is 75 years of age and living in a custodial home. He can get around, but he needs someone to be certain to see that he eats his meals and takes his medicine. Patient A has a severe heart attack. He goes to the hospital for 90 days. He is then transferred to an "Extended Care Facility" for 100 days. He then goes back to the custodial home where he has lived for the past two years. He can never again become eligible for Medicare benefits under Letter No. 65 because there is 8 hours a day of "nursing service" available.

Two years later he falls and breaks his leg. Under Letter No. 65 he can obtain no medicare benefits because this residential care home is defined as an ECF or skilled nursing home because it has an LPN as a charge nurse. The travesty lies in the fact that this residential care home is considered by SSA to be an ECF solely for the purpose of not breaking this "spell of illness." SSA would never certify this residential care home as an ECF or as a skilled nursing home for participation in Title XVIII or Title XIX programs. In those instances, SSA would judge this residential care home to be below the standards required of a facility for it to be certified as an ECF or a skilled nursing home.

Patient B is 68 and lives in his own home. He is not well but is able to take care of himself. He has a serious heart attack. He is in the hospital for 90 days. He goes to an "extended care facility" where he remains for 100 days. Thereafter he is transferred to a nursing home where he remains for 60 days. He then goes home and 10 days thereafter he falls and breaks his leg. He is not eligible for Medicare.

Patient C is 70 years of age. He has a serious heart attack. He goes to a hospital for 90 days and is then transferred to an "extended care facility" for 100 days. He then goes home and during the next 60 days he exhausts his 100

home health care visits under Part A. On his 61st day he falls and breaks his leg. He is eligible for Medicare benefits.

Patient C is eligible for Medicare because he had such resources that after being discharged from an extended care facility, he could be taken to his own home. He could receive 100 home health care visits and his new "spell of illness" would start 60 days from the date that he was discharged from the ECF. In other words, an individual is not required to have a 60 days "spell of health."

State Agency Letter No. 65 makes one's Medicare benefits turn on his station in life or on the circumstances under which he is living at the time that he enters the hospital. The individual who needs Medicare benefits the most is denied them.

In each of these three instances we have a new illness but because of the technical misinterpretation placed on the word "extended care facility" by SSA two of these elderly people have what amounts to a cancellable health insurance policy where it seems certain that Congress did not intend such a catastrophe to happen.

Our objections to Letter 65 are threefold. First, it nullifies the definitions of Congress and causes undue hardships to those who need medical care most. Second, it defines a "facility primarily engaged in skilled nursing care" as one that is not rendering skilled nursing care. We have fought for over 10 years to raise standards of professional care which SSA now downgrades. Third, it makes "spell of illness" turn in part on one's station in life. We thought Medicare did away with any kind of a means test.

"Spell of illness" should be defined in terms of a new medical illness. Accordingly, we suggest that Section 1861(a)(2) on "spell of illness" be amended to read as follows (amendment is italic):

> "(2) ending with the close of the first period of 60 consecutive days thereafter on each of which he is neither an inpatient of a hospital nor an inpatient of an extended care facility, *under Title XVIII for the same medical illness.*"

APPENDIX 2

LETTERS AND STATEMENTS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1: STATEMENT FROM MARK BERKE, EXECUTIVE DIRECTOR, AND DR. HARRY WEINSTEIN, DIRECTOR OF MEDICAL EDUCATION; MOUNT ZION HOSPITAL AND MEDICAL CENTER

EXHIBIT A. STATEMENT OF THE U.S. SENATE SPECIAL COMMITTEE ON AGING

The practices which have the greatest potential for *reducing* the cost of medical care also have the greatest potential for *improving* the quality of care.

The cost reduction can be achieved by utilizing the least costly facility or service appropriate to the patient's need (and by preventing illness or the advance of illness or by providing restorative services which enable the patient to be served by a less costly facility).

The improvement in quality of care stems from developing the full constellation of facilities necessary to supply appropriate care at lower cost. The over-utilization of high cost facilities such as the acute hospital represents not only wasted dollars but poor care because of the inappropriateness of the facility for the patient's need.

Efforts to reduce the number of individuals in need of expensive services have been advocated by many and we do not wish to be trite by joining sanctimoniously in such advocacy. Nevertheless, there is no broad-based, consistent, effective program of prevention and early diagnosis for the aged in this country and such programs must be established to serve the ends of lower cost and higher quality.

Facilities which must be available in addition to the acute hospital include:

- Intensive Rehabilitation Unit.
- Extended Care Facility.
- Long Term Care Facility:
  - Nursing Homes.
  - Homes for Aged.
- Coordinated Home Care.
- Individual Home Services: i.e., Nurse, Physical Therapist, Medical Doctor, etc.
- Day Centers:
  - Outpatient Department.
  - Private Office.
- Substitute Homes.

Multi-disciplined patient care planning teams must be involved early after hospital admission in order to shorten hospital stays and choose the appropriate alternative to hospitalization. Such teams can also participate in planning which prevents hospitalization.

The greater the success we have in using appropriate alternatives to hospitalization, the more the cost of care per patient day in the acute hospital must go up, since only the sickest patients requiring the most service and use of the most elaborate "hardware" will be served in such institutions.

Ultimately, then, we must arrive at a true assessment of health costs in terms of total community expenditure per 1,000 persons over age 65. Of the two costs involved, the one expressed by the per diem rate in the hospital must go up. Our only hope there is to stabilize the rise, i.e. to diminish the speed of rise. The other cost expressed as communal cost can go down by coordinated community effort. The community can make certain that its dollars are effectively spent and that it gets more for its money through avoidance of unnecessary duplication and of over-utilization of expensive services and facilities.

ADDITIONAL COMMENTS

1. Medicaid should switch to reimbursement on a cost basis because the current negotiated basis is leading to provision of inadequate levels of care.
2. Incentives to reduction in cost are difficult to devise because we have not found ways of measuring our product.
3. The intermittent services of a homemaker or home health aide for as little as 8–12 hours per week may keep an older person out of a hospital or a long-term care facility. Therefore, in establishing the criteria for eligibility for such "covered" services, the term "custodial" should be discarded. Eligibility should be based upon the existence of an active medical care program for the aged person. In all instances, such services should be provided if, in the opinion of a competent professional, they will enable the person to avoid institutionalization and remain with safety at home.
4. The great success enjoyed in upgrading the quality of care in acute hospitals through the Joint Commission on Accreditation of Hospitals should be extended to Long Term Care Facilities including Homes for the Aged. Licensure is not enough.
5. The barriers to the establishment of meaningful relationships between proprietary and non-profit institutions are almost insurmountable. After several years of trying, we have not been able to establish any relationship beyond a relatively unimportant transfer agreement. Great support should, therefore, be given hospitals for the development of their own geographically proximate Extended Care and Long Term Care Facilities.

ITEM 2: LETTER FROM PHILIP E. BROWN, CHIEF ADMINISTRATOR, CALIFORNIA CHIROPRACTIC ASSOCIATION HEALTH SERVICE FOUNDATION

OCTOBER 17, 1968.

DEAR SENATOR WILLIAMS: In compliance with your request, we are submitting pertinent information which we believe has a direct bearing upon the purpose of the investigation of the United States Senate Special Committee On Aging of which you are a member. Unfortunately, we were not given any time on your program to present facts relating to costs for the care of the elderly when administered by doctors of chiropractic.

In depth statistics compiled by Dr. H. G. Higley, who is head of the Department of Research and Statistics for the American Chiropractic Association reveal some interesting facts. Dr. Higley is a qualified statistician and his conclusions can be buttressed by data which he has compiled. The most pertinent information, which we feel would have a direct bearing upon your search for lower costs in health care of the aged comes directly from the statistics compiled during a two year period (July, 1962–June, 1964) of treatment of patients under the Public Assistance Medical Care Program in California.

Number of patients treated by chiropractic doctors during this period	43,279
The expected cost on the basis of "Medical Care Expenditures" for all three services (M.D., D.C. and D..)	$3,449,177
The startling fact was that the actual cost of the treatment of the above patients under chiropractic care was only	1,474,025
The difference between the expected cost based on the Medical Care Expenditures and the actual cost of chiropractic aid	1,975,152
The average cost per case under chiropractic management	34.06
The average cost per case under medical care, all professions (M.D., D.C. and D.O.)	79.70

From the above it can readily be seen that the inclusion of chiropractic care does not represent increased costs to any program, but rather represents a savings, which should be apparent from the above. Please keep in mind that the bulk of the conditions being treated were musculo-skeletal problems, which are treated by all the hearing professions. Consequently, the difference in cost as noted above, would be predicated primarily on a difference in approach to therapy.

The California Chiropractic Association has been dedicated for many years to providing the highest quality health care to the public, while at the same time curbing spiraling costs. Toward that end, we have instituted educational symposia and local review committees which have been most effective and beneficial to the public and profession alike.

We would welcome an opportunity to appear before your august body, or to submit further information if it should be desired.

Very truly yours,

PHILIP E. BROWN, D. C.,
Chief Administrator, CCA-HSF.

ITEM 3: LETTER AND STATEMENT FROM JOSEPH W. EHRENEICH, DIRECTOR, UNIVERSITY OF SOUTHERN CALIFORNIA RESEARCH INSTITUTE OF BUSINESS AND ECONOMICS

November 11, 1968.

* * * * * * *

DEAR SENATOR WILLIAMS: A point which is major, in my opinion, but which does not emerge clearly is that the health care problems of the elderly are but a reflection of a bigger underlying problem. This is the fact that our health care system is so structured that its prices must continue to rise inordinately, while its amenities continue to decrease. Physicians are in a position to set their fees almost by whim; as a group, because of increasing demand for their services and a small increase in the supply of physicians, they enjoy a protected monopolistic position. This is enhanced each year by the relatively small number of annual graduates from medical schools. There are now fewer practising physicians per 1000 people than there were in 1950. The other major source of health care costs—hospitals—are similarly insensitive to consumer economic needs. Operating largely on a cost reimbursable basis and as non-profit institutions, they have no real incentives to effect major, radical economies.

Put another way, the health care industry is basically non-competitive and accordingly, lacks the normal business incentive to keep its costs and its prices as low as possible.

To introduce the benefits of competition into the industry, major institutional change is necessary. I have elaborated on this theme in a presentation to the 1967 National Conference on Private Health Insurance, a copy of which is attached. In this presentation a number of possible changes are described.

The economic impacts of what might be called—non-market oriented biases—in the health care system are particularly severe upon the many elderly who have to live on relatively fixed incomes. With a high incidence of expensive acute and chronic ailments, with other living costs rising regularly, with their other special costs, the rapidly rising prices that they must pay for health care becomes a most severe burden. Certainly Medicare and Medicaid help tremendously, enabling many of the elderly to obtain care heretofore impossible for them. For the individual, these plans make the personal cost in most cases. However, for society as a whole, the total cost must rise for two reasons. First, more people with more care simply means more dollars spent for health care; and, of course, these extra dollars come from society. Second, the resultant increased demand puts additional upward pressures upon medical fees and hospital prices. Since these upward pressures are not being relieved by concomitant supply increases, prices will tend to rise.

You also asked me to comment upon deficiencies in the organization of health services for the elderly, and about the relationship of federal programs to the broad scale development of prepaid medical centers.

I believe the organizational deficiencies have been well noted in the Hearings. I am not an expert in this field and I have nothing but personal prejudices to add. I would like to stress the danger however, of not considering such deficiencies in the context of larger wholes: namely; the organizational deficiencies of health care generally: and, for another, in the context of the elderly person's total social and psychological health. It is in this later regard that so many nursing homes and extended care facilities seem to fail completely.

As for government participation, my personal view is that it would be far better for the so-called third parties, or for labor-management groups to take the lead in developing the new institutional arrangements that are needed if incentives

for efficiency and low prices are to be effective. However, the federal government can play a significant role in bringing appropriate people together from these groups and working with them to start such activities. The government has done this successfully in the past and I hope it can again for this important social problem.

For the immediate future and some time to come, however, the government is in the best position to alleviate the health care problems of the elderly. Certainly something more needs to be done about substandard Medicaid plans, about high drug costs to the elderly, about better enforcement to avoid abuse by the vendors of medical care (note attached clipping from November 8, 1968 L.A. Times), about the problem of chronic illness care. Medicare represents a big step forward for acute health problems; the costs of chronic illness still represent a most formidable threat.

An area in which the federal government can improve its activities in order to help alleviate the health care problems of the elderly as well as other health care problems relates to its research grants procedures. Under the current system, millions of dollars are being spent on various studies of health care organization and delivery. However, because of procedures followed, most funded studies tend to be very specific and actually prevent the investigator from doing the sort of broad study and general casting about that is essential for the creation of new break-throughs. Thus, while many specific, narrow studies of health care and of the elderly exist, no really comprehensive scientific view nor tested set of recommendations exist. Largely because of the grants procedures, the information we have on the health policy question is fragmented, full of gaps and generally inadequate. This deficiency is not the fault of the researchers, or the research organizations, but rather stems directly from the philosophy and practice of the research grant system.

Yours sincerely,

JOSEPH W. EHRENREICH.

[Enclosure]

EXHIBIT A. CREATING COMPETITION IN THE HEALTH-CARE INDUSTRY: SOME REFLECTIONS ON POSSIBLE IMPACTS OF MAJOR GROUP PURCHASERS ON COSTS AND QUALITY OF HEALTH CARE

Among the thousands of studies prepared in recent years on the health-care industry in the United States, there are virtually none concerning the potential effects of major group purchasers upon the system. This is strange, in that all the other participants in the industry have been reported upon in exhaustive detail. The providers of care, the so-called third parties, and the governments have been studied both in general terms and in great detail. However, the major group purchasers—the single largest source of the funds that flow into the system—have received scant attention.

Accordingly, I was most pleased when the Department of Health, Education, and Welfare asked me to prepare a background paper for the National Conference on Private Health Insurance on the question of how management and labor might act to restrain the soaring prices of health services while their quality was, at least, maintained. The Medical Care Price Index, based on 1957 to 1959 as 100, was 122.3 in 1965, 127.7 in 1966, and up to 135.7 by May of this year. In the last twelve months alone, it has risen almost .7½ percent.

It is always stimulating to be connected with a pioneering effort, and that is what this paper is. It is not designed to be comprehensive, or convincing, or in any way conclusive. It is rather designed to expand understanding, to present some possibly new views, and to be a basis for discussion, argument, and dialogue. From these and from the refinement and extension of this work, it is hoped that some advances in our nation's capacity to cope with the problems of the health-care market may ultimately result.

While, as usual, the author of this paper must take full blame for all errors and inanities, I have been uniquely fortunate in the advice I have had. Not wanting the paper to be limited by my own ideas and prejudices, I invited distinguished Los Angeles representatives of management and labor to discussion meetings in which many of the thoughts herein presented were developed. As a measure of the tremendous interest and concern with which such people view the health-price problem, it is noteworthy that of thirteen people invited, eleven attended or sent alternates. The twelfth, a union executive, had to cancel at the last minute because of a strike problem; the thirteenth, an insurance-company official, could not attend because of a death in his family.

We were most privileged to be able to draw upon the experience and thoughts of the following men, although none of them should be considered as necessarily endorsing this report: Cass D. Alvin, Education Coordinator, United Steelworkers of America; Wallace J. Andrews, Consultant, Merchants and Manufacturers Association; Charles Boren, Executive Vice President, Association of Motion Picture and Television Producers, Inc.; John Despol, Representative, United Steelworkers of America; Anthony M. Frank, President, State Mutual Savings and Loan Association; Caniel Johnston, Daniel Johnston and Associates; Harold Klein, Administrator, Food, Health and Welfare Fund, Retail Clerks Union; Irvin P. Mazzei, President, Los Angeles County Federation of Labor; Lawrence A. Peifer, Labor Relations Associate, Ford Employers Council, Inc.; and Harry Winston, Manager, Industrial Relations Branch, Lockheed-California Company. Particular appreciation is due Dean Robert Dockson and Professor Donald E. Yett for their constructive suggestions; to Max Fine of the Department of Health, Education and Welfare for his sage advice and help; and to Robert Sigmond for his incisive comments.

The literature abounds with history, data, and proposals about the problems of health-care costs and their quality—what the problems are, their causes, and their remedies. Excellent materials are available, particularly the books *Bargaining for Health* by Munts,[1] *Health Plans and Collective Bargaining*, by Garbarino,[2] *How to Get the Most out of Medical and Hospital Benefit Plans*, by Brecher.[3] Tilove's article "Pensions, Health and Welfare Plans",[4] and the many splendid papers prepared for June's National Conference on Medical Costs.[5] It cannot really be useful to restate these or even to add more of the same. However, there is a dearth of material regarding the roles that management and/or labor—the major group-health-care purchasers—play or can plan in these problem areas. There are some materials describing and analyzing what they are doing in health, but, except for some material in the book by Brecher and Brecher, one looks in vain for any analysis of group purchasers' interests and attitudes toward health care, their role perception, their options for action and policies, or their view of where their responsibilities begin and end.

Accordingly, it is the purpose of this paper to try to conceptualize and categorize how the major group purchasers do and can influence the costs and quality of health care. This paper will then attempt to suggest deficiencies in the ability of the current institutional organization to solve the big problems and to indicate possible revision which might make it more effective.

Many of the ideas that have been expressed over the years for expanding the supply of health-care providers, for reducing demand, or for introducing controls over the noncompetitive aspects of the industry have been ineffective, in my opinion, for two interrelated reasons. First, the ideas were just that—ideas. They might be considered as interesting hypotheses, based largely upon faith or judgment or prejudice. Many have plausible rationales, but, fraught as they are with implications for disruption of the accustomed ways and for acrimony with established institutions, they do not have an adequately hard, factual basis for activation. Plausibility is not enough. There is always difficulty, and rightfully so, in changing major social policies or programs without strong evidence that the changes will, in fact, have the desired results.

The related reason that the ideas have had tough sledding is that, in addition to lacking a firm intellectual basis, they have lacked the support of any significant power group. The providers of medical care have generally opposed significant changes through their organized associations, the third parties have been relatively passive and divided, and the individual consumers—the actual payors of the rising health costs—are unorganized and not fully cognizant of what has been happening to them.

Management and labor, working together in some instances and separately in others, have been the largest organized payors of health costs, either through payment of premiums or through direct payments to health-care providers. The

---

[1] Raymond Munts, *Bargaining for Health* (Madison University of Wisconsin Press, 1967).

[2] Joseph W. Garbarino, *Health Plans and Collective Bargaining* (Berkeley: University of California Press, 1960).

[3] Ruth Brecher and Edward Brecher, *How to Get the Most Out of Medical and Hospital Benefit Plans* (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1961).

[4] Robert Tilove, "Pensions, Health, and Welfare Plans," in Lloyd Ulman (ed), *Challenge to Collective Bargaining* (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1967).

[5] Washington, D.C., June 27–28, 1967 (Publication of the Conference proceedings, by the U.S. Department of Health, Education, and Welfare, forthcoming 1968).

Southern Pacific Railroad Company established its still-existent medical-care prepayment system in 1868; the first national union health program was set up in 1877 by the Granite Cutters' Union. Now, there are thousands of different plans. It is estimated that two-thirds of the civilian population of the country are covered by a health plan purchased by or through a management and/or labor group. Yet the effects of these on restraining general health-care costs are probably quite negligible.

When management and labor reach agreement in their negotiations about health care, then they may bargain with third parties for the best buy. But they then are bargaining with the wrong group. The bargaining, at some point, has to be with the providers of health care. The ability of our free-enterprise system to regulate economic forces through competition needs; among others, three conditions to enable it to work: there has to be a mechanism for dialogue between the buyers and the sellers for bargaining to occur, there has to be knowledge on the part of the buyers, and there must be alternatives so that each side has bargaining power. As I see it, these do not exist to any adequate extent. For this, as well as other reasons, management and labor, despite their thousands of individual plans, have failed, together or separately, to correct the conditions that have led to the soaring costs.

Since management and labor, as the major purchasers of group coverages, are the natural choice to act for the consumer as a power force in opposition to the vendors' force, and since they do have economic as well as humanitarian motives for obtaining the best medical care for their people at reasonable cost, it seems appropriate to consider how they might be a more effective force in the health-care market. This is a particularly urgent task, because what choices are there? Who else will represent the consumer—the immediate victim of the cost spiraling? Ultimately, of course, the entire economic system is the victim. If management and labor fail this challenge, if third parties do not radically revise their orientations, the Federal Government may have to step in as the consumers' representative. There is no other group existent that can exert the types of pressures that are necessary if health prices are to be restrained.

Consequently, this paper will focus on the roles that major group purchasers might plan in regard to this national problem. It is based on several premises: first, that health-care prices will continue to rise inordinately unless something new happens; second, that when they rise, management and labor will become increasingly concerned and will examine the problem more deeply and become more knowledgeable and sophisticated; third, that when they do so they will move toward constraining measures such as those that follow. Analysis of their possible actions is built on two simple models of the market as it exists:

Model A (a three-segment model, in which the major group purchasers buy coverage from a third party, who in turn pays the vendors):

- Major group purchasers:
  - Third parties:
    - Hospitals.
    - Physicians.
    - Drugs.
    - Other.

Model B (a two-segment model in which the first parties deal directly with the second parties):

- Major group purchasers:
  - Hospitals.
  - Physicians.
  - Drugs.
  - Other.

In the following section, this paper considers each of these models to explore the different strategies they afford the major group purchasers. In the final portion, there are some suggestions regarding the implementation of these strategies and ideas through institutional modifications in the health industry and through experimental research.

IMPACTS INVOLVING THIRD PARTIES—MODEL A

One pattern of involvement of group purchasers in the task of controlling health-care costs and maintaining quality is through the third parties, who so often serve as intermediaries between the purchasers and providers of health care. Despite the fact that the third parties are themselves victims of increasing prices, and despite their occasionally serious losses due to unexpectedly high

claim experience and their own frustration at their inability to contain the health-cost inflation, third parties remain the immediate point of contact of most group purchasers with the health-care system. This seems particularly curious. On the one hand, the Blue Cross and Blue Shield plans are closely affiliated historically and in terms of current board memberships with the principal vendors—physicians and hospitals; and the private insurance companies are mainly in the business of risk control. Neither group has, in the past, considered the sustained, hard-nosed pursuit of lower costs as one of its prime functions. This is not to say that they have been indifferent, but rather that they have not seen their role as one of vigorous bargaining with vendors on the consumers' behalf. On the other hand, their group-purchaser clients, which include some of the most rational, sophisticated, and economically powerful organizations in the country, have diffused their bargaining power in the health area by turning this matter over to the third parties.

As the principal payors of hospital and physician bills, the private insurance companies and the Blues have frequently been criticized for not exercising more of an influence in controlling health costs. Some insurance companies and some Blue Cross and Blue Shield plans, in some ways, have tried to keep costs down. Careful review of claims for surgical fees, follow-up discussions with physicians whose charges were considerably out of line and with local medical societies, direct and indirect involvement with hospital boards of directors have all been tried by some companies. The effects are not measurable, but obviously have not been adequate. Several Blue Cross plans have tried to stimulate efficiencies in hospital operations through incentive provisions in proposed reimbursement formulas and through suasive processes. Hospitals have, by and large, successfully resisted these attempts. Blue Shield plans have been somewhat more effective in helping to establish pre-set medical fees for lower-income subscribers.

However, once this is said, it is clear that still more needs to be done. More active programs of restraint on the part of individual third-party organizations would be very costly, and their success would be uncertain even in the short run. In the longer run, if a few such organizations were to initiate a program of restraint, their extra costs and possibly worsened relations with the medical profession and with hospitals would soon put them in a competitively untenable position. This is in the sense that if a few companies were to charge a price adequate to cover their costs, their customers would shift to other companies. It does not follow that if all the third parties acted together the same result would occur. But stimulation by an outside consumer force might lead to a greater willingness on their part to incur these economic and political costs. An expansion on this thought appears later.

What, then, can major group purchasers do to control the costs and quality of medical care through third parties? From the viewpoint of the public, most of whom pay for their health care through these third parties, the price of care consists of two sets of costs: the internal costs (including any profits) of the financial intermediaries and the prices charged by the providers of health care. It seems to me that the major group purchasers can, in the three-segment model, influence costs in both these areas through impacts on products specifications, by consumer education, through influence on third-party administrative costs, and directly on medical and hospital prices.

Product specifications

It has been pointed out by many observers that socially noneconomic health services are often provided or prescribed because it is advantageous for an individual patient. One commonly mentioned example is the utilization of hospital facilities for simple procedures that can be done in an office or a convalescent home, solely because the former are covered by a hospitalization policy while the latter are not. It has also been pointed out that the huge variety of health plans that are available makes it impossible for most purchasers to evaluate plans comparatively because of differences in coverages, levels of benefits, and claim-payment policies. It seems to me that major group purchasers can do something about each of these.

Comprehensiveness of products.—Group purchasers can push for plans that are more comprehensive (I differ from those who say that completely comprehensive prepaid plans are needed now. Such plans—at this time—would lead to abrupt increases in the demand for additional services and, with the well-known shortages in the supply of health resources, further price increases). More comprehensiveness is needed to avoid the common misallocations of scarce resources occasioned by today's usual restrictions. There are, admittedly, risks

of abuse in any steps of this type, but how can progress be made without risk, and how can management policies be formulated to reduce these risks until actual experience is obtained?

Standardization of products.—Group purchasers can take more initiative in developing specifications of what they want, in detail, in a prepaid health plan, be it of an indemnity or service type. Some large groups have been conspicuously successful in doing this, usually because of union pressures, exercised through the collective-bargaining process. The Steelworkers, Auto Workers, and Mine Workers have used this approach on a national basis for almost two decades; the Clothing Workers for even longer. Some local collective-bargaining units also have initiated similar programs. But, in general, the group purchaser still relies upon the third parties for development of package plans and for proposals. Group purchasers, in so doing, invite confusion and nonrationality because they cannot usually make knowledgeable cost-benefit analyses of the different proposals. It would be much simpler to specify what is wanted and then to obtain bids from several third parties. This would tend to force the third parties to compete on economic grounds, with all the concomitant pressures, for cost control and more efficiency.

A big obstacle to this approach occurs, however, in the many cases in which the collective-bargaining procedures that lead to the group purchase result in an agreement on health-coverage expenditures rather than on types and levels of benefits, or in an agreement to give the coverage to a specified third party. (The Steelworkers' one-time preference for having Blue Cross and Blue Shield provided their health insurance is an example of the latter.) In either of these situations, the advantages of competitive bidding are lost. Accordingly, it would be well for labor and management to bargain for health benefits rather than for the amount of money to go into this fringe benefit. I realize this is a much-debated subject and that many arguments can be made for labor-management agreements on health-premium dollars rather than benefit levels, but I suggest that in the interest of injecting the advantages of free competition into at least part of the health industry, emphasis should first be on benefits. Obviously, it would be completely unrealistic to bargain on benefits without some consideration of the price levels involved, but this is a solvable problem, since the number of consulting actuarial firms can be expected to increase to provide this service as it is needed.

Consumer education

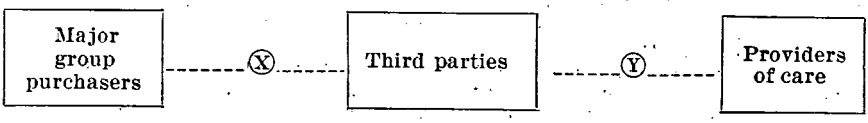
It would be of little avail for sophisticated group purchasers and third parties to develop economic approaches to health care if the consumer remained naive about them. If the consumer does not recognize the value of patronizing accredited hospitals or, most important, does not realize that he is affected by the rising costs of health care even if he does not get ill, and even if his employer pays the entire health-care premium, then, in the long run, group purchasers will continue to face an uphill battle in trying to reduce costs and maintain quality.

The economics and sociology of health care are quite complicated. In our democratic society, public awareness and the resultant support or protest ultimately come to be reflected in private and public policies. For these to be sound, the public' awareness must hopefully be based on fact. In our case, the development and acceptance of policies to control costs will benefit from broader consumer understanding. The group purchasers—union and management—can help accomplish this by programs to teach the consumer such things as how much health care costs, who is paying for it, why there are certain restrictions in coverages that are necessary, alternatives that may have been possible and why they were not taken, the consequences to costs of claim abuses, the pros and cons of group practice and solo practice among physicians, the proper role of paramedical personnel, and the proper role of extended-care facilities other than hospitals.

Factors that are generally considered in attempts to increase the efficiency of an institutional system include the possibilities of effecting more economies of scale, of effecting economies through division of labor, of building in automatic restraints of cost escalations or inefficiences, and of shifting some fuctions to lower-cost alternatives. Persuasive cases can be made for how these suggestions will help realize these possibilities, not only as they apply to the insurance carriers but also as they apply to the providers of health care themselves.

Third-party management policies

As large-scale customers deciding on the expenditure of hundreds of millions of dollars for health insurance each year, the major group purchasers can have a great deal of influence on the management policies of third-party intermediaries. They have had, in many instances, but an area of potential influence in which little has been done is that of the relationship between the third parties and the providers of medical care—sphere Y as diagramed below:



Applications of influence have been primarily in sphere X. In the section that follows, the X sphere will be commented upon, but it is also suggested that sphere Y offers significant opportunities for group purchasers.

Third-party costs (sphere X).—Conceivably, the group purchasers could radically affect third parties' operations. Over the years, they have been instrumental in, among other things, stimulating dramatic reductions in retention rates. According to Louis S. Reed, in 1948, private health insurance organizations (including Blue Cross-Blue Shield plans, insurance companies, and independent plans such as community-consumer programs and employer-employee-union programs) retained 29.7 percent of subscription or premium income. In 1964, the comparable figure was 12.8 percent. Included in these figures are the retention rates for individual as well as group coverages, and the differences are interesting. In insurance companies, the retention rates on individual policies decreased from 62 percent to 45 percent between 1948 and 1964, or more than a fourth. During the same period, the group insurance rates dropped from 30 percent to 8 percent, or almost three-quarters.[6]

It is impossible to attribute any specific share of this dramatic reduction to the direct influence of the group purchasers, because other factors also were at play, but it seems clear that they have been responsible for a significant portion.

Major group purchasers can go further in stimulating additional reductions in the operating and marketing costs of third parties. They can do this in a generalized fashion through an emphasis on more comprehensive plans and more standardized packages, as mentioned earlier. Similarly, a better-informed employee body will tend to enable third parties to operate with lower costs through fewer abuses and more individual-consumer bargaining with vendors. More specifically, and in addition, sample screening of claims by major group purchasers to nip abusers and abuses in the bud, periodic claim reports and analyses, efforts directed toward reducing the hundreds of different claim-reporting forms so that providers could routinize their completion, and other similar steps would have some, although probably relatively minor, effects on costs. A more important step would be to rationalize the commissions paid for group business. Under State laws based upon antidiscriminatory concepts, a commission has to be paid by insurance companies for group business. Accordingly, despite the fact that salaried employees frequently do all the necessary work, a commission expense must be incurred. Some individuals frequently reap handsome rewards for doing virtually nothing. Group purchasers would seem to have an opportunity to help eliminate this economically unnecessary requirement by aggressive action at the State legislative level.

Furthermore, the whole question of an indemnity system of insurance is something for group purchasers to consider. There is a large body of informed opinion that believes that, in Raymond Munts' words, "indemnity insurance is part of the problem rather than part of the solution".[7] For this reason, many purchasers have sought service-benefit coverages, and indemnity-type carriers have shifted some coverages—hospital room charges and major medical provisions, for instance—into a service basis. Consequently, if further investigation proves that an indemnity system of coverage does, in fact, tend to promote higher factor prices and does not deter inferior care, then it would seem reason-

[6] Louis S. Reed, "Private Health Insurance: Coverage and Financial Experience, 1965," *Social Security Bulletin* XXIX (November 1966), 12.
[7] Munts, op. cit., p. 129.

able for the major group purchasers to use their power to do away with such plans.

In this connection, an interesting collaborative idea is being explored by a number of life insurance companies and the Harvard Medical School. Through an exchange of technical assistance and guidance, the insurance carriers and the School are looking toward ways whereby, in the Boston area, the groups of insureds will have the choice of obtaining service benefits from a division of the Medical School. Similiar explorations are now current with other carriers and will certainy be watched closely by other health insurers as well as by hospital administrators and the medical fraternity.

Factor prices (sphere Y).—The curious structure so often found whereby strong group purchasers turn over their buying power to third parties, who in turn are less than effective in controlling either vendor prices or the quality of care, has been remarked upon previously. When the third party expends the group purchasers' funds for health care, what are his responsibilities? What should they be? These are questions which need to be asked and seriously considered, but which are not within the scope of this paper.

Our question is, can group purchasers influence third parties to exercise more vigor in their vendor relationships? It seems to me the answer to this has to be Yes, of course, large purchasers can wield great influence with sellers. However, there are three elements to this: one, the purchasers must act with unified purposes; two, the third parties must reorient their thinking to accept the control activity as one of their primary roles; and, three, the third parties must develop and implement appropriate policies. In the final section, on suggestions, this theme will be expanded.

IMPACTS DIRECTLY ON PROVIDERS—MODEL B

Up to now, this paper has consisted of reflections on how major group purchasers might exercise their considerable influence in stimulating third parties to control costs and prices. Now we turn to consideration of how this influence might be brought to bear directly upon health-care prices—how group purchasers can affect the charges made by the providers of health care.

Direct operation of health-care organizations

There are two strategies that major group purchasers could, and have pursued: one, the direct approach, in which they would support their own facilities, paying salaries to the nonmedical staff and reimbursing the medical staff on some negotiated basis rather than the usual, unilaterally established fee for service. Examples of successful ventures of this sort are the Southern Pacific Employees Hospital Association, the Kaiser Plan, the United Mine Workers' program, and the International Ladies' Garment Workers Union health centers. These programs are each quite different in scope and approach, but are similar in giving their sponsor more administrative control over the costs and quality of health care. This, in turn, is reflected in lower costs and prices.

This is not an easy way to proceed, as evidenced by the rough sailing in one way or another that each plan has had. The hostility of organized medicine, the lack of awarness or appreciation of the individuals in the plans, the conflicting objectives of union politics, comprehensive care, individuals' wants, and adequate funding have all been problems. Yet the fact remains that, through these programs, expenses were constrained, quality care could be sought, and the defenders of the status quo could be shaken and induced to reexamine their position. They were, to some extent, influenced to be competitive either through price-increase restrictions or through the development of new, countering institutions. An interesting one that developed to counter expansion of the Kaiser Plan is the San Joaquin Foundation for Medical Care, which was established by the San Joaquin County Medical Society in California to provide care at predetermined fees, using third-party mechanisms.

Prepayment medical centers.—Given the high interest in health care among many giant unions and many giant business firms, it is conceivable that, if other methods failed to control costs, then these groups could combine to create a national chain of prepayment group-practice centers with hospital, convalescent-home, and nursing-home affiliates. If these centers were open to the community, they would certainly provide a potent competitive force in the marketplace—one that existing providers could not ignore in setting their fees.

Self-insurance indemnity programs.—It may seem a natural corollary to this "do it yourself" approach for major group purchasers to expand their self-insurance indemnity programs. Self-insurance, combined with purchased stop-loss

coverage for extraordinarily high claim experience, would seem a likely way to reduce the prices of health care. Potential savings on a private carrier's marketing costs, the mandatory commissions, contingent reserves, possibly, and the State premium taxes have been estimated by the the Food Employers Council of Southern California at about ten percent. Quite a few employers and union groups have moved in this direction.

It is not clear to me, however, that these savings are permanent or that they compensate in the long run for lost opportunities to achieve economies of scale through specialization of function. There is also a problem, in self-insured group plans, concerning the people leaving the group. With a private carrier, they can ordinarily convert their group certificates into an individual policy, but the self-insured plans usually cannot do this. Accordingly, I wonder under what conditions a self-insured indemnity plan is really more effective; I could not find any defintive analysis of this question. This seems a worthy subject for further study, with results that would be useful to both major group purchasers and to private carriers.

The health-insurance industry, perhaps more now than ever in the past, is competing in a market where the ground rules and even, to some extent, the name of the game are rapidly changing. Union pressures for service-type benefits, new health-care alternatives and combinations of alternatives, Medicare and Medicaid, shifting medical attitudes, Federal concern about costs, and the as yet unknown effects of the Comprehensive Helath Planning and Public Health Amendments of 1966 (Public Law 89–749) make the role of the private carrier a particularly difficult one and call for new adaptions and philosophies.

Management-labor coalition

An alternative strategy open to management-labor groups, besides actually operating health-care organizations, is the indirect one whereby the potential power of major group purchasers to establish their own health-care organizations is assembled and focused in some suitable organization and maintained as a deterrent to capricious increases in prices and careless administrative practices.

A point that cannnot be overlooked in any consideration of how major group purchasers can affect providers directly is the fact that, to some extent, major group purchasers run the private hospitals. The boards of directors of these hospitals are largely composed of businessmen, with an increasing number of union leaders joining them. What often seems to be needed, however, is more recognition by these men of the intermingling nature of their two roles.

SUMMARY AND SUGGESTIONS

Up to this point, this paper has briefly discussed various ideas that major group purchasers might employ to restrain increases in health-care costs and encourage quality care. Actually, of course, these are more than ideas; most. if not all of them, are being practiced by one or more major group purchasers. Yet prices continue to soar.

Does this mean that the strategies are nonvalid? No, I don't believe so. Probably, without them, prices would have gone even higher. It does seem to indicate that a more massive, vigorous application of the strategies is needed to counteract the basic cause of the extraordinary inflation we are experiencing in the health field. The fragmented, partial applications that we have are not enough.

Some stronger force is necessary to negotiate effectively with the providers in the health field. It seems likely that unless some such force develops, the Government will initiate some control devices. It has become a generally accepted function of Government to concern itself with policies to control general inflation; it is simple to expand this perspective to include such a special problem as that of health care.

Reading and reflecting on these issues as summarized in the preceding pages have brought me tentatively to the following beliefs:

First. the rising prices of health care stem. to a large extent, from the noncompetitive markets in which physicians and hospitals operate. This is reflected in the physician's almost unilateral control of his fees and in the hospitals' ability to operate with little regard to economic rationality.

Second, unlike other markets. the bargaining power of the ultimate health-care consumer and his opportunity to shift from higher-priced sellers to more economical ones are very limited.

Third, if the healthful effects of a competitive market are to be introduced in the medical marketplace, a continuing countervailing force that does not now exist will be needed.

Fourth, hospitals are unlikely, of their own volition, to relinquish some of their socially disfunctional high levels of autonomy and independence.

Fifth, the labor and/or management groups have one of the biggest stakes in the game, but have been sitting relatively quietly for a long time. As prices continue to go up and as the Government focuses increasingly on the problem, this group will be increasingly heard from in one or more of the ways described above.

Sixth, there is no shortage of ideas about what should be done. There is, however, a shortage of well-tested ideas and, most important, there is a shortage of ideas of how to get change started, how to get the ideas implemented.

These beliefs, in turn, lead me to the following conclusions: Fundamentally, there is a need for reinstitutionalizing the health-care industry to place the physicians and the hospitals in a posture vis-a-vis the consumer that is more typical of buyers and sellers in other markets.

As prices continue to rise, stronger pressures will build toward change. While this paper has concentrated on possible actions by labor and/or management, it is obvious that the sparkplug role may be taken anywhere in the system—by the vendors, by the third parties, by the Government. But, based on current trends and present orientations, the major group purchasers may well emerge as the major stimulant toward change.

Possible approaches to a competitive environment

What form will this change take? It is hard to say, of course. The situation is complex, and there are many social and political considerations. In this paper we have already mentioned several possibilities. The following discussion concerns these and additional possibilities:

Broad-scale development of prepayment medical centers.—Imagine the effect on the organization of health care and on costs if, in each urban area, there were prepayment community health centers, similar to the Kaiser Plan, available as an alternative to the public. Other hospitals, independent physicians, and drug suppliers would be faced with adequate, but not overwhelming, competition.

Massive self-insurance indemnity programs.—The expansion, by major group purchasers, of their self-insurance indemnity programs is not a likely occurrence; among the major unions, at least, there is a strong preference for nonindemnity-type coverages.

Management-labor coalitions.—Regional coalitions of management and/or labor could bargain and negotiate directly with the vendors of health care, stimulate effectiveness in community health planning groups, institute improved claim-control systems, and in general assume the role of the consumers' representative. There is reason to believe that this type of coalition may be more than a dream. Recently, the California Health Plans Alternatives Committee was established by the Teamsters, Steelworkers, Carpenters, and Longshoremen in the State for this very purpose. It plans to invite members of industry shortly. There are several interesting elements to be observed. First, despite the fact that each of these unions already has advanced health plans, they still feel the need for a more forceful combination. Second, despite differences in philosophy, values, and pay rates, and despite continuing jurisdictional disputes, the unions can cooperate with each other on common problems. Third, despite geographical differences in their organizations and differing relationships with their national unions, these unions can overcome problems of regional autonomy when necessary.

Much of industry is no less concerned about the problem than is labor. It would seem, therefore, that, if a catalytic agent could be found that would bring the major labor and management groups together, it might be possible to form regional combinations that would be large enough to be effective.

A variation of this would be a regional coalition of management, labor, and Government to accomplish these purposes. In some areas, Government may be needed as the sparkplug to get things going. This may be the eventual shape of the comprehensive regional planning activities created under the Comprehensive Health Planning and Public Health Amendments of 1966.

Private-company operation of medical facilities.—A new private company, patterned after the American Telephone and Telegraph Company in State-by-State organization and after the Communications Satellite Corporation in ownership arrangements, could operate the nation's voluntary, nonreligious hospitals and extended-care facilities on a for-profit basis. Owned by public shareholders, with prices and quality regulated by State agencies, such a company would provide the overall planning, direction, and control that are now lacking among hospitals.

With the additional stimulation of the profit motive, and of a size to permit economies of scale and command top-grade management, such a company should be expected to:

1) Remove duplication and fill in gaps of service
2) Eliminate or convert noneconomic hospital plants
3) Purchase centrally
4) Create specialized centers for health care as needed
5) Engage in continuous research and development, leading to improved technologies and new economies of management
6) Find ways to reduce hospital construction costs
7) Find better ways to serve professional staffs—physicians, researchers, dentists
8) In general, operate on a rational, coherent, cost-effective basis.

This company would not be granted a monopoly. Anyone could establish a for-profit hospital. Thus, a competitive element and additional stimulus to efficient management would exist.

Establishment of such a company would be fraught with difficulties and unanswered questions. How would hospitals be induced to join? How would physicians be treated? How would proprietary hospitals fit into the system? Can urgent human health needs be handled in a way that is compatible with profit maximization? Can costs really be restrained if there is a guaranteed maximum-profit rate? These are a few of the serious questions that need discussion and exploration. The difficulties may be more apparent than real, and the potential advantages of this system may be sufficient to justify such further exploration.

Third parties as agents of major group purchasers.—Less drastic, and simpler in some ways to accomplish, would be a new relationship between major purchasers and third parties. It is doubtful that major purchasers are anxious to undertake radical new roles and responsibilities. Third parties, too, would certainly not be enthusiastic about their doing so. This suggests that there is substantial room for a revision of roles wherein the third parties—principally the Blues and the private carriers—would explore new approaches together with management-labor groups. This, in itself, is not new; what is suggested is that it be done with a new "psychological set". The third parties would regard themselves as the agents of the major group purchasers rather than merely as financial conduits. They would, as agents, develop new bargaining relationships with the vendors of care; negotiate contracts with them; encourage competitive buying behaviour by consumers; if warranted, move into service benefits; insist on more effective regional hospital planning; and actually be the countervailing force.

The need for evaluation

In reflecting upon the health-care-cost problem, I have been struck by the lack of conclusive data that can be used for decision-making. In this regard, many people have pointed to the need to experiment with the many ideas that have been promulgated. Actually, experiments of a noncontrolled sort are already in process all over our country. This paper has only briefly touched on a few of these: there are many more. We should think of these as experiments, and we should organize efforts to document what each is doing, to ascertain results, and to evaluate the experiences. It is too bad that such noble ideas as Health Insurance Plan of Greater New York, the San Joaquin Foundation for Medical Care, the program for hospital planning in Allegheny County, Kennicott Coppers' health program in Utah, the food industry's program in Los Angeles, and on and on, are not systematically studied by economists and management specialists so that the needed lessons could be learned.

With the Medicare program coming up for review by Congress within the next twelve months, it would seem in order to undertake an impartial, scholarly study, adequately staffed and funded, to evaluate its effects on health costs and develop recommendations for ameliorating the negative ones. It seems clear that the effects so far have been massive. To the extent that people who would otherwise not have received care did expand the demand, this is good. But any negative effects also need to be identified and evaluated with a view toward their elimination or reduction.

Conclusion

I believe that those who argue for allowing the consumer a substantial number of health-care choices are correct. Tastes and values differ and these differences should be respected.

There are no villains responsible for the soaring costs. What we have are responses to the forces of supply and demand, operating in a unique economic

marketplace. What we therefore should seek to do is reduce the differences in this market through improvements in its organization and productivity.

The sounder social programs are those that evolve because they are right for the time and place rather than those that are superimposed extraneously.

Ordinarily, the best way to create a competitive-market environment where one does not exist is by eliminating the barriers to competition. In the case at hand, however, I have been unable to find or think of any practicable way to put hospitals in a competitive framework, or to set physicians to competing with their associates.

Through regional health planning, it is possible to effect some significant economies among hospitals. But it is doubtful to me that such an approach is a substitute for the sort of buyer-seller price-and quality negotiating that is the essence of a competitive system.

Accordingly, I suggest in this paper that new, countervailing power arrangements be considered and, if deemed worthy, stimulated and nurtured. Through these, the effective, competitive conditions can be developed that are necessary, in my opinion, if health-care prices are to become market-responsive.

Several ideas of what these countervailing power arrangements might be have been presented. The one that seems the best for all, in my opinion, is that in which third parties adopt a new role—that of "agent" for the major group purchasers. In this role, the third parties would maintain their functions of risk control and health-care-money transfer, but in addition would act as negotiators and bargainers with the providers of health care. This would entail major changes in their product, their methods or procedure, and their perception of themselves.

As we look to the future, it seems inevitable that some, if not all, of the participants in the health-care model will have to change their viewpoints and behavior. Current positions are incompatible with our societal and economic values, and now the winds of change are blowing. Some will be actors, and some, reactors. It is difficult to say which group will be which; but certainly the third parties' group would seem from many viewpoints the best candidate for leadership if it can organize. If it doesn't, the task will devolve upon management and labor, or upon the Government.

ITEM 4: LETTER AND NEWSPAPER ARTICLE FROM MARION B. FOLSOM, HEALTH COUNCIL OF MONROE COUNTY, ROCHESTER, N.Y.

OCTOBER 16, 1968.

DEAR SENATOR KENNEDY: The concise summary that appeared in the Democrat and Chronicle of a local study has some relevance to the Congress, I believe. It points to the fact that we need many more facilities and services which will keep persons independent. Specifically we need, as a community, a system of patient evaluation to prevent unnecessary placements in general hospitals, state mental hospitals, and nursing homes. If we are to stop misplacing these elderly people, we, in Monroe County, would require roughly 2,000 apartment units with supportive services, and 2,500 congregate living facilities.

Hopefully, we will be able to move on these problems under the Comprehensive Health Planning Act of 1966 (89-749) and the 1967 Partnership for Health Amendments. I hope there will be opportunity for consultation among the localities, the State, and the Federal government on local-State priorities and action. William J. Curran, Professor of Health Law, Harvard, comments in the American Journal of Public Health, June 1968, in an article entitled "Public Health and the Law: Comprehensive Health Planning: Audacious Law-Making," that "The legislation actually gives the local (areawide) planning agencies no power or authority."

Beyond this, comprehensive planning seems to be inadequately funded, and the responsibility for comprehensive planning is placed well below the Secretary's office in the Department of Health, Education, and Welfare.

We would be glad to send you a copy of the Health Care of the Aged Study if you or your staff would wish one.

Sincerely,

MARION B. FOLSOM.

[Enclosure]

[From the Rochester Democrat and Chronicle, Sept. 23, 1968]

MONROE CRITICALLY SHORT ON AGED CARE

(By Don Byington)

A community study group said yesterday that 41 per cent of the elderly people in Monroe County who need health care are "either receiving no care or the wrong type of care."

It said, for instance, that there are 5,000 persons in the county who are senile—but that most homes for the aged and nursing homes have a policy against admitting these people.

The group, headed by Marion B. Folsom, former secretary of health education and welfare, was composed of leaders in the health field and was generally self-critical.

It put the blame for the current situation on two factors:

An "unsystematic and piecemeal growth of care facilities and service."

A change in emphasis by existing institutions, with resulting gaps.

The five-year study noted that homes for the aged have tended to become nursing homes and that there is now a scarcity of "custodial care" facilities for older individuals who cannot get along by themselves but who do not need all of the health services of a nursing home.

It said that about 20 per cent of the people now in nursing homes fall into this category. They could just as well be in some type of "congregate living facility"—if such a facility were available.

The five-year study of health care for the 61,832 persons in the county over 65 was supported by the Ford Foundation. It was conducted by the University of Rochester's department of preventive medicine and community health, the Health Council of Monroe County and the Council of Social Agencies.

A report by the group also said:

For every elderly person receiving public health nursing service at home, there were four others judged to need it, but not getting it.

Between one-half and two-thirds of older patients were judged to be "misplaced" in terms of the kinds of health facilities and services they were receiving.

There is a need to include mental health services at all levels of care for the aged, as more than half of those in need of care have some kind of mental impairment.

That "sheer chance," such as the action of an ambulance driver, an emergency department attendant, or an admitting clerk, can decide the kind of care an elderly person ultimately receives.

These "temporary misplacements," awaiting openings in the appropriate facility, have a way of becoming permanent misplacements.

ITEM 5: LETTER FROM JAY W. FRIEDMAN, D.D.S., ASSOCIATE RESEARCHER, UNIVERSITY OF CALIFORNIA, LOS ANGELES

JANUARY 14, 1969.

* * * * * * *

DEAR SENATOR WILLIAMS: The main problems confronting our population with respect to dental care are the shortage of personnel and allocated funds, the lack of organized programs for the direct provision of care, and the absence of qualitative standards and administrative controls. These problems apply across the board for all segments of the population. There is little prospect for their resolution in the near future without massive governmental assistance. This assistance will not be forthcoming until the federal government establishes dental health as a major priority among its goals. With these "givens" in mind, I shall comment on your questions.

1. "What, if any, Medicare coverage should there be for dental care?" Complete dental care should be included along with medical care. Dentistry is, after all, a specialty of medicine. The separation of dentistry from medicine is

arbitrary but one cannot arbitrarily separate the oral cavity from the human body.

2. "What advantages and/or disadvantages do you see with regard to coverage of dental care under Medicare?" The major advantage is, of course, the compulsory allocation of funds for this specific purpose to assist the aged in receiving a needed health service they might not otherwise be able to afford. When these programs are attempted on a voluntary basis, there is always the risk of "adverse selection" of participants. But unless well-defined standards are established and adequate administrative controls applied, the surge in demand for dental care can endanger the fiscal soundness of the entire health care program, as happened recently in New York State's Medicaid. The main problem here is to overcome the dental society's traditional opposition to responsible controls—both qualitative and economic. In this latter respect, governmental programs should be based on *fixed-fee schedules* rather than the "usual and customary" fees currently advocated by the dental society.

3. "What, if any, Federal legislation on dental problems and opportunities of the elderly would you recommend?" I tend to feel that the need is not for special legislation directed towards the elderly but rather for the population as a whole. The dental problems afflicting the aged do not differ substantially from those of younger persons. If we were to decide, nonetheless, that programs were to be established for the elderly, then I would like to see the establishment of federally sponsored health centers for the aged based on the principles of group practice and including a dental component. Though not specifically related to the dental problems of the aged, the anachronism of state dental licensing should be eliminated in favor of national licensure to allow dentists greater mobility. Some parts of the country attract more elderly persons. They therefore have greater need for dentists who should not be hampered in their movement by protectionist policies of state professional organizations.

4. "What, if any, Federal programs to *prevent* dental difficulties in old age would you recommend?" Dental difficulties of the aged have their origins in youth. The major preventive achievement in dentistry is fluoridation of public water supplies. Federal legislation should be developed to require fluoridation of all public water supplies to reduce the incidence of dental decay. This single procedure would be more effective and less costly than any programs of repairing teeth once the damage is done. Since the major problems of the aged are related to tooth-loss, it is the prevention of premature tooth loss that is most important.

Group Versus Private Dental Practice

5. "What, if any, legislative or administrative actions by the Federal government would you recommend to stimulate and encourage greater use of dental auxiliaries?" Again, we need to eliminate the archaic state restrictive controls by developing rational national enabling legislation to permit more sophisticated use of dental auxiliaries. The main concern is that the average private, solo practitioner may himself not be sophisticated enough or trustworthy enough to pass on the economic advantages of auxiliaries to the consumer. More important, however, is that greater controls are necessary to assure quality. But it is extremely difficult to exercise controls over solo practitioners. Also private solo practice is very inefficient. In a detailed study of a group dental practice in Los Angeles I have found the group practice to be 50 to 90 percent more efficient than the average private dentists. I feel it is extremely important that the Federal government assist in the organization and financing of group dental practices no only for its economic advantages but also for its potential of greater production of services, i.e., more care for more people. These groups could be even more productive if they were allowed to expand the functions of auxiliary personnel.

A very important area for investigation is the training and utilization of dental hygienists. These persons, mainly women, are in the main grossly overtrained for the services they provide. This field should be opened up to men as well as women. There is need for a large number of lesser skilled persons to do routine prophylaxis (cleaning) and for more highly trained dental hygienists who would really be periodontal therapists. The Federal government should actively promote developments along these lines.

6. "Is there a shortage of dental auxiliary personnel, and, if so, what Federal action would you recommend to cure this shortage?" I have already commented on some aspects of this question. Given adequate numbers and utilization of auxiliaries it is possible that there are almost as many dentists as are required.

At any rate, regardless of whether there are enough dentists or not, there is a vast shortage of certain types of auxiliaries—mainly dental hygienists or their equivalent. We have approximately 100,000 active dentists in the United States but only 8,000 dental hygienists. We probably need as many hygienists as dentists since prophylaxis is one of the most important preventive procedures. For example, past age 35 most teeth are lost from pyorrhea which has its origins for the most part from tartar deposits on the teeth. Therefore, preventive oral hygienic procedures are directly related to the ultimate dental health of the aged, provided they are begun early in life and continued periodically.

There is also a shortage of skilled dental technicians. This would become worse with the expansion of prepaid group practices, especially if technicians were to be employed on the staffs. Currently, most training of dental technicians is by commercial firms, vocational schools, and apprenticeship. I would like to see Federal support given to the development of dental technician training schools in university dental schools so that dental technicians and dental students can learn to work together from the beginning of their careers.

But again, all of these suggestions are based upon a higher degree of organization of health care services, mainly through development of group practices. Training of more personnel will be wasted if there do not exist organizations capable of employing them. Solo practice is too inefficient to employ the variety and numbers of auxiliary personnel that are necessary to maximize productive efficiency.

MEDICAL AND DENTAL NEEDS OF ELDERLY

7. "How well do you think Medicaid (Title XIX) is serving the dental needs of the elderly, and what, if any, recommendations would you have for making this program more responsive to the dental needs of this age group?" Medicaid is not serving very well for the simple reason that the majority of eligible persons fail to utilize the programs. In California, for example, probably not more than 15 percent of eligibles seek dental care in any one year, and California has one of the best programs in the nation. Those that seek care do not necessarily receive the best care since preventive services often are valued lower (re: fees) than prosthetic services such as dentures. Dentists can make three or four times as much per hour on dentures as compared with filling and cleaning of teeth!

Another problem relating to elderly persons eligible for Medicaid is the maldistribution of dentists. Dentists tend to locate in the middle class areas, not the urban ghettos where most of the aged poor reside. Therefore, programs should be developed to bring dentists to these areas. The best way would be for the state and/or federal government to establish group practice programs in these areas. The key to the success of these programs is good administration. Unfortunately, there appears to be a dearth of good dental administrators in this country. We urgently need training programs developed in schools of public health in dental care administration. These programs require Federal financing since the universities do not have the funds to support them locally.

8. "To what extent do you believe that failure or inability to receive proper dental care results in medical conditions covered by Medicare, thus forcing Medicare expenditures by the government and individual which could have been prevented?" Not much. I am enclosing the complete paper on "Dentistry in the Geriatric Patient: Mutilation by Consensus" which expressed my views on this matter quite completely. (The article brought to your attention was abstracted from this paper).

I am not satisfied with these brief responses. But your questions were so comprehensive that anything less than a dissertation with background and supporting data for the opinions expressed would be unsatisfactory. Nonetheless, I hope you will find these remarks for some interest and value. Needless to say, I would be glad to offer assistance (and opinions) in the future since we share common concern for the well-being of our compatriots—old and young together.

Sincerely,

JAY W. FRIEDMAN, D.D.S., M.P.H.,
Associate Researcher.

[Enclosure]

EXHIBIT A. DENTISTRY IN THE GERIATRIC PATIENT*

MUTILATION BY CONSENSUS

(By Jay W. Friedman, D.D.S., M.P.H.)

Approximately 50% of Americans have lost all their teeth by age 65. More than two-thirds are totally edentulous by age 75.[1] It is obvious that dental care for the geriatric patient is overwhelmingly characterized by the extraction of his teeth. This massive destruction of the mouth is not the result of an insidious, unpreventable disease process of aging. Rather, it is the result of little concern by the public for the preservation of teeth, and the regressive social character of the dental profession which has the technical knowledge but has failed to develop the manpower necessary to apply it on a universal scale. To be sure, there are degenerative processes of the oral mechanism with aging. But these processes can be modified to such an extent that the vast majority of the population could retain teeth throughout life.

The degenerative dental condition of the geriatric patient generally is a product of cumulative neglect which begins in childhood and progresses to a state of partial and then total edentulatism (Fig. 1). But neglect is not a simple function of disinterest or negativism, although both these attitudes are present to an alarming degree. It is also a function of relative social, economic, and health values. Little social stigma is attached to loss of teeth even though we have advanced beyond the stage where it is viewed as a "coming of age." Economically, dental care is relatively low on the priority of expenditures. The simple fact is that the United States is a commodity culture in which the acquisition and consumption of manufactured goods are conditioned needs taking precedence over what are considered nonessential health care services. Although dental neglect *inevitably* leads to pain and infection which require treatment, the loss of teeth either singly or totally does not represent a significant health hazard. Conditions leading to the loss of teeth may be hazardous to health, but once the teeth are lost the person is nearly the same physiologically. However, there may be serious social and psychological hazards which have untoward effects on the person's well-being.

To place these remarks in perspective, the function of the dentition, the diseases that ravage it, and the knowledge and techniques that are known to preserve it are reviewed.[2]

Function of the dentition

The most obvious function of teeth is the mastication of food in preparation for digestion. Incisors are designed for tearing and cutting up food and molars for shredding and grinding it prior to swallowing. Saliva lubricates the food bolus and supplies enzymes which begin the digestive process in the mouth. Prior to forks and knives, this process undoubtedly was of great importance. But with the development of processed foods and the emphasis on the soft texture of cooked foods the physiologic importance of mastication has declined. Edentulous persons do not necessarily suffer from an inability to masticate foods properly. Prehistorically, human teeth also functioned as weapons of aggression and defense as they do presently among the lower animals. However, man has subsequently developed more efficient weapons. Teeth also are sexual symbols as evidenced by their implied virility in the advertising media. Loss of teeth can be equated with loss of virility which is certainly an important psychological factor in the process of aging. Therefore, the geriatric patient may accept the loss of his teeth, but want them replaced with an esthetically attractive artificial denture. Teeth also are important in speech. Many sounds are dependent upon the position of the tongue and lips against the dentition. Yet it is apparent that edentulous patients are not at a loss for words, so this function also should not be overemphasized. In short, teeth have their functions but they are not *essential* to the longevity of the species in the modern world. It would be a grievous error, however, to view the dentition as a dispensable vestige with little more significance than the appendix.

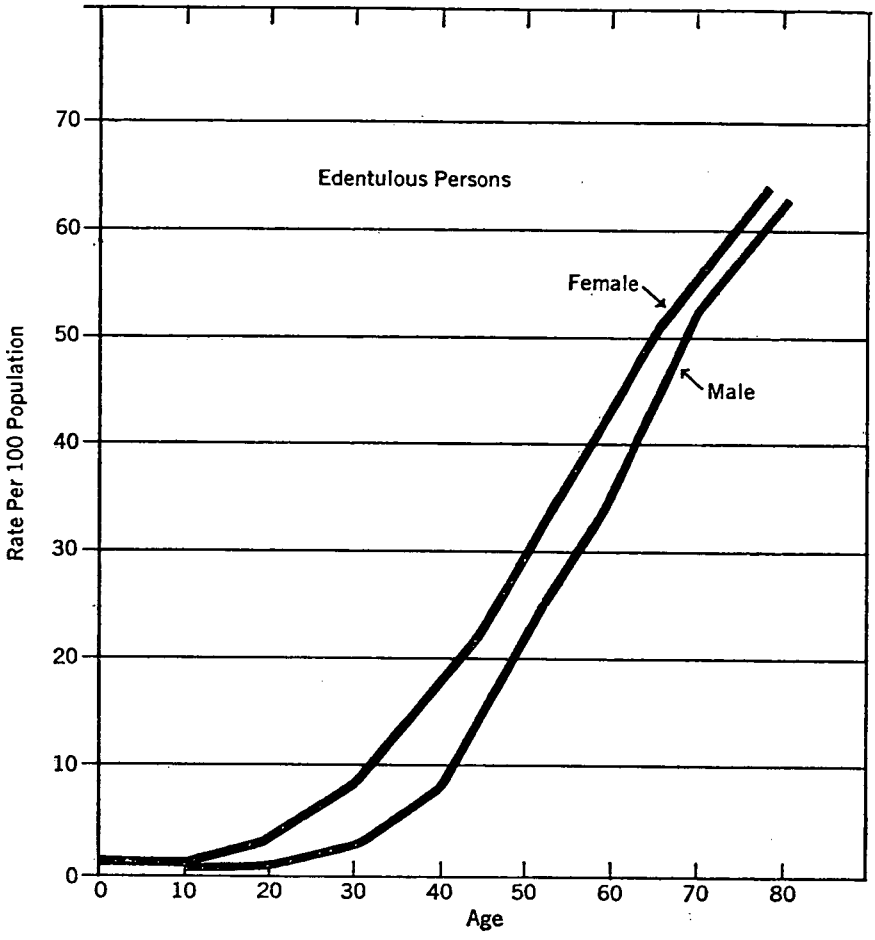
---

* Reprinted from Geriatrics, Vol. 23, pp. 98–107, August 1968.

[1] Loss of Teeth, Health Statistics from the U.S. National Health Survey: U.S. Department of Health, Education, and Welfare, Public Health Service, PHS Publ. No. 585–B22. Wash-

[2] Current Therapy in Dentistry, Vols. 1 and 2. Edited by H. M. Goldman, S. P. Forrest, D. C. Byrd, and R. E. McDonald. St. Louis: The C. V. Mosby Co., 1964.

FIG. 1. *Rate of edentulous persons per 100 population by sex and age**



*U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE. PUBLIC HEALTH SERVICE. HEALTH STATISTICS FROM THE U. S. NATIONAL HEALTH SURVEY: LOSS OF TEETH - P.H.S. PUB.584-B22

Diseases of the dentition

Although many systemic diseases manifest symptoms in the oral cavity, the science and art of dentistry is mainly concerned with diseases of the dentition, foremost of which are dental caries and pyorrhea. Dental caries occurs commonly in children with the eruption of the primary molars. It continues throughout life and is the greatest cause of tooth loss up to age 35.[3] Periodontal disturbances also occur early in life, mainly as gingivitis. But gingivitis in childhood and early adolescence usually is without clinical significance. With the increased deposition on teeth of calivary calculus that occurs during late adolescence and continues throughout life, the gingiva become irritated and eroded. If the calculus is not removed periodically, irreversible degenerative changes in the periodontium—gingival and bony tissues and the periodontal attachment—may occur which lead to loosening and eventual loss of the teeth.

[3] Pelton, W. J., Pennell, E. H., and Druzina, A.: Tooth morbidity experience of adults. J. Amer. dent. Ass. 49 :439, 1954.

This process—pyorrhea—is the greatest cause of tooth loss after the third decade of life.[4] Most pyorrhea is produced by the physical presence of calculus. It is therefore preventable by early and periodic removal of calculus. Another form of pyorrhea, periodontosis, appears to be unrelated to calculus deposits. It is characterized by rapid dissolution of the dental alveolar bone, the cause of which is unknown, in contrast to the slow progress of calculus-induced pyorrhea. Fortunately, periodontosis is a relatively uncommon dental disease.

Many other diseases of the hard and soft tissues of the mouth, including cysts and carcinomas, affect the teeth and other oral structures.[5] Functional conditions such as malocclusion, temperomandibular joint disturbances, and pernicious habits involving the tongue, lips, and swallowing process may require corrective dental treatment. Also, traumatic injuries and fractures of the jaws come under the purview of the dental profession.

Systemic diseases such as blood dyscrasias, diabetes, and epilepsy under Dilantin® therapy commonly cause inflammation and hypertrophy of the periodontal tissues. Avitaminosis, a frequent occurrence in the aged, may be associated with cheilosis. Also, individuals suffering from vitamin deficiencies as well as those who have recently completed antibiotic therapy may be more susceptible to acute and chronic monilial infections. Localized diseases of the periodontium, such as trench mouth and dental abscesses, may produce generalized systemic infection which is characterized by fever and, if untreated, septicemia. Dental extractions or even gingival curettage—cleaning of the teeth—produce transient bacteremias which can cause subacute bacterial endocarditis in those patients with a history of heart damage due to rheumatic fever.[6,7]

While some dental diseases occur more commonly at different ages in life, few can be considered age-specific. However, physiological and functional changes occur with aging that may affect the course and the success of dental treatment. The oral mucosal lining tends to become thinner and less resilient and thereby more susceptible to pressure ulceration from artificial dentures. Salivary flow may decrease, causing dryness of the mouth which makes denture retention more difficult. The enamel of teeth may be worn off the occlusal and buccal surfaces, creating sensitivities and greater susceptibility to dental caries. The temperomandibular joint is subject to wear, especially the articulating disc. Also, decrease in vertical dimension, the distance separating the mandible from the maxilla, occurs with loss or excessive wear of teeth. The resultant change in the articulation of the mandible may be accompanied by temperomandibular joint pain and, in extreme cases, impairment of hearing. When teeth are lost, the alveolar bone forming the supporting ridges for dentures is gradually resorbed. Thus the elderly patient's jaws frequently present flat ridges that are inadequate for the stabilization of artificial dentures.

Of particular interest to physicians caring for geriatric patients is the "theory of focal infection" as it pertains to the teeth. A few decades ago it was not uncommon to have physicians and dentists recommend the removal of suspicious teeth in the hope of curing rheumatism and arthritis. But it has long since been demonstrated that asymptomatic teeth, including those that are nonvital or have been devitalized by root canal therapy, do not serve as foci of infection. Therefore, teeth should only be removed for sound dental reasons and not on the presumptive hope that cures for systemic diseases will be effected.[8]

Prevention and treatment

The most common dental diseases of caries and pyorrhea cannot be entirely prevented. However, the incidence of dental caries can be reduced by 60% through the fluoridation of public water supplies.[9] A further decrease can be effected by the reduction in the consumption of refined carbohydrates.[10] Unfor-

---

[4] Peridontal Disease in Adults. U.S. Department of Health, Education, and Welfare, Public Health Service, PHS Publication No. 1000 Series 11, No. 12, Washington, D.C.: Government Printing Office, 1965.

[5] Bhaskar, S. N.: Synopsis of Oral Pathology. St. Louis: The C. V. Mosby Co., 1961.

[6] Brandt, C. L., Korn, N. A., and Schaffer, E. M.: Bacteremias from ultrasonic and hand instrumentation. J. Periodont. 35:214, 1965.

[7] Handbook of Dental Practice. Edited by L. I. Grossman. Philadelphia: J. B. Lippincott Co., 1952.

[8] Grossman, L. I.: Focal infection. Dent. Clin. N. Amer. Nov. 1960, p. 749.

[9] Fluoridation as a Public Health Measure. Edited by J. H. Shaw. Washington, D.C.: Amer. Ass. Advancement of Science, 1954. Also see J. Amer. dent. Ass. Vol. 71, No. 5, November 1965 for more recent papers on facts and issues in the fluoridation controversy.

[10] Jay, P., Beeuwkes, A. M., and Hughey, M. J.: Dietary program for the control of dental caries. In: Lippincott's Handbook of Dental Practice. 3rd ed. Edited by L. I. Grossman. Philadelphia: J. B. Lippincott, 1958.

tunately the food industry caters to the "sweet tooth" of the populace as well as playing a determining role through advertising in the development of dietary habits. Although the modern diet may be nutritionally adequate, from the dental viewpoint it is too soft to provide proper stimulation of the gingival tissues during mastication and serves as a feeding ground for the complex bacterial and chemical decay process. Nonetheless, dental caries can be effectively treated by the removal of the areas of decay and the restoration of the teeth with fillings and crowns. Teeth need seldom be lost due to this disease.

Pyorrhea is also largely preventable, as mentioned, through the semiannual or annual removal of calculus deposits on the teeth. Relatively sophisticated techniques have also been developed for the preservation of teeth that have already experienced loss of supporting alveolar bone. But as yet, there is no public health method comparable to fluoridation for the prevention of pyorrhea. Dental prophylaxis must therefore be carried on throughout the life of the individual.

Some problems of dentures

Given proper periodic dental care, there is little reason for the geriatric patient to lose his teeth. Yet, in the United States perhaps only 10% of the population receives adequate care.[11] For example, in any one year it is estimated that only 40% of the population visits the dentist at least once, most likely for the removal of teeth. Half the population by age 65 has or needs artificial dentures. But far from having solved the problem, the average denture patient has a sore mouth, dissatisfaction with his chewing capacity, and the fear that his teeth will come loose at embarrassing moments. Many elderly patients have given up chewing with their dentures and use them only for appearance in social situations. Although temporary stability may be obtained by use of denture adhesives, it is very short-lived and denture wearers find these powders and pastes literally distasteful.

It is debatable if there is such a thing as a well-fitting denture, although maxillary dentures are more easily retained and provide considerably more satisfaction than mandibular dentures. The reason is that both dentures "float" in the mouth during function, and the mouth is in constant movement even during sleep. Nevertheless, there are definite criteria for the proper fit of dentures, such as the maximum area of the base support that the tissues and musculature can tolerate, the correct centric relationship of the opposing dentures, and the proper vertical dimension. Even though these criteria are met, the success of dentures is still dependent upon the individual's adaptive capacity. Generally, the younger the patient, the more successful the adaptation. The subjective element is so great that even poorly fitting dentures can be worn successfully by some individuals, whereas many have the greatest difficulty with dentures that satisfy all known functional requirements.

As the patient ages, it is important that radical changes not be introduced by the dentist simply to satisfy the textbook criteria. This error most frequently occurs when an elderly patient decides to have a new set of dentures because the teeth are cracked or the denture base looks unattractive, although he is otherwise satisfied with the fit of his ten- or twenty-year-old plates. In these cases the patient's separation of maxilla and mandible has decreased. He has what dentists call a "closed bite." It may be the result of an original error in which the artificial teeth were too short or the alveolar ridges may have been resorbed under the dentures. Proper vertical dimension is itself an arbitrary concept which may vary as much as five millimeters without violating the principles of sound denture construction. The over-enthusiastic dentist may decide to restore the geriatric patient to a 35-year-old level of vertical dimension to improve his profile and make his teeth show more. While this procedure is most likely indicated for the 50- or 60-year-old patient, it is hazardous for the very elderly who have accommodated successfully to the gradual closing of their bites.

Ill-fitting dentures can represent hazards other than occasional sores and generalized dissatisfaction. In particular, constant irritation of the oral mucosa can produce cancerous lesions. These lesions occur most commonly along the periphery of the dentures. In the early stages they cannot be distinguished from pressure sores. However, if the ulcerations persist beyond ten days or two weeks after mechanical relief or adjustment of the denture, biopsy examination is indi-

[11] This is based on the fact that "only one-tenth of the population accounted for about two-thirds of all dental visits." (Blue Cross Reports. Dental expenditures, utilization, and prepayment. Sept.-Oct. 1963) But whether the consumption of the bulk of dental services really implies "adequate" care must remain moot until adequacy is defined and measured.

cated. With or without sores or dissatisfaction, most dentures require rebasing or replacement about every five years to readapt them to changes in the supporting tissues caused by alveolar resorption. It is generally believed that less alveolar resorption occurs under well-fitting dentures.

Alternate choices

For the most part, the upper dentures are easily constructed and well tolerated by patients. When there are only a few sound maxillary teeth left few dentists would hesitate to recommend a complete denture. Such is not the case for mandibular dentures. In contrast to the board, relatively immobile maxilla which provides a wide base of support for denture stability and retention, the mandible forms a narrow horseshoe shape. In addition, the peripheral mucobuccal fold of the mandible is far more active as a consequence of the greater mobility of the mandible. The lower lip, the tongue, and the sublingual musculature are in vigorous motion during speech and swallowing. The effect of these actions is to unseat the lower denture. For this reason, mandibular teeth should be maintained as long as possible to provide anchors of retention for partial dentures. Even if there are only two cuspids remaining they should be retained rather than removed for a complete lower denture. The reason for citing the cuspids is that they tend to be least susceptible to pyorrhea by virtue of their long, strong roots, and are more likely to be present in the geriatric patient.

In this brief review of the major dental problems of the aged, mention of fixed bridges has been omitted. Certainly, fixed bridges are indicated for the replacement of natural teeth wherever possible. When too many teeth have been lost or the cost of fixed restorations is prohibitive, partial dentures should be constructed. Full dentures are a last resort, and are the consequence of oral failure.[12] When the cost may run into thousands of dollars, alternative treatment plans rather than full dentures are frequently little more than exercises in fantasy.

Locales of treatment—the private office and the hospital

The preceding discussion is intended to provide a broad background of common conditions that are applicable to the population at any age and to indicate that the main geriadontic problems result not from aging but from neglect. Responsibility for this neglect falls upon the public which readily accedes to its consequences. But it must be shared also by the dental profession which has in the past opposed the development of auxiliary manpower and methods of financing care to meet the needs of the population. Only within the last few years has the profession seriously addressed itself to this problem of auxiliaries, although the level of experimentation is often ludicrous in light of known accomplishments elsewhere.[13] Thus, the vast majority of the population arrives at old age with the complete destruction of its natural dentition despite the fact that the dental profession has the scientific knowledge and technological ability to avoid it. A revolution in our social values is required to overcome this mutilation by consensus.

Meanwhile, there are some practical considerations that are of special concern for the dental care of the geriatric patient. Foremost of these is his state of ambulation. Dental care is most effectively performed in a well-equipped office. The responsibility of the physician is to ensure that his patients seek and receive necessary dental care, especially with regard to elimination of present and potential oral infections. The relatively well ambulatory patient is easily referred to a private dentist, provided he can afford treatment. The nonambulatory patient presents a special problem. Since many of these patients have been, will be, or are hospitalized, they should receive needed care before being discharged from the hospital. Therefore, every hospital should have completely equipped and staffed dental facilities.[14] All patients should be required to have a dental examination and necessary treatment should be provided before discharge to those who are unlikely to receive it afterwards because of anticipated immobility. For the geriatric patient, the treatment most likely needed is removal of infected teeth. It would be easier and safer to perform this minor surgery in a hospital rather than to await an acute toothache or infection in a nursing home that lacks adequate facilities.[15] Also, the hospital concentrates patients, thereby making best

[12] Friedman, J. W.: A Basic Guide to Qualitative Standards for the Evaluation of Dental Care Programs (mimeo). Los Angeles: UCLA School of Public Health, 1965.

[13] Hillenbrand, H.: Keynotes: an address to dental examiners and dental educators. J. Amer. dent. Ass. 74: 1464, 1967.

[14] Weyer, I. E., and Casey, G. J.: Planning the dental unit. Am. Hosp. A. J. 41: 69, 1967. For methods of practice, see B. L. Douglas and G. J. Casey, eds. A guide to hospital dental procedure. Chicago, Am. Dent. Assoc., 1964. 195 pp.

[15] Douglas, B. L.: Dental care for the aged. N. Y. J. Dent. 29: 53, 151, 1963.

use of dentists' time. Programs have been developed for the provision of care in nursing homes and the patient's home.[16 17] I consider them inordinately wasteful of dental manpower which is already in short supply.

For dental care to be incorporated into hospital practice the physician must pay more than lip service to the concept of treating the whole patient rather than the admitting diagnosis. Many hospital staffs govern themselves according to the by-laws of the medical *and* dental staff. But even in those hospitals that have rather highly developed medical staff organizations, dental participation is most often limited to oral surgeons with the consequent emphasis on maxillofacial and interoral surgery rather than preventive and restorative dentistry. More recently, a number of hospitals have instituted well-equipped dental facilities for restorative treatment of patients under general anesthesia, especially those suffering from cerebral palsy and similar disabilities. However, only a few of the larger governmental hospitals such as those operated by the Veterans Administration include normal dental care in the total medical care program. In these hospitals newly admitted patients are screened by dentists and care is provided where it is deemed supportive of the general medical condition. For example, a long-term diabetic patient may receive dental treatment whereas a short-stay patient with a limb fracture may not. For this approach to be effective, general dental practitioners and prosthodontists must be present on the hospital staff and directly involved in diagnosis and treatment.

The manpower problem

Concerning the larger issue of dental manpower and especially the creation and expansion of duties of auxiliaries, the medical profession's passive attitude toward dentistry requires alteration. Dentistry is, after all, a specialty of medicine. What is true of medicine generally therefore is applicable to dentistry. As a corollary, the orthopedist is not expected to construct and fit prosthetic appliances or to personally train the patient in their use. Put another way, state medical practice acts do not specifically prohibit medical technicians from looking at, much less touching, patients. Yet, that is the status of dental practice legislation in this country. The law specifically prohibits dental technicians and assistants from taking impressions and fitting dentures. Laboratory technicians are even prohibited from taking the shade of the patient's natural teeth in order to match the color of prosthetic appliances, a process that requires visual but hardly physical contact. In order to remove tartar and stains from the exposed surfaces of the teeth, one must be either a licensed dentist or hygienist. There are historical reasons for these restrictions, but abuses of the past do not necessarily form a rational basis for present practices. Certainly it is not proposed that inadequately trained or unlicensed individuals be allowed to practice dentistry, rather that more rational practices be adopted in accord with present needs. Given adequate organization and surveillance controls, lesser trained auxiliaries can perform many dental tasks without jeopardy to the public. Indeed, this has been the experience of medical practice and there is no reason why it should not be applied to the practice of dentistry. Without this application there is absolutely no possibility of preventing the destruction of the natural dentition with or without the consensus of the public.

As stated previously, the American dental profession no longer opposes the expansion of the role of auxiliaries as such. It is even engaged in experiments to determine the feasible parameters of this expansion. Hundreds of thousands of dollars are being expended to discover if dental assistants can take study impressions as well as dentists or place amalgam in prepared cavities.[18] Many elements of the profession consider these experiments audacious if not outrageous, whereas others cite them as indicative of a progressive posture. However, these experiments are little more than simple demonstrations of the obvious, which has been known for nearly half a century. To be specific, New Zealand has been training school dental nurses since the 1920s.[19] These nurses are trained in a two-year course to perform fillings, extractions, and other procedures for children. They work independently in dental operatories located in public schools. Parentheti-

[16] Douglas, B. L.: Dental care for the special patient (handicapped—chronically ill—aged.) Practical Dent. Monographs, Jan.–Feb. 1966. 28 pp.

[17] Waldman, H. B., and Stein, M.: For the Chronically Ill and Aged—A Plan for Total Dental Services (mimeo). Cleveland: Western Reserve University School of Dentistry, 1967.

[18] Hammons, P. E., and Jamison, H. C.: Expanded functions for dental auxiliaries. J. Amer. dent. Ass. 75: 658, 1967.

[19] Fulton, J. T.: Experiment in Dental Care; Results of New Zealand's Use of School Dental Nurses. (WHO Monograph Series No. 4) Geneva: World Health Organization 1951.

cally, restriction of their services to children represents an economic concession to the dental profession rather than being based on differential skills, since children are often more difficult to work on than adults. Thus, New Zealand's school dental nurse program has not advanced internally much beyond its original design. But it has demonstrated that lesser trained auxiliaries can effectively perform many dental procedures far more sophisticated than those presently under consideration in the United States.

Other countries are responding to the dental needs of their populations by adopting the New Zealand approach.[20] While most of these countries are designated as underdeveloped such as Ceylon, Singapore, Malaya, Thailand, Indonesia, and Ghana, it is also being adopted in more advanced nations such as Great Britain and Canada. However, by dental standards, *all* nations are underdeveloped and it is only a matter of time before the New Zealand pattern is adopted universally. Concerning the major needs of the geriatric population, such as dentures, Canada already has legalized denturists who are specially trained and licensed technicians.

The future

What do these developments portend for the future of dental practice? With the expansion of the numbers and duties of auxiliaries, dentists will be relieved of the vast bulk of simple mechanical procedures that presently consume most of their time. They will be able to devote themselves to the practice of dental medicine. Problems of growth and development of the oral structures will receive greater attention, resulting in more preventive and interceptive treatment. Oral and maxillofacial surgery, advanced periodontal therapy, and orthodontics will most certainly remain the prerogatives of the dentist. Prosthodontics will be more concerned with the correction of oral clefts, traumatic injuries, and defects caused by cancer than with the construction of dentures for edentulous persons. As a consequence of these developments, more dentists will practice in hospitals. Also, more group practice clinics will be developed which employ auxiliaries to perform the simpler tasks under the direction and surveillance of fully qualified dentists.

In view of these prognostications, it is possible that the current concern over the shortage of dentists is misplaced. What may be needed is not more dentists per unit of population but more and better trained dental auxiliaries. Otherwise we must place our hope in the discovery of immunization against dental decay and pyorrhea, or else consign the majority of the population to the eventuality of edentulism. Though hope springs eternal, the stuff of progress is pragmatism.

ITEM 6: STATEMENT OF SEYMOUR E. HARRIS, UNIVERSITY OF CALIFORNIA, SAN DIEGO

October 28, 1968.

In reply to Senator Williams invitation, I comment on some aspects of the health problems of the aged.

MEDICARE

Of course Medicare greatly improves and extends health services for the old. The net effect of Medicare is to pour several billion dollars into the pool of medical resources available to the old. In 1968, thru OASDHI (health insurance for the aged) $4½ billion in benefits were received. (S.S.B., September, 1968, p. 3). Before the introduction of Medicare, the old accounted for about 9 per cent of the population and considerably more than 9 per cent of medical costs; but also obtained considerably less than the medical needs of this age group. Should, for example, $5 billion additional be made available to the old, then total medical resources for this age group might well double.

DRAIN OF HOSPITALS

Unfortunately the net gain to the elderly is much less than might be suggested by the additional funds thus being made available under Medicare. One reason for this result is the diversion of part of the additional funds to the hospitals which use medicare as a means of improving their financial position. The disposition now is to increase charges for the elderly and thus reduce the excess of hospital costs over charges. The additional resources thus obtained by the hos-

[20] Grayland, E.: The Colombo plan brings dental health to Asia's children. CAL Magazine 29 : 8, 1967.

pitals reduce the net gains of the elderly. Medicare has in part become an institution for making hospitals financially viable.

The availability of several billions additional per year also tends to increase costs of operating hospitals and thus cuts gains of the elderly. With hospital costs rising by about 15 per cent a year, the recovery of additional costs is facilitated by payments under Medicare. But the new resources made available also tends to make possible large rises in pay of hospital workers.

The Somers in their recent book on "Medicare and the Hospitals" have raised a vital question. Hospitals are guaranteed recovery of costs. With such guarantees and with no other restraints, are not costs likely to rise at an unacceptable rate? Indeed, the major reason for the current rise in hospital costs may well be the low pay of the past which is not easily tolerated in a full employment economy. But surely the inflow of medicare cash facilitates the rise in pay of hospital help. The new resources, however, do not merely facilitate increases in pay scale; they also assure a greater supply of labor for the hospital and hence to that extent facilitates improved service. Without the increase of funds and the accompanying rise of pay scales, the hospitals would be confronted with serious shortages of labor in a full employment economy.

Doctors and other health personnel necessarily profit from the increased cash thus being injected into the system. The large rise of income for physicians post-medicare is explained to a considerable extent by the billions being poured into medicare. The physicians' incomes rise as with slow response of supply of doctors to rising demand, incomes automatically rise. On top of that many physicians seek higher rate of pay by pushing for direct reimbursement by patients rather than obtaining compensation thru the intermediary of the hospital. Hence with the inflow of medicare dollars, the struggle between hospitals and physicians for a greater share of the medical dollar is intensified.

DOCTORS' COMPENSATION

In the discussion of recent advances in medical costs, there is some disposition to adhere to the position that medicare has not improved the economic status of the doctors.[1]

I do not subscribe to this interpretation. The rise of costs for service of physicians has recently been much greater than in the premedicare period.

Senator Robert Kennedy commented thus on the costs of doctors' services pre- and post-medicare:[2]

"There have been some studies made in the State. I don't want to take too much time, we have a lot of witnesses, but here is an article from Watertown which shows that an office call before the passage of this legislation was $3; afterwards it was $6.50; a home call, $4; afterwards $8; special service, initial visit, $7.50; after the passage of the bill, it was $20."

This excess is not by any means explained merely by the general inflationary trends. Nor am I convinced by the argument that costs of physicians' services recently have not risen more than the costs of services generally relevant especially for the younger population. The crucial point is that billions of additional funds are being channelled into the medical stream. Doctors' income accounts for about one quarter of the total medical income. In view of this fact and the large rise of costs per doctors' services, and of physicians' income and the inelastic supply of doctors, the only conclusion I can draw is that medicare has indeed raised costs of physicians' services, and the income of physicians.

That Medicare operates through fee for services is also unfortunate. This method of payment induces excessive services. The costs are compounded because of the absence of adequate quality control.

Another inflationary factor derives from the opposition of doctors to assignments. By refusing assignment (fees based on current practice) the doctor can impose much higher fees and with the patient recovering only part from the government.

DENTISTRY

Improved economic status has accrued not only to physicians and hospital personnel. Medicare has especially been effective in stimulating services previously greatly under-supplied. One significant area has been dentistry. The pro-

[1] *Senate Hearings, Costs and Delivery of Health Services to Americans,* 1968, pp. 370–71.
[2] *Costs and Delivery of Health Services to Older Americans,* Hearings, Subcommittee on Aging of U.S. Senate, p. 371.

vision of medicare dollars has helped correct the deficiencies of dental services. One result has been very large rises of dental incomes, with incomes of a dentist in *some instances* rising to about $100,000. (The difficulties of covering dental services under insurance accounted to some extent for the under-provisioning of this type of service.)

THE RELEVANCE OF INSURANCE

Older citizens have gained less from medicare than may be assumed from the amounts received for medicare because the increased availability of insurance in itself tends to waste resources. The insured tend to consume service not needed just because they are insured. I hold this position though Mr. James Brindle, head of the Health Insurance Plan of N.Y.C., found no increase in services in response to additional insurance. The tendency is to consume more whether needed or not, just because insurance becomes available. The purveyors of medical services, moreover, also contribute to wastage as they increase charges to patients who are insured. They are more disposed to raise fees when insurance increasingly carries the burdens.

PRESSURE ON RESOURCES

In the period during which medicare was under discussion, the fear was frequently expressed that the introduction of Medicare would result in serious pressures on medical services and especially shortages of hospital space.

So far it seems that the concern was excessive. Despite Medicare, despite medicaid which also inserted large additional funds into medicine and despite the unusual prosperity, the pressure on limited facilities brought no serious bottlenecks.

The explanation of this outcome so far, lies in the increased use of nursing homes—though far from a *satisfactory* expansion in this area—the large excess capacity available before Medicare, and the improved planning of hospital use made possible by Hill-Burton and Medicare: "During the first year of operation, the older people of the nation received from 12–20 per cent more inpatient hospital services than in previous years; and they received these services without the over-crowding of facilities which some people had predicted." [3]

But it is well to note that further extension of medical services—e.g. more services and extensions of medicare to younger age groups and further growth of insurance—all of these together may well raise demand vis a vis supply to an uncomfortable level. Any special measures to improve medical services to minority groups would further increase pressures.

The net balance between supply and demand will depend on a number of other factors. In the last few years medical outlays have been rising by about $4 billion a year, or around 8 per cent. A major part of this increase is explicable by the rise of prices. But this rise of prices is not exactly independent of the rising demand for medical services.

COMPETITION FOR FUNDS

The adequacy of medical services will also depend on the developments in the economy and other (related) segments. Thus educational outlays (also roughly $50 billion a year) are also increasing at about $4 billion a year. Competition for construction, for tax dollars and services are significant in these two areas. Should the unusual prosperity of the last 8 years continue, then excess capacity of plant and personnel will be at a minimum and additional demands for services will be reflected more in rising prices than in rising supplies.

THE RELEVANCE OF VIETNAM

Much will depend also on Vietnam. Should the war end, it is estimated by the top authorities in Washington that from $10 to $30 billion additional would be available for welfare outlays—the exact amount depends on what would be done with the (say) $15 billion saved in military and $15 billion out of additional taxes as incomes rise. It is conceivable that with $15 billion available $5 billion would go for improving our cities, $5 billion for anti-poverty programs and $5 billion for welfare inclusive of medicine and education. It is clear that pressures on medical markets would intensify, the larger the peace dividend, and the less spent on other welfare programs.

---

[3] *1st Annual Report of Medicare,* 1968, p. 7.

THE RELEVANCE OF THE NEGATIVE INCOME TAX

On the assumption that substantial expenditures will be made on behalf of the minority groups, we should examine the effects on the medical segment of our economy. There is increasing support for an anti-poverty program, which would be based on a negative income tax—i.e. guaranteeing all families a $3,000 income. It has been estimated that the cost would be $900 per capita, or about $200 billion. This is clearly out. But a subsidy to the roughly 10 million families with income below the poverty line would cost from $7–$49 billion.[4]

For our problem, the significant point would be that recourse to a negative income tax, that is payments to the poor to get their income up to a minimum level, might well have the result of reducing outlays for medicine. The negative income tax generally suggests that the poor would get cash and *they* would determine how to spend it. Would not the result then be less spending by government on medicine, housing, etc. and more by the poor on television, sports, clothing, furniture, etc.?

MORE DOCTORS OR IMPROVED ORGANIZATION?

In the New York hearings on *Costs and Delivery of Health Services to Older Americans*, the official witnesses leaned towards an explanation of required therapy that stressed especially improved organization, e.g. neighborhood health centers, rather than an increase in the supply of doctors. These experts doubted that it would be possible to entice doctors to move into the low income areas. They are concerned at the large proportion of the population in slum areas not serviced by doctors. Doctors prefer to practice in the high income areas. In their view, greater production of doctors would not yield a flow of doctors to the poor neighborhoods. The New York experts seemed to argue that the inducement of group practice and salary payments would attract and has attached able young doctors.

I find it a little difficult to accept this though surely there is some point at which the supply of doctors in the affluent areas becomes so large that the doctors will begin to desert the affluent areas. But it seems to me, we are far from this state now. Indeed, the income of doctors is already less in such cities as New York and Boston than in middle-sized towns. But this is explained in part by the penchant to practice where standards are high, research facilities good and cultural activities are attractive.

The Senators who seemed skeptical of the approach of Dr. H. Brown and others seemed to lean towards emphasizing the need of increased output of doctors rather than improved organization supported by some New York officials. I lean towards the views of the Senators.

MINORITY GROUPS, FINANCING MEDICAL EDUCATION

An indication of the rising needs of minority groups is given by the Health Service Administration of New York City.[5]

"Our projections are based on 4,000,000 New Yorkers being Medicaid eligible. While projections indicate no increase in New York City's population over the next 15 or 20 years, these same projections indicate a continuance of trends prominent between 1950 and 1960, to wit: an increase in the population of individuals over 65 by 35%, an increase in the population under 15 by 13%, a decrease in the white population by 12%, an increase in the Puerto Rican population by 149% and an increase in the non-white population by 48%. While continued increases in these statistics might not be as great as in the previous decade, it seems fair to assume that New York City will have enough of a shift in these population groups to offset any changes in Medicaid eligibility which may be passed by the Congress."

It is generally agreed that a shortage of physicians prevails and even if increased use were made of sub-professionals.

One expert would increase the output of physicians from 9,000 to 20,000. He would have the Federal Government finance the entire costs of $5.000 per physician to the School, $4,000 for upkeep of the student, and the additional con-

[4] Tobin, Pechman and Mieszkowski, *Is a Negative Income Tax Practical?* 1967. These are rough figures, with the estimated cost related to size of basic allowance, and the tax imposed on recipient on income beyond basic amount, and also savings on welfare programs.

[5] *Op. Cit.*, p. 375.

struction costs. The total costs over a 10 year period would be about $5 billion. He would finance the upkeep of the student because now students predominately come from high income groups.[6]

Though I am sympathetic with the general position, I find it difficult to accept this additional burden on the Federal budget at the present time. The case would be stronger in the post-Vietnam era.

But even then one may raise the following issues. Why subsidize the medical student to this extent and not introduce similar programs for scientists and teachers who are equally scarce?

The case is especially weak for the future physician because the income of the practising physician is now $30,000 to $40,000 a year. Would it not be more equitable to finance the future doctors by a loan program? The physician would then finance it by paying a percentage of his life time income depending upon the amounts borrowed during his training period. So long as incomes are high the doctor will pay proportionately more. This program could easily be integrated with a loan program for all college students and financed over the life time of the students. In this manner, society will finance part of the cost of training in that as incomes rise as a result of inflation or rising productivity, the financial burden on the doctor will be reduced and society's contribution will be increased. Should doctors' income rise as much as incomes of all members of the labor market—doctor's income have been going up more rapidly—then in 50 years we might expect doctors' income to rise to about $300,000 a year.

Such a loan program would enable all students of quality to get a medical education, to choose any school where he is acceptable, and he would finance his education over his active life instead of being burdened exclusively during his years of training.

ADEQUACY OF MEDICARE

Medicare of course marks a great advance: in funds going into medicare; in providing additional help to the group that needed it most—the aged; in accepting the principle that compulsory health insurance for a large segment of the population.

But there are still many reservations. Under Medicare, benefits are still restricted in the payment of doctors' bills. Expert estimate coverage—once allowance is made for corridors, co-insurance, exclusion of dental and other benefits—at only about 50 per cent of doctors' services. Moreover, the doctors seek to avoid assignments, which means higher charges to the patient, and are frequently criticized for charging in excess of usual charges. To get an increase, a requirement of Blue Shield of New York is that the rise apply to all patients, not merely those covered under Medicare. Much unhappiness also prevails because the doctor is compensated on the basis of fees for services thus increasing the difficulties of those (notably hospitals and group plans) where payment is on a capitation basis.

Yet something can be said for the limited coverage and benefits.

Had coverage been complete, the pressure on resources would have been much greater, and prices risen even more than they have. Moreover, under these more generous conditions, the pressure for universal compulsory insurance would have increased greatly. Ultimately the country is likely to accept compulsory insurance. But there is something to be said for experimentation on a restricted basis at first and also for the avoidance of another inflationary pressure in the midst of general inflationary trends. Medical shortages and bottlenecks have contributed much to the inflation of the last few years. The contributions to inflation comes from Medicaid, and private insurance as well as Medicare. The price of medical services and especially of hospital services has especially soared. But we should observe that in some areas, the quality of service on the introduction of new and costly procedures raise prices. In part these increases may be described as non-inflationary. That is to say, the quality of services has improved—an offset to higher prices.

---

[6] Dr. Cherkasky pointed out that 50 percent of physicians come from those in the top 12% of income levels.

ITEM 7: LETTER FROM DAVID LITTAUER, M.D., EXECUTIVE DIRECTOR, CEDARS-SINAI MEDICAL CENTER, LOS ANGELES, CALIF.

NOVEMBER 18, 1968.

DEAR SENATOR WILLIAMS: In 1965, before Medicare was available, the California State Department of Public Health studied all admissions for a 6-month period to 35 home health agencies in California. The Bureau of Chronic Diseases has furnished me with the following evaluation of the replies:

"One question on the discharge form asked the private physician. "After observing this patient in a program of home nursing care would you please answer the following question: If home nursing care had not been available would you have had to: Send the patient to the hospital? Send (or keep) the patient in a nursing home?" (For patients referred from a hospital the question was: "Would a longer hospital stay been required?") A majority of the physicians did not see these two choices as alternatives but physicians did indicate that one out of every five patients would have had to be in a hospital if home nursing services had not been available. One out of every six patients would have been sent to a nursing home. So for over one third of the patients (35.9 percent) a much more expensive form of care would have been imperative if these services had not been available to the private physician.

"There was considerable variation in alternate care needed depending upon the diagnostic condition which brought the patient under care. For example, 35 percent of the cancer patients would have had to be hospitalized and another 14 percent would have had to go to a nursing home. Twenty-six percent of the stroke patients would have been sent to nursing homes while an additional fifteen percent would have been in hospitals. An entirely different picture appears for patients with arthritis where 20 percent would have been sent to nursing homes and for only 6 percent would a hospital have been the alternative.

"This study was conducted before home health services were made available under Medicare and many physicians were not aware of this type of service. It seems reasonable to assume that early referral of patients was not always made. For example, agencies with liaison nurses in hospitals or some other similar arrangements had a much higher percent of their admissions made directly from a hospital. Nine agencies had at least 30 percent of their admissions made directly from a hospital while ten agencies had less than 10 percent of their admissions referred directly. Obviously, with a good referral system cases can be evaluated early and sent home as soon as feasible. Home nursing services would then be substituted for more expensive hospital care."

In 1961 I was project director of a comparative study of 15 home care programs, using the coordinated (comprehensive) home care program of the Jewish Hospital of Saint Louis, where I was then executive director, as the base. The answers to several of the questions posed in your letter are found in the report of this study, which was published as Monograph #9, Hospital Monograph Series, by American Hospital Association, Chicago, publication no. G164. A copy of this monograph is enclosed. The evaluation of benefits to patients is as valid today as it was then. I refer you particularly to the Critique (pp. 65–70), which I hope your staff will extract as a part of my comments as needed.

In September, 1967, the Division of Medical Care Administration of the Health Services and Mental Health Administration of the U.S. Public Health Service held an invitational conference on Home Health Agencies after one year of Medicare. I had the privilege of participating in this conference and of collaborating in the preparation of the final report: "Home Health Agencies After One Year of Medicare", published in mid-1968. (Since I have only one copy of the report in my possession, I cannot send it, but I am sure copies are available on application to the appropriate office of the Public Health Service).

It was the consensus of the conference group that ways must be found to bring home health services into the main stream of community health for patients of all ages and economic levels; home health services should be made a part of voluntary individual and group health insurance plans as well as of government programs. Home health services should be included by State and community

planning agencies under the provisions of P.L. 89–749 (Comprehensive Health Services) and P.L. 89–239 (Regional Medical Programs). Both rural and urban areas need networks of home health agencies capable of furnishing comprehensive services.

The recommendations of this conference include:

Formation of a national organization for Home Health Services to facilitate continuing communication on a group basis among State agencies, providers of service, fiscal intermediaries and community leaders with the Federal agencies. (In California we recently organized the first state association, California Association of Home Health Agencies, of which I have the honor to be the first President).

Representatives of the medical profession should be invited to suggest ways in which physicians can be involved in planning and administering home health agencies.

The Social Security Administration should provide analyses of information that is accumulating regarding kinds of services being used by various types of patients.

Task Forces should recommend solutions to specific short-range and long-range problems.

The Public Health Service and the Social Security Administration should study home health services on a continuing basis as an appropriate health entity within the health service system.

I hope the above comments will be helpful to the deliberations of the Special Committee on Aging. If I can be of further assistance, please let me know.

Sincerely yours,

DAVID LITTAUER, M.D.,
Executive Director.

ITEM 8: QUESTIONS SUBMITTED BY THE CHAIRMAN TO DR. GEORGE B. MARKLE, IV, DIPLOMATE OF THE AMERICAN BOARD OF SURGERY

1. What, if any, action by the Federal government would you recommend to reduce the number of unnecessary tests and examinations, thus saving money for both its medical care programs and for their beneficiaries?
2. Is any governmental action on this problem possible without interfering with and overriding the exercise of private medical discretion?
3. Your article seems to infer that utilization review procedures have thus far been ineffective to prevent unnecessary tests and examinations. Is that a valid conclusion? If so, why do you believe utilization review has been ineffective? Can anything be done to make utilization review more effective to prevent unnecessary procedures?
4. To what extent do you believe the ordering of unnecessary tests and examinations is caused by fears of malpractice suits? What, if any, solution do you believe there is to this problem?
5. Your article in Medical Economics points out that some physicians defend a liberal policy in ordering tests and examinations on the grounds that they have some value in early detection and prevention of unrelated conditions. To the extent that unnecessary tests cannot be eliminated, what, if anything, do you think can be done so enhance the preventive value of such procedures?

(The following reply was received:)

* * * * * * *

NOVEMBER 8, 1968.

DEAR SENATOR SMATHERS: Where I stand—on the front line of medical care in a moderate sized community—I can give your committee a perspective that will be different from the one you get from medical school deans and big medical center authorities. These men see all the complicated cases and the rare difficult cases, and really don't appreciate that the great bulk of medical problems are really quite ordinary and can be handled by ordinary means by ordinary doctors on the community level. If doctors would seek to be practical, we would cut costs considerably.

The article you refer to in Medical Economics Sept. 30, was published in slightly changed form in Hospital Physician in June 28. As I don't have reprints on the former, I enclose a reprint of the letter.

To answer some of your questions:

1. The Federal Government probably shouldn't try to rule on the necessity for specific tests. Conditions vary too widely, and what is necessary or unnecessary is too controversial in many cases. For example, in some areas, a routine V.D.R.L. (test for Syphilis) is a good thing from a public health point of view. There may be no more reason to do such a test, however, on a patient admitted with a broken arm than there would be to do one on any other group, whether in the hospital or on applying for a drivers license. Generally these routine tests are made obligatory by the hospital rules and by the record and utilization committees. Undoubtedly they are often good, but I would like the attending doctor to decide if there is advantage in them, not just as a routine.

2 and 3. Too often the value of a particular test or Xray is of such an individualized consideration that even a utilization committee might argue over it indefinitely. Thus, you can't make hard and fast laws. I suggest that Federal hospitals might be encouraged to drop most of their mandatory routines so that individual doctors may omit tests, etc., that have no bearing on the problem. Examples of this are mentioned in my article. On the other hand, use of tests which might expedite diagnosis and treatment should certainly be permitted so long as they are pertinent and not done just to display the erudition of the doctor, or for simple curiosity. Under research conditions, of course, a lot of tests are done, not to benefit the patient, but to enhance medical knowledge—this is a special situation.

4. A lot of tests and Xrays are ordered more to protect the doctor and the hospital than for the benefit of the patient. Fear of malpractice is behind perhaps half of the Xrays we take in cases of trauma. A doctor by oversight in a career of 50 years of caring for sprained ankles, for example, can lose in court more money than he ever earned in that field. Loss of one life might cost him more than he earned in a life time of saving lives. It makes one inclined to limit his practice to safe and sure procedures and even then, to cover himself in every way possible by documenting everything with Xrays and tests. I have heard suggestions that malpractice be handled something like compensation cases. The patient, too, could share some of the risk.

A related influence towards excessive testing is the trend toward big medical center care. A big medical center is expected to never make a mistake and so they tend to test everything. A private doctor can Xray or test just what he is looking for, and then if results are negative, he can call the patient back for another test or two. The clinic can't easily do this if the patient lives at a distance from that city; hence the tendency to give a battery of tests and Xrays all at once, some of which would be unnecessary if the results of the first few were known at the time.

Both the malpractice threat and the "have to be perfect" concept are the result of the rising expectations of the public as well as rising standards among us doctors. This is good in a way, but fear of overlooking something does definitely increase the use of unnecessary (as far as the patient is concerned) tests and Xrays.

5. As for using tests and Xrays for public health reasons or as preventative measures, the restriction is mostly economic. If 200 million Americans had annual physical exams, Xrays and basic laboratory tests, a lot of good would result, but obviously the cost would be enormous. Medicare couldn't provide routine complete exams for its millions of elderly without tremendous changes in its financing. There are not enough doctors to do all this anyway. Even if it were possible, we wouldn't eliminate all disease—probably we would be doing good in only 10 or 20%. One of the big problems, usually not mentioned in articles on medical planning is that over 50% of patient visits are more concerned with emotionally caused conditions than purely physical ones. I don't see how more frequent physical exams or tests can help that problem.

We can help to educate the public in when to see a doctor and what they can do to prevent illness themselves. The American Cancer's Society's 7 warning signals of cancer is a very good approach as to the former. I have written a book "How to Stay Healthy All Your Life", published by Frederick Fell Inc., New York, which can help in both these respects. This sort of book could cut down doctor-patient visits perhaps 20%. Probably 75% of ill health is preventable. I have asked my publisher to send you a complimentary copy. It is not the usual health book, and is quite readable.

There are now some ways to do a lot of this testing less expensively. Machines which larger laboratories can afford can now automatically do a dozen different tests on one blood sample that are quite reasonable, and so, even if you are not interested in half of the results, the total cost is fairly cheap. For a long time some hospitals have had miniature X-ray machines that take small films of the chest (a common requirement) as a screening procedure. The use of mobile, free chest X-ray units is standard in some communities, using this inexpensive method, and is a good thing.

The biggest variable in medical costs is up to the individual doctor; how he manages each case. I have illustrated this in another article published in Medical Economics, Aug. 5, 1968, "Spare the Purse and Please the Patient", a reprint of which I enclose. The savings our profession could manage, if we were all as cost conscious as I am, are enormous, certainly hundreds of millions a year. However, I don't see how you could legislate that certain cases must be done as outpatients and others as inpatients, or whether or not to use general anethesia, etc. All we can do here is preach and teach. Some doctors don't have facilities for minor office surgery and some are not confident enough to do anything outside of the hospital atmosphere. Some just weren't trained to do things simply. Again malpractice threats influence some unduly.

I think your committee would be interested in a third article published in Medical Economics Sept. 3, 1968, "The Case for Small Town Specialism". Regional health planners are talking about sending more and more medical cases to big city centers or clinics and de-emphasizing community care. I refute that concept as being economically catastrophic and medically undesirable. This article describes the problems and how a community hospital really can give excellent care for all but the rare or unusual cases.

I am sorry that I am not in a position to supply your committee with meaningful statistics. I suspect you have enough of them already. All I can supply is the philosophy of the practicing doctor on the front line of medicine. As I say, spokesmen for medicine are mostly from medical schools or big centers and their view lacks total perspective. My articles and my book may, I hope, give you a different slant.

Please feel free to contact me at any time. I am very concerned about the cost of medicine and would be glad to help your committee in any way I can.

Sincerely yours,

G. B. MARKLE, M.D.

[Enclosures]

EXHIBIT A: SHOULD HOSPITALS REQUIRE SO MANY TESTS?

[From Medical Economics, Sept. 30, 1968]

Definitely not, says this doctor, who contends that too many hospitals are routinely ordering medically unnecessary tests and examinations. By reducing the number of such unnecessary tests, he argues, physicians can help to cut the cost of medical care.

(By George B. Markle IV, M.D.)

Everyone is complaining about the sharp rise in health-care costs these days, but finding ways to reduce those costs is no easy matter. "Rising costs aren't our responsibility," physicians are likely to say. True, most higher costs are due to higher hospital bills, but we physicians do have a lot to say about those bills.

I'm not talking about reducing bills by cutting down on unnecessary admissions and shortening hospital stays. We're all aware of such important ways of saving the medical dollar, and we're probably doing about as much as we can in that direction. But I don't believe we're doing enough about doing away with medically unnecessary examinations and tests when we must admit our patients to hospitals.

My hospital's record committee, for example, has just returned some charts to me because physical examinations weren't complete. One chart was that of a young man who had suffered second-degree burns of his back and arms when a can of gasoline exploded. Although the burns were limited, I still hospitalized him for a couple of days to give him open-air-exposure treatment. He'd no other complaints, and he told me that he'd been in good health. In fact, he needed only a bit of nursing care and a bed where I could watch him. But the hospital insisted that he have a complete blood count, a urinalysis, a chest X-ray, and a V.D.R.L. These tests, like the complete physical that I'd omitted were strict hospital policy.

Another patient had two toes crushed by a mine car. He needed bed rest, with elevation of his leg, frequent medication for pain, and observation for possible infection or gangrene. Though hospitalization was indicated, I saw no need for a complete examination, since he didn't require a general anesthetic. I didn't do a rectal exam, and I ordered no lab work. Of course, the work was done anyway—and I was the recipient of a little billet-doux from the record committee.

In a third instance, a little boy fell off a horse and suffered a supracondylar fracture that I reduced under a general anethetic and immobilized in plaster. The boy's mother gave me a negative past history and a negative history for any of his current problems. So I checked his throat, heart, and lungs, and went to work. I admitted him to the hospital because of possible pain, possible ischemia of the arm, and to elevate the arm for a day or two under observation. Since I wrote no lengthy history, I got back the chart with snide remarks to the effect that it hadn't been completed. The lab work, to top things off, had been finished about an hour before the boy was discharged, and the lab report was sent to the record room for the greater glory of the record committee and the Joint Commission on Accreditation of Hospitals.

How often does this sort of thing occur in your hospital? Daily, I'd guess. Think of the unnecessary cost to the patient for tests that aren't likely to benefit him! And what about the doctor's time? You can't do a thorough systemic review, past medical history, social history, followed up by a complete physical examination in much less than 30 or 40 minutes. Of course, I'm talking about only the isolated injury or the simple complaint. If the patient seems to have other ailments or if the diagnosis is obscure in any way, then the execution of a good history and physical is obviously indicated, and routine lab work plus the needed specific tests and X-rays becomes justified.

Granted, we did all these tests and physical exams as a matter of routine when we were attending medical school. But, as part of our training, they were designed to benefit *us* as much as the patient.

What about annual physical exams? I'm all for them. Suppose that, in the absence of any medical indications for a lot of work-up, the hospitalized patient asks for a complete examination and is willing to pay for it. The doctor in charge should certainly agree to it. He can do the examination either then or later in his office if that is more convenient. But what if—as sometimes happens—the patient expects his hospital insurance or Medicare to pay for the exam? Health insurers and Medicare don't ordinarily pay for routine annual physicals, yet in some cases they're unwittingly paying for this extra work when it isn't medically indicated—all in the name of the record committee, the tradition, and the holy accreditation commission.

Many doctors and hospital administrators, I expect, will charge me with advocating sloppy medicine. They'll use statistics showing that in some communities the routine V.D.R.L. or other serology tests do pick up an occasional unsuspected case of syphilis and that some hospitals do find a few cases of active tuberculosis by routine X-rays. A heart murmur in a child may be picked up, and sometimes this is a good thing to know, and sometimes not. During physical exams, I sometimes find an unsuspected hernia, though the patient would probably have found it himself soon enough.

Well, I'll concede that routine testing has some merit—*but only for certain types of patients.* For example, those with a history of promiscuity probably should have a V.D.R.L. whenever you can catch them. Others, particularly heavy cigarette smokers, should have chest X-rays often. Elderly people, since they're more prone to various ills, should be given regular physicals. Last month, for instance, I discovered breast cancer in an elderly woman who had been admitted to the hospital for phlebitis.

What it boils down to is that all medicine, at best, is a compromise between the ideal and the practical. Ideally, we could pick up more diseases by giving people physical exams throughout the year. But, practically, we can't advocate that kind of medicine. If we did an upper G.I. series on all adults annually, we could find an occasional stomach cancer. But we don't because the yield is too low to justify the cost of such exams. And how many doctors regularly have sigmoidoscopies done on themselves?

Some physicians are just as guilty as hospitals are in overtesting. Rather than aim for individual tests, the diagnostician often resorts to a shotgun approach in the hope that some diagnosis will fall in his lap. Testing has become a matter of blindly following routine. Yet any doctor should be able to determine when a patient needs a physical exam and specific tests. By using this more selec-

tive system, we may miss an occasional item of importance, but with the present routine we sometimes do so, anyway.

We don't have to follow this routine. When we must hospitalize a patient, we should weigh our reasons for doing so—and resist the hospital's battery-of-tests policy. If the diagnosis is uncertain or if we're suspicious, we should explain to the patient why we must investigate further—and then go ahead and do so. In testing, we ought to be guided by the golden rule, paraphrased thus: Do unto your patient as you would have him do unto you.

TOO MUCH TESTING? THE PROS AND CONS

At least one physician agrees with the idea that Dr. George B. Markle proposes in the accompanying article. Reduce the expense of a patient's hospitalization by discarding some routine tests and examinations. William A. Nolen, a general surgeon in Litchfield, Minn., would go a step further and eliminate routine lab work entirely. The physician and the patient, says Dr. Nolen, benefit most from lab work that's ordered for a specific purpose. But when it's done routinely, as is often the case, the attending physician probably doesn't even check the report. What if the hospital is strongly opposed to the elimination of this fixed procedure? Then, he says, each doctor could at least determine if his patient needed such tests, instead of making them a necessity by virtue of hospital law.

"Sometimes, in an attempt to prevent an extremely rare disaster," Dr. Nolen continues, "hospitals adopt policies—either voluntarily or because accreditation boards compel them to do so—that aren't statistically valid. Such policies, once they've become routine, are blindly continued and rarely if ever questioned by those who use them. In fact, once adopted, it's almost impossible to modify them, and the tired 'We've always done it this way' comment is usually given as an explanation for their continuance."

With medical expenses at an all-time high and with medical personnel in short supply, Dr. Nolen concludes, "it's high time doctors refused to accept such an explanation as adequate for the continuance of illogical and expensive routines."

A number of other physicians who read a prepublication draft of surgeon Markle's article disagree with his recommendation to do away with routine hospital tests. Dr. Charles U. Letourneau, a hospital consultant in Chicago, calls it "not very good advice. I hope I never fall into his hands!" Says Forrest P. White, a pediatrician in Norfolk, Va.: "Dr. Markle has a bone to pick with a record committee that is simply trying to get him to practice good, modern medicine. As a record committee chairman, I can't go along with the examples of 'unnecessary' testing that he cites. As I see it, there's absolutely no excuse for any physician not doing a complete basic testing and physical exam on each of those patients."

This need for complete care of the patient is emphasized by internist Walter E. O'Donnell of Gloucester, Mass., who writes: "Dr. Markle apparently feels that his responsibility in the case of the patient with the two crushed toes begins and ends right there. The rest of the patient doesn't seem to come in for much attention unless there's something grossly wrong. Actually, the tests Dr. Markle describes as 'costly and unnecessary' include the simple blood, urine, and chest X-ray package, the actual cost of which is less than $25 and has long since been accepted as a reasonable minimum by most physicians and hospitals."

Another internist, Alfred P. Ingegno of New York City, points out that "certain routine tests have been found advisable from bitter experience, and the bitterest experience comes from sloppy routines all too common on surgical services. A minimum of a decent history and physical, plus urine, blood count, blood sugar, and chest X-ray are certainly needed to prevent carefree major surgery on, say, a decompensated diabetic. If only we could get our surgeons to understand the need for such reports! Do they think that 'routine' evaluation of the bloodclotting status in a T. & A. patient is a frivolous procedure? Instances of uncontrolled bleeding after such omissions in the past may give them pause.

"Such 'routine' tests," Dr. Ingegno continues, "are easily done by the staff that's usually available in any well-run hospital. These tests can give valuable information, and their cost is reasonable. I suspect that the major problem is the other way around: not enough indicated tests by attending physicians who assume too much."

The value of low-cost testing is stressed by Irving M. Levitas, director of rehabilitation medicine at Hackensack (N.J.) Hospital. "When tests are inexpensive, as they are in mass screening," he says, "they're worth what they cost for case findings. At 10 cents a test, why not have them?"

Mass health screening is seen as a solution to the problem by Richard C. Bates, an internist in Lansing, Mich. "The answer to Dr. Markel's dilemma probably lies in the computerized exam," Dr. Bates writes. "When each citizen goes through such a routine yearly, the need for all these expensive hospital test batteries will largely disappear. But until that time, I think the Joint Commission is wise to use the hospital admission as a means to insure a fairly thorough going-over for everyone who is considered sick enough to be hospitalized."

One needless hospital expense that Dr. Markle overlooked, according to Curtis D. Benton, Jr., an ophthalmologist in Fort Lauderdale, Fla., is the routine pathology report. "All surgical specimens," Dr. Benton says "must be sent to the pathologist, who charges $3 to $10 to report that the penny the attending physician removed from a child's throat is 'a coin.' We have to send the pathologist cataracts, foreskins, bullets, and all sorts of obvious foreign bodies. This costs money.

"But there's one point that Dr. Markle doesn't mention," Dr. Benton concludes. "When certain tests and procedures are considered routine and standard and a physician fails to do them, he won't have a leg to stand on should a lawsuit follow and the case go to court. Most physicians are willing to go along with some 'unnecessary tests' for our patients because we can't accept the legal risks of not doing so."

EXHIBIT B: SPARE THE PURSE AND PLEASE THE PATIENT

[From Medical Economics, Aug. 5, 1968]

Why not do minor operations in your office, instead of a hospital? Use a local, rather than a general anesthetic when it's safe? Give patients drugs from your sample drawer? The author does these and other things to help his patients beat the high cost of medical care.

(By George B. Markle IV, M.D.)

The high cost of medical care today is, like the weather, something that everybody talks about but nobody does much about—except politicians and bureaucrats busily preparing new rules and restrictions for hospitals, the drug industry, and the medical profession. I think we doctors had better do something about it—soon. Sure, many of us do make some effort to spare our patients' pocketbooks, but too often we overlook the little ways to same them needless expense.

Some of the suggestions I'm about to pass along will save only a few dollars. But to many of our patients, $3 represents the income from one, two, or even three hours of work. It may never occur to the affluent doctor that so small a sum is worth saving. But it means a lot to a low-income worker, and a doctor's thoughtlessness can easily multiply the patient's cash outlay manyfold.

Let me give you an example. Jim Martinez, a laborer who supports a wife and four children on the $2 an hour he earns when he has work, came to the office of a colleague one day with a painful abscess in his axilla.[1] The surgeon, recognizing the need of incision and drainage, admitted him to the local hospital and scheduled him for surgery the next morning under a general anesthetic. Following hospital policy, he got a routine c.b.c., urinalysis, V.D.R.L., and chest X-ray. That evening the surgeon did a fairly thorough physical exam and dictated his findings. The anesthetist talked with him and ordered the usual pre-op medications. An orderly shaved his axilla and half his thorax and arm.

Next morning he was taken to the operating room and anesthetized. The O.R. aide donned sterile gloves, carefully draped off the area with sterile towels, and prepped the axilla, taking about 10 minutes of anesthetic time. Then the doctor, scrubbed and gowned, draped the wound. This required four more sterile towels, a half sheet or two, and a full-sized laparotomy drape. The O.R. nurse had opened up enough instruments for an appendectomy, and the circulating nurse was prepared to supply more.

Then came the moment of truth! The doctor stuck a scalpel into the bulging mass, drained out an ounce of pus, took a culture, and stuffed in a bit of gauze. The anesthetic time was 15 minutes; the operative time one minute. A dressing was applied and the patient taken to the recovery room and thence to his room. He had a little pain before dismissal and was given a tablet. He was discharged with a prescription for $8 worth of an antibiotic.

---

[1] Armpit.

The surgeon sent Jim a bill for $50—an amount the doctor felt was quite reasonable. Because Jim had no health insurance, the doctor hadn't charged for the first office call nor for the two postoperative visits, and he'd done a history and physical, not to mention the bother of scheduling surgery and going out to the hospital to do it.

Jim's bill from the hospital was $140, which the administrator assured him was very reasonable when broken down: routine lab, $13; culture and sensitivity, $17; X-ray, $10; room, $25; medications (four), $6; prep of area, $2; anesthesia, $30; and O.R. fee, $35. There was a $2 charge for the recovery room.

By an odd coincidence, Jim's cousin, Pedro, came to me not long after with an identical abscess in the axilla. I quickly shaved the area, wiped it with alcohol and Merthiolate, and with a very fine needle infiltrated a little 2 per cent procaine. Then, without gowns, gloves, or drapes, I made the same sort of incision and tucked in some gauze with a hemostat. I gave him an injection of long-acting penicillin and half a dozen capsules for pain. I had him return once, and after that he dressed the wound himself a few times—and got well.

Pedro's total bill was $15, against $198 for cousin Jim! It took me only a few minutes, against an hour or two for Jim's doctor. Timewise, I was the better paid, and Pedro was 20 hours ahead of cousin Jim.

Thus, No. 1 on my list of ways to save patients money is to do in the office those procedures that can easily be done there. Some insecure doctors, I know, insist on hospitalization not for the patient's sake but for their own. They're afraid they might need help in an emergency or become the target of a malpractice suit if anything should go wrong. But it's amazing what you can safely do with a modest little setup. A manual such as "Surgery of the Ambulatory Patient," by L. Kraeer Ferguson (J. B. Lippincott Company), will open your eyes to numerous possibilities. I know many doctors who give pulmonary or other therapies in their offices; many urologists do cystoscopies. You can probably think of more.

My second suggestion is, of course, to use a local rather than a general anesthetic whenever this can readily and safely be done. This not only permits surgery in the office, but it will save money and time when the patient needs to be hospitalized. For example, I do ganglion cysts under local in most cases, sometimes in the office and sometimes for a hospital outpatient, who is then charged only the O.R. fee. I find that, with a little premedication, all but the most nervous patients can tolerate an arm tourniquet for the half-hour it takes.

I've reduced a great many Colles' fractures[2] under local, with or without premedication. This is especially convenient when the patient has recently eaten and I don't want to have to return to the hospital several hours later. And, of course, with rare exceptions, local anesthetics are safer than general anesthetics are.

In addition to office and hospital savings, we can materially lighten our patients' expenses at the drugstore. We tend to forget how drug bills can add up, since we habitually douse our own families' minor illnesses out of the sample drawer. Woe to anyone in my family who comes down with a condition that isn't treatable from my sample collection. I just won't allow it!

Seriously, though, that sample drawer can serve a good purpose. Perhaps your patient has a temporary diarrhea, a bit of a cold, or a little muscle spasm. You surely have some samples that will get him by. If you do some office procedure or minor surgery that will be painful for a day or two, you can find a few analgesic pills to give him. You might even keep a bottle of them on hand just for such small but frequent demands; there are several good analgesics that don't require narcotic accountability. For my very poor patients, I keep and dispense vitamins and iron, too. It costs me almost nothing, and it pleases the patients no end.

If a poor patient must continue on a medicine for a long time, why not call his pharmacist and arrange for the patient to get a large supply for just a bit above the wholesale price? This is only one of many good reasons for getting to know your local pharmacists. Most of the pharmacists I know are glad to help in this way—or in other ways they themselves may suggest—for needy cases.

Another way we can make the patient's medical dollar go further is to use oral medications instead of injections whenever possible. Most menopausal women get along quite satisfactorily with oral estrogens or stilbestrol instead of injections, and aren't daily oral vitamins really better than a weekly injection? One old doctor I know says, "Yes, but shots keep the patient coming in regularly, so I can follow him better." I happen to know that such patients rarely get past his nurse, who gives practically all those routine shots.

[2] Colles' fractures are the common type of wrist fractures of one or both bones.

We also add to medical costs when we don't give our patients credit for ordinary common sense. Most of them have it, and we can save them money by letting them take some responsibility for their own care. After I've dressed an uncomplicated wound a time or two, for example, I let the patient dress it himself with only an occasional check by me. I simply tell him that if it should get red or drain, or in any other way look or feel as if it's not progressing well, I'll be glad to see him.

If your patient needs some physiotherapy, he may be able to do at least a part of it at home if you or a therapist will show him how. Most doctors have diabetic patients check their own urine, thus saving a lot of visits. Instead of waiting for such vague signs as fever blisters or a dry mouth, most patients can learn to take their temperatures so they'll know if they need to see you for a respiratory infection or other condition. Many doctors help chronic patients take some responsibility for their care by giving them appropriate pamphlets or by recommending books. One overburdened G.P. has found he can save much of his own time and his patients' money by preparing and distributing brochures containing his standard instructions on a topic like "Your Child and You."

We can save more money for our patients by avoiding "nuisance" consultations. I know some specialists who, when treating a fracture, for instance, won't treat the same patient simultaneously for a common cold. Some surgeons won't treat a catheter cystitis but will call in a urologist who has better things to do. A little myalgia doesn't require an orthopedist, nor a little anxiety a psychiatrist. When you call in another specialist you put him on the spot. You've made an issue of the problem, and he feels he has to be thorough. So the patient's little sniffle will cost him at least $10, and sometimes a lot more. It shouldn't be beneath our dignity to treat the simplest things, even if we don't treat them ordinarily. It's a way to show concern for the patient and his pocketbook, and I've found it's appreciated.

When you do refer to a consultant, be sure to tell him whether the patient has limited means. Since the consultant presumably hopes for more referrals from you, he may be spurred to effect some of the economies I've mentioned and will try to keep his own fees modest.

Remember that time is money, for both you and your patient. If he needs hospitalization, make it as brief as possible. Do what work-up you can while he's an outpatient, and get him out of bed and out of the hospital as soon as it's safe. Then get him back to work. Loss of income from not working may be a bigger financial blow to him than the medical costs. Furthermore, mental as well as physical rehabilitation is usually faster when the patient is back trying to lead a normal life. Oversolicitous delay can make a patient a semi-invalid for months.

Those are just some of the ways I've found to cut medical costs. No doubt you can think of many more. They're not likely to hurt your income because, as I've shown in some examples, your productivity will increase. And who knows, such savings may enable—or even inspire—some otherwise nonpaying patients to pay your fees.

EXHIBIT C: MORE WAYS TO SAVE YOUR PATIENTS' MONEY

[From Medical Economics, Aug. 5, 1968]

Among the physicians who read and commented on the preceding article before publication were three MEDICAL ECONOMICS contributing editors. They volunteered some cost-cutting tricks of their own.

Richard C. Bates, internist in Lansing, Mich., is down on medical tubes. He writes: "Avoidance of tubes of all sorts—I.V., nasal oxygen, and catheters—not only permits the patient more freedom and comfort, but it cuts costs. I'd guess that over half the cases with such tubes that I see are being treated unnecessarily. When a patient is dehydrated and able to take oral fluids but won't. I give him a teaspoon of salt out of the shaker. For each teaspoon of salt he takes, he'll crave two glasses of water, which will give him the equivalent of 500 cc. of normal saline I.V. Taken intravenously, that would cost him $5."

Forrest P. White, pediatrician in Norfolk, Va., writes: "When I prescribe clubfoot shoes and a Denis Browne splint for an infant, I have the mother bring the whole apparatus to me when the baby has outgrown it. She's usually glad to sell it for about 60 per cent of what she paid. So when the next baby with the same condition and shoe size comes in, I offer the used shoes

and brace to that mother. If she accepts, she writes out a check to the first mother, and we mail it. The transaction never goes through our books; I'm just an unpaid middleman. Both mothers are happy—the first because she got some of her money back, the second because she got something she needed at a substantial discount. And when her time comes, she'll probably be able to sell the apparatus for 60 per cent of what *she* paid for it."

Curtis D. Benton Jr., ophthalmologist and pediatric otolaryngologist in Fort Lauderdale, also passes along certain temporary appliances from patient to patient, such as plastic shields to wear after eye surgery. But Dr. Benton's chief cost-cutting enthusiasm is for reducing the time that his younger patients spend in the hospital for T. & As. "Last year," he writes, "my surgical patients were spared the expense and inconvenience of 300 unnecessary days—or more precisely, nights—in hospital beds. Most hospitals have regulations requiring patients scheduled for elective surgery to be admitted the night before their operation. But the period of hosptialization for T. & A.'s on children under 14 in this community has been cut to just 24 hours.

"We've been able to accomplish this by pre-admission preparation. When surgery is scheduled, the history and physical are done in the office. All necessary lab work is done in the hospital O.P.D. the day before the operation. Pre-op and post-up orders, plus the typed examination results, are in the hands of the admitting clerk when the child arrives at 6 A.M., with empty stomach and eyes wider than his mother's. Johnny goes straight to the children's ward, gets his sedative shot, and is on the operating table by 7:30 A.M., before he has the time to start thinking and sprout nervous second thoughts.

"I haven't yet convinced the hospital authorities that the same procedure would work just as well with adults. But my 300 younger patients last year were saved about $10,000 in hospital costs by not spending an unnecessary and probably sleepless night in the hospital awaiting surgery the following

---

ITEM 9: MATERIAL SUBMITTED BY DR. RUSSELL B. ROTH, VICE-SPEAKER, HOUSE OF DELEGATES, AMERICAN MEDICAL ASSOCIATION

EXHIBIT A.: THE PHYSICIAN AS A GUARDIAN OF HEALTH CARE COSTS

(By Russell B. Roth, M.D.)

The concept of the physician as a guardian of anything other than the health and immediate best interests of his patient is, I believe, a relatively modern development. Certainly in those less turbulent Oslerian days at the turn of the century there were at best only minimal and incidental ways in which the physician was called upon to dilute his concern for his patients with consideration for the community, for hospitals, for third party payors, for government, or for the tax-paying public.

Times have clearly changed. Janus, the God of gates and doorways, needed only two faces—for looking in and looking out. The physician today, in his role of guardian, needs to be more Hydra-headed in order to keep primary focus on his patient, while casting a wary eye on the hospital to be sure it is not over-utilized, on the insurance company to be sure it is not over-charged, on the community to be sure it is well serviced, and on Medicare and the rest of the tax-financed programs to be sure they are not abused.

Nonetheless, it is the thesis of my presentation that the competent, ethical physician is indeed the *only* able guardian of the public interest in the area of consumer expenditure for medical care. As an aside, I should note that, despite my published title, I do not intend to deal with Health Care *Costs*, since, in the language of the economist "cost" is overwhelmingly a matter of the price-tag on labor, materials, supplies, utilities—elements generally apart from the influence or control of physicians. The area of physician concern, quite obviously, is that in which he influences expenditures by or on behalf of his patient for the goods and services of the Medical Care Industry.

It is important to recognize that the guardianship to be exercised by physicians is one dealing chiefly with specific services involved in individual cases. It is concerned with professional medical decision making. Is it necessary to hospitalize this patient? Do we need extensive laboratory and X-ray studies? How about private-duty special nursing care? What medications will do the job? Is

surgery indicated? These are the decisions that translate into dollars—into many dollars per case, and these are decisions which can be made only by physicians.

Beyond this, of course, the physician has full responsibility for his own clients, and we will come back to this in due course, since it is a highly publicized issue at this point in history. The preponderant share of the medical care dollar, however, is not paid to the physician—it is paid for the goods and services which he recommends. It follows that this is the area of greater economic significance. In the $4.6 billion spent for Medicare in 1967, only 25% went for Part B payments to physicians.

It is worth contemplating for a few moments the track record of government as a guardian of the public pocket book. The chief and overwhelming distinction of government at the Federal level has been its unbridled enthusiasm for spending. For example, since 1961 the Gross National Product has increased 49%. During this time consumer spending increased 46% and Business spending 47%, but government spending went up 63%, and if one considers only non-military spending it went up 77%. The appropriations of Congress and of most State legislatures scarcely bear testimony to a philosophy of frugality. It is government which in effect has written the blank check for Medical Care and must look to someone else to fill in the amount. It is in large part this abundance of governmental dollars chasing after scarce services that has created the problem.

In the field of direct patient care government has long operated the world's largest hospital-medical-surgical program, in the Veterans Administration. Many kind things have been said about V.A. Hospitals, the quality of care, and the role they have come to play in teaching and research, but these compliments have not included any citations for economy and efficiency. Quite to the contrary there have been many allegations that when the government has been in complete control average patient stays for comparable illnesses are distinctly longer than in community general hospitals, that physician productivity is substantially less in terms of patients per doctor and in physician working hours per week. The V.A. Hospital System can be compared to a vast closed panel group practice plan, with prepayment of a sort. I have not heard that anyone has seriously championed the fiscal feasibility of extending this type of care to the entire population.

One could cite other evidence of the fact that government has not pioneered in economy in medical care, but in addition government, through its democratic processes too often stands as a threat to quality of care as well. Perhaps you have seen the news stories about the Commissioner of Health in Cattaraugus County, New York, who resigned his position rather than to certify payments for Chiropractic services under Medicaid. I am delighted to report that he is now heading a Health Department in Pennsylvania, and I believe he is doing a great deal more to promote quality of health care than has the New York State Legislature, in foisting payment for chiropractic on the public.

Government could, of course, impose controls of various sorts. The popular one at the moment, called for by the AFL–CIO, and assorted legislators and columnists, is for the establishment of fixed fee schedules. This of course addresses itself to the lesser part of the problem, since it does not touch utilization—only physicians fees. Presumably several investigations of the matter of physicians fees are to be conducted by Congress, or under its auspices, and it is my personal opinion that this should not be upsetting to any physicians who are charging reasonably and fairly by existing professional standards. It is surely not the policy of the profession or its organized societies to uphold the right of the individual physician to charge unconscionably or immoderately. One would hope that any "investigation" on this score would, in addition to documenting abuses, study carefully the opportunities for their elimination. If it is appropriate to investigate the financial dealings of Senators and Congressmen I would concede that it is all right to check up on physicians. It should be remembered that the medical profession itself has made considerable progress in the development of review committees, grievance committees, and the like. There must also be a preservation of perspective, since in respect to Medicare at least—the elimination of a full 7% increase in physicians fees, which constitute less than 25% of the program expenditures, would amount to a 1&¾ percent saving, overall. Ill considered, punitive efforts to fix prices—a position generally abhorred by government in respect to most business—could be productive of unintended and unhappy results. I would submit that, compared to the capacities of the medical profession itself, government is ill equipped to remedy the difficulties.

The situation in respect to third party payors, or consumer groups, as guardians of public expenditures for health care, is quite different from that of

government. Underwriters have obviously had a sincere interest in safeguarding their own funds. None of them could survive the sort of deficit operation which is a way of life in government. But among all of the voluntary prepayment plans, the prepaid closed panel group practices and the private insurance companies no alternative to physician review has ever been found. It is quite true that claims review is becoming automated and sophisticated to the extent that machines pick out cases which depart from a programmed range of acceptability, but the actual evaluation of the case and the charges depends upon physician judgment.

This brings us back to my initial allegation that physicians are the only qualified guardians of the public interest in the realm of expenditures for direct patient care. It remains to consider the extent to which they are being helped or hindered in so functioning, and to discuss ways in which they may function more effectively.

Utilization Related to Expenditures

Utilization of hospital facilities and services, for example, is directly related to expenditures. But this is not a simple straight line relationship. That is to say, a reduction in use does not bring about a corresponding reduction in cost. The simple illustration is the hospital room. The most expensive item in the hospital is the unoccupied room. The cost of maintaining it in large part continues, without off-setting revenue. If a zealous utilization review committee should somehow decrease hospital occupancy to the 50% level for any significant period of time what would happen to the per diem cost? It would go up—not down. The most efficient, most economical form of hospital operation is that which uses its facilities and its personnel at close to tolerance levels. Without the application of a great deal of wisdom, the coalescent wisdom of the medical staff and the hospital administration, there may be great imbalances, to the disadvantage of the patient. Hospitals, per se, function poorly as conservators of the public dollar.

In order to judge the propriety of charges for goods or services it is necessary to know what the charge is, as well as the cost on which it is based. For this reason I feel that the flight from fee-for-service is progress in the wrong direction. How is it possible to judge the equity of a hospital charge which becomes unidentifiable with an overall per diem rate. How can one pass on the reasonableness of a fee which is never established as a charge against a pre-paid premium or as a credit toward the physician's salary? To abandon fee-for-service, as is currently championed by so many critics of medicine, seems to me to be forsaking the only real opportunity to identify and isolate the opportunities for economy, and to equate the price tag to the value of the item purchased. By this I imply that it is being made increasingly difficult for anyone—physicians included—to appraise the value of goods and services when the charges are submerged and lose their individual identities.

In this connection it may be of interest to report to you a small study which I have just made in my own 500 bed community general hospital. If, as I have postulated, the physician has this important role of guardian in respect to patient expenditures, how familiar is he with the prices charged to his patients in the hospital? I listed 20 of the more common things ordered by physicians in our hospital—items such as a blood sugar, a chest X-ray, a special duty private nurse, and the like. I asked 17 physicians to fill in what they thought each item cost the patient. 12 were practicing physicians with many hospital patients. 5 were residents in training, responsible for much of the ordering. The pattern became clear, and I didn't feel that I needed to add a lot more people in order to establish statistical validity. Doctors don't know very accurately what charges are made. The spread per item varied from 150% to 600%. 29% of the answers were correct, or close enough to count as correct. 31% of the guesses were high. 40% were low. Residents were a bit wilder than the attending men. All this, I believe, simply points up an important opportunity for improvement. I believe any business man would seek deliverance from a buyer who didn't know the price of what he bought.

You have been hearing much about group practice and especially about the notion that pre-paid closed panel group practice may conserve dollars. I regard this as undocumented, especially where quality as well as quantity requires consideration. No one, I believe, has suggested that any type of practice arrangement converts an inadequate physician into an adequate one. I don't recall who first said it, but I would agree that one thing worse than an incompetent physician would be a group of incompetent physicians. Our quest is not for bargain-base-

ment medicine, but for competent medical care, fairly given and fairly compensated. In this quest there is still great room for innovation, experimentation and improvement. There is still much virtue in our non-system of care as against the rigidity of systems as devised by the British, the Germans, the Swedes and the others. It is naive of our government to think that the heart of the matter is how the doctor is paid, or how the patient pays.

If the common denominator is the ethical competent well-motivated physician—almost any system will work well. If not, it seems impossible to devise a system which can't be beat. This is the quandry enveloping those who discredit the medical profession. They have no happy alternative to turn to.

Frankly, I believe that those who downgrade the medical profession, who diminish its status and who undermine its authority are self-defeatists. To the degree that estrangements have developed between government and medicine, between labor and medicine, between hospitals and doctors, there are tragedies of our time. It has indeed progressed to the point where a substantial number of physicians sincerely wish to have nothing to do with government subsidized programs of care. How much better off would we be if there were constructive cooperative attacks upon our problems of financing and the delivery of services by all parties involved. I believe the medical profession needs the understanding, the support, and the effective assistance of all interested parties to do the job that only it can do. And when that support and assistance is proferred I believe the medical profession should accept it.

Two Canadian physicians, in writing a book called "Medicine and the State" which analyzes in depth the principal government-operated care plans—England, Germany, Russia and the like, reach what I regard as a significant, a highly important conclusion. They state it this way "In the field of health care it does appear that once personal responsibility is removed, collective selfishness replaces the restraints of the individual experience. Experience suggests that individual morality declines as public responsibility increases". For patients and physicians alike we should consider the need to strengthen the sense of personal responsibility and to fortify the restraints of the individual conscience.

The professional association, in this country, has done much to potentiate the efforts of individual physicians, not only in pursuit of scientific excellence, but in the exercise of civic responsibility. Therefore all professional associations of physicians should dedicate a share of their efforts in this direction, but the one instrument best suited for the purpose is the County Medical Society—accessible to the full complement of ethical competent physicians, each belonging to a vigorous progressive State Association, and all integrated in to the American Medical Association. Despite the abundance of brickbats aimed at the AMA, largely because of its conservatism and its resistance to government interventions and controls, it has generally been recognized as a major force for good in the advancement of scientific medicine, physician education, and the development of quality controls. The track record of the medical profession in respect to self discipline and the imposition of high standards is most encouraging. The admission requirements for medical school are self-imposed and they have been so high as to occasion howls of anguish. It was the profession itself, through the AMA that acted importantly in the elimination of medical diploma mills. All of the specialty societies and certifying Boards have been voluntary developments. The evolution of tissue committees, medical audits, and restrictions of privileges in hospitals have been developed by the profession itself, as have the mechanisms and organizations for accreditation of hospitals and other medical facilities. Insurance claims review committees and grievance or mediation committees are inventions and developments by physicians and their medical associations. That these self-imposed controls are less than perfect is not surprising. That there is room for improvement is obvious. But this is working machinery and these are functioning programs. The bright hope lies in perfecting what we have.

Conclusions

Now I should like to try to pull these observations together in order to draw some useful conclusions.

1. Much of the expenditure of public and private funds under the general heading of medical service is outside the range of direct patient care and is beyond the immediate influence of the practicing physician. These elements relate to expenditures for research, education, capital construction, operation of institutional facilities, and the like. They need to be identified and financed as such.

2. Expenditures by, or in behalf of individual patients for direct patient care are greatly influenced by physicians, and there is a great opportunity to improve physician awareness and exercise of responsibility in this respect.

3. Despite extensive efforts on the part of medical societies to encourage medical schools to include instruction in medical-economic understanding and responsibility little has been accomplished in the schools of this country, and virtually nothing has been or can be accomplished in the foreign schools which train so many of our physicians.

4. Opportunity exists for medical economic orientation at the interne and resident level, and this may present an excellent place for cooperation between hospital training programs and local medical societies.

5. Since the physician alone is in position to make decisions in the individual case as to reasonable alternatives in expenditure for diagnostic and therapeutic services, other interested parties should aid and abet the physician in the exercise of this decision-making responsibility.

6. Individual physicians can best be oriented and assisted by their own professional associations, which are already responsible for most of the progress in the area of utilization review, claims review and other efforts to contain expenditures for medical care.

7. Government, labor, industry, third party payors, and consumer groups should lend their support and assistance to medical societies in constructive approaches to the problem.

8. Physicians and their associations should be receptive to any genuine help which may be proferred.

9. The physicians who have remained aloof from organized medicine and the AMA should be vigorously encouraged to become participants in active programs to increase physician responsibility. They should be encouraged by their schools, their employers, their hospitals, and perhaps even by their patients.

10. Irrational, divisive bickerings by all interested agencies and organizations should be set aside in favor of cooperative assault on a massive problem.

EXHIBIT B: MEDICAL CARE COST CONTROL

[From the AMA News, Apr. 8, 1968]

ONLY M.D.'S CAN CONTROL CARE COSTS, PANEL TOLD

Organized medicine, through a concerted effort by state and county medical societies, is "potentially the greatest ally" of the public in controlling expenditures for medical services, participants at the second national American Medical Association Congress on the Socio-Economics of Health Care were told.

Russell B. Roth, MD, Erie, Pa., vice-speaker of the AMA House of Delegates, said, "Vast programs of financing medical care must be supervised, must be audited, must be equated to need, and must be protected against abuse."

Government "Ill-Equipped"

Government, considered by some to be the answer to the problem, could impose controls, he said, but compared to the medical profession, it is "ill equipped to remedy the difficulties.

"It is government which in effect has written the blank check for medical care and must look to someone else to fill in the amount," Dr. Roth said. "It is in large part this abundance of governmental dollars chasing after scarce services that has created the problem."

Despite efforts of third party payors and voluntary prepayment plans, no alternative to physician review has ever been found, he said.

"It is quite true that claims review is becoming automated and sophisticated to the extent that machines pick out cases which depart from a programmed range of acceptability, but the actual evaluation of the case and the charges depends upon physician judgment," Dr. Roth pointed out.

Areas of Need

Proper utilization of hospital facilities and services, fee-for-service payment, and quality of care are areas in which the physician can function more effectively and help to identify and contain expenditures, he said.

Critics of the medical profession, including labor-management, and government, are "self-defeatists," Dr. Roth emphasized.

"I believe the medical profession needs the understanding, the support, and the effective assistance of all interested parties to do the job that only it can

do," he said. "And when that support and assistance is proferred. I believe the medical profession should accept it."

Dr. Roth made the following suggestions in regard to the future role of organized medicine as "guardian" of the consumer's interest in expenditures for medical care:

Identification of public and private expenditures for medical service which differ from elements relating to direct patient care, to improve physician awareness.

Identification of public and private expenditures for medical service which differ from elements relating to direct patient care, to improve physician awareness.

Instruct medical societies to encourage medical schools to include medical-economic understanding and responsibility in their curriculums, especially at the intern and resident level.

Encourage physicians who have remained aloof from organized medicine to become active participants.

Solicit aid of other interested parties in decision-making for constructive cooperative approaches to the problem.

Make use of medicine's professional associations, while remaining receptive to any genuine help which may be proferred.

ITEM 10: STATEMENT OF DR. ALEXANDER SIMON, DEPARTMENT OF PSYCHIATRY, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO MEDICAL CENTER

Probably few countries have begun to face the full implications of the aging population for health and welfare services. Our experiences with Medicare and Medicaid have only suggested the variety and magnitude of the problems presented by a program directed at providing even minimal health services to an increasingly larger group of elderly persons in our population. The incidence and prevalence of mental disorders in this group is high, and comprehensive health services for them should include continuity of care from prevention through screening, outpatient and hospital treatment, and aftercare, and should cover medical, psychiatric, and social and supportive services. Although in most cases specific methods for the prevention of mental illness and for the treatment of many mental disorders in the elderly are not yet possible, at least the severity of disorder may be ameliorated by symptomatic treatment, its personal and social consequence can be mitigated, and the care and treatment made available can be humane.

I am not well acquainted with the details of costs related to the delivery of health services in general, but I should like to emphasize the need for close liaison and coordination among all agencies, health care personnel, and services working in this field. The problems associated with prevention, treatment, and rehabilitation of the geriatric mentally ill not only are enormous and complicated by lack of knowledge, but also are inextricably tangled. Coordination of efforts is necessary from screening and the identification of persons with problems through treatment and aftercare and the provision of supportive services. Screening, for example, is useless if services for referral are not available or are not located where they are easy to reach or if transportation and assistance to get there are not available. Screening programs that see patients at times of psychosocial crisis have shown the wide variety of resources needed: general hospitals, psychiatric units in general hospitals, public and private mental hospitals, medical and psychiatric office care and home visits, psychiatric outpatient clinics, nursing and boarding homes, family care homes, old age homes, and homemaker services, visiting nurses, "Meals on Wheels," and other services to make it possible for some elderly patients to remain at home. But who is to assume responsibility for continuity of care and for the necessary flow of information from one facility or caretaker to another?

Government at all levels, as well as the community as a whole, must be concerned with the availability, quality, and delivery of these services. Community studies have found moderate or severe psychiatric impairment in approximately 20 per cent of elderly persons living in the community. Yet, only one and a half to two per cent of the patients seen in outpatient psychiatric clinics are aged sixty-five or over. In addition, office psychiatric care of the elderly has dis-

criminatory limitations on cost, in contrast to other types of medical care. Well over three hundred thousand persons aged sixty-five and over with mental disorders were resident in long-stay facilities in the United States in 1963. About half of these were in state and county mental hospitals and the other half in nursing homes, geriatric hospitals, homes for the aged, and related facilities. The figure for the mentally ill in nursing homes and such facilities is undoubtedly a minimum one and has considerably increased since the advent of Medicare.

Alternative Placements Discloses Problems

The present trend to make use of alternative placements for those elderly mentally ill who traditionally have been committed to state mental hospitals has brought to attention some serious problems. Nursing and boarding homes are in increasing use both for the initial placement of patients and for the transfer of aged patients already in state hospitals. But standards of care provided in these facilities must be raised, and this means increased costs. Adequate licensing and review procedures for each type of facility, relating to personnel requirements as well as to physical plant facilities, are imperative. There must be better coordination of licensing agencies. Some homes now are licensed by the Department of Social Welfare, some by the Department of Mental Hygiene, and some by the Department of Public Health, and some unification and clarification of licensing procedures clearly is required. The most crying need is for social workers to deal with families and rehabilitation workers to inaugurate and carry out activity programs in the various types of home.

The need for training programs and the upgrading of salaries and experience is especially obvious in relation to nursing personnel—nurses and nursing aides—who care for the elderly. There is a rapid turnover of nursing personnel, largely because of poor pay, and a continuing scarcity of adequately trained and experienced aides. Training courses might well be made part of licensing requirements. Operators of boarding and family care homes greatly need training courses, and psychiatric consultative services should be made available to them and their use encouraged. The psychiatric profession must become increasingly involved. At present, psychiatrists are not adequately trained or experienced in working with the elderly mentally ill, and they are not called upon often enough by those who operate and staff these facilities.

Not only are the geriatric mentally ill being placed initially in alternative facilities rather than in state mental hospitals, but patients already in these hospitals—some for many years—are being transferred out in increasing numbers. Most of these are placed in nursing home or family care settings, although some are able to return to the community. Careful evaluation and screening for appropriate placement are essential, as are continuing social work and medical and psychiatric supervision, if such programs are to be successful.

In summary, the need for health services for the elderly is great, and the nature of the problems of this age group is such that only a truly comprehensive health program can adequately meet their needs. Coordination of the efforts of all resources and personnel is essential if services are to be made available and easily accessible to the large group of elderly persons who are in many cases in really desperate need of help.

Exhibit A: Questions Submitted by the Chairman to Dr. Alexander Simon, University of California, San Francisco Medical Center

1. What has been your experience with the use of outpatient mental health services to the elderly? What reception has it received from the elderly?
2. What is the current status of the geriatric screening unit in San Francisco? What has the record of this unit been in reducing the number of admissions to mental institutions?
3. What are the missing links in the current range of mental health services generally available to the elderly? What changes in Federal policy or legislation may be needed to close such links?
4. You may remember that, at the Subcommittee hearing in the Bronx, New York, that Dr. Israel Zwerling described problems related to the release of geriatric patients from mental institutions when they were unprepared for reintroduction into society? What more can be done to overcome this problem?

(The following reply was received:)

NOVEMBER 14, 1968.

DEAR SENATOR WILLIAMS: I am glad to reply to your request for comments on some questions relating to the costs and delivery of health services to older Americans. Probably few countries have begun to face the full implications of the aging population for health and welfare services. Our experience with Medicare and Medicaid have only suggested the variety and magnitude of the problems presented by a program directed at providing even minimal health services to an increasingly larger group of elderly persons in our population. The incidence and prevalence of mental disorders in this group is high, and comprehensive health services should include continuity of care from prevention through screening, outpatient and hospital treatment, and aftercare, and should cover medical, psychiatric, and social and supportive services. Although in most cases specific methods for the prevention of mental illness and for the treatment of many mental disorders of the elderly are not yet possible, at least the severity of disorder may be ameliorated by symptomatic treatment, its personal and social consequences can be mitigated, and humane treatment and care can be made available.

I am not well acquainted with the details of costs related to the delivery of health services in general, but I should like to emphasize the need for close liaison and coordination among all agencies, health care personnel, and services working in this field. The problems associated with prevention, treatment, and rehabilitation of the geriatric mentally ill not only are enormous and complicated by lack of knowledge, but also are inextricably tangled. Coordination of efforts is necessary from screening and the identification of persons with problems through treatment and aftercare and the provision of supportive services. Screening, for example, is useless if services for referral are not available or are located where they are not easy to reach or if transportation and assistance to get there are not available.

Screening programs that see patients at times of psychosocial crisis have shown the wide variety of resources needed: general hospitals, psychiatric units in general hospitals, public and private mental hospitals, medical and psychiatric office care and home visits, psychiatric outpatient clinics, nursing and boarding homes, family care homes, old age homes, and homemaker services, visiting nurses, "Meals on Wheels," and other services to make it possible for some elderly patients to remain at home. But someone must assume responsibility for continuity of care and for the necessary flow of information from one facility or caretaker to another. The elderly person needs a "representative" to look out for his interests and to assist him in obtaining needed care. Especially pressing are the need for outpatient psychiatric services and the need to remove various restrictions on psychiatric care in contrast to general medical care.

NUMBER OF ELDERLY MENTALLY ILL

Government at all levels, as well as the community as a whole, is vitally concerned with the availability, quality, and delivery of services to the elderly. Community studies have found moderate or severe psychiatric impairment in approximately 20 per cent of elderly persons living in the community.[1] Well over three hundred thousand persons aged sixty-five and over with mental disorders were resident in long-stay facilities in the United States in 1963, about half of them in state and county mental hospitals and the other half in nursing homes, geriatric hospitals, homes for the aged, and related facilities.[2] The figure for the number of mentally ill in nursing homes and related facilities undoubtedly is a minimum one and has increased considerably since the implementation of Medicare.

The present trend to make use of alternative placements for those elderly mentally ill who traditionally have been committed to state mental hospitals has brought to attention some serious problems. Nursing and boarding homes are in increasing use both for the initial placement of patients and for the transfer of already hospitalized aged patients. But standards of care provided in these facilities must be raised, and this means increased costs. Adequate licensing and review procedures for each type of facility, relating to personnel requirements as well as to physical plant facilities, are imperative. There must be coordination

[1] Lowenthal, M. F., Berkman, N., and Associates. *Aging and Mental Disorder in San Francisco* (San Francisco: Jossey-Bass, 1967, p. 37.

[2] Kramer, M., Taube, C., and Starr, S. Patterns of use of psychiatric facilities by the aged. In A. Simon and L. J. Epstein (Eds.), *Aging in Modern Society*, Psychiatric Research Report No. 23 (Washington, D.C.: American Psychiatric Association, 1968), pp. 89–150.

of licensing agencies; in California, for example, some homes now are licensed by the Department of Social Welfare, some by the Department of Mental Hygiene, and some by the Department of Public Health. Unification and clarification of licensing procedures are required. The most pressing need is for social workers to deal with families and for rehabilitation workers to inaugurate and carry out activity programs in the various types of home.

As to the need for psychiatric outpatient services for the aged, the National Institute for Mental Health has been collecting and publishing data on the numbers and characteristics of patients receiving services in outpatient psychiatric clinics since 1954. The clinic population has been weighted heavily with children under eighteen and adults in the 18–44 year age groups, with relatively small proportions in the age groups 45–64 and 65+. Persons aged sixty-five and over constituted only 2 per cent of the total admissions to outpatient clinics in 1965. In contrast, persons in this age group constituted 29 per cent of all first admissions to public mental hospitals for the same year.[3]

Although psychiatric clinics claim not to discriminate against particular groups, there does seem to be a de facto discrimination against geriatric patients. A survey of admissions to the Outpatient Department of the Langley Porter Neuropsychiatric Institute for the year July, 1963, through June, 1964, showed that slightly less than 2 percent of these admissions were of persons over the age of sixty. Subsequent conversations with professionals involved in the private and public sectors of social services, with psychiatrists in private practice, and with non-psychiatric physicians in private practice suggested, however, that there was a large need for outpatient services for people in the older age groups. Our feeling was that if the public could be informed of a special clinic that had a particular interest in the psychologic disorders of the aged, there would be substantial utilization of the clinic's services. Such a program might also provide social agencies with consultative services regarding difficult client problems and a psychiatrist who could make house calls on clients who, for physical or psychologic reasons, could not go outside their homes for help.

Training for Care of Elderly Mentally Ill

The need for training programs and the upgrading of salaries and experience is especially obvious in relation to nursing personnel—nurses and nursing aides—who care for the elderly. There is a rapid turnover of nursing personnel, largely because of poor pay, and a continuing scarcity of adequately trained and experienced aides. Training courses might well be made part of licensing requirements. Operators of boarding and family care homes greatly need training courses, and psychiatric consultative services should be made available to them and their use encouraged. The psychiatric profession must become increasingly involved; at present, psychiatrists are not adequately trained and experienced in working with the elderly mentally ill, and they are not called upon often enough by those who operate and staff these facilities.

Not only are the geriatric mentally ill being placed initially in other facilities than state mental hospitals, but patients already in these hospitals—some for many years—are being transferred out in increasing numbers. Most of these are placed in nursing home or family care settings, although some are able to return to the community. Careful evaluation and screening for appropriate placement are essential, as are continuing social work and medical and psychiatric supervision, if such transfer programs are to be successful.

Geriatric Outpatient Program

In the summer of 1967, with support from a grant by the State Administration on Aging, The Langley Porter Neuropsychiatric Institute Outpatient Department began a Geriatric Outpatient Program. A press release was sent to the San Francisco daily newspapers, and one of the papers printed an extensive interview with the coordinator of the program. In addition, there was a radio interview on a popular noontime program. Representatives of many agencies dealing with the elderly population were invited to meet with the staff of the project to discuss its work and the kinds of involvement the agencies would like to encourage. As a result of these conferences, a psychiatrist was added to the staff to work as a consultant with the social agencies and to see patients for them, either individually or in groups, and also to conduct evaluations and treatment of homebound patients referred by the agencies.

---

[3] Kramer, *et al., ibid.*

Within four days after the initial publicity in the newspapers, the project received 60 telephone calls. These were taken by the project social worker, who evaluated the urgency of the need and tried to have the most pressing cases seen first. Other requests were placed on a waiting list, and these applicants received letters from the Project Coordinator saying they would be called as soon as time became available. Patients who were accepted were evaluated by a trainee (who might be a psychiatric resident, social work student, medical student, or post-master nursing student) and then were discussed at an interdisciplinary staff meeting. The patient then was assigned for appropriate psychothrapy and received medication and other somatic therapy when indicated. The Inpatient Services of the Institute were available for those patients needing hospitalization.

During the first ten months of operation, the admissions of persons aged sixty and over to the Outpatient Department rose from slightly less than 2 per cent to 13.5 per cent of all patients admitted. Sixty-six geriatric patients were admitted for outpatient psychotherapy following evaluation of 162 requests. Half of the patients seen came for five or more visits. Seven required hospitalization at the time of the first interview. Most of the patients seen were diagnosed as having depressive reactions.

Our experience shows that when a psychiatric clinic expresses interest in their problems, older people will avail themselves of outpatient services to a degree more closely approximating their representation in the general population than is generally the case. Age does not preclude a meaningful psychotherapeutic intervention.

A valuable side-result was obtained with respect to the attitude of trainees involved in the program. Although most trainees came onto the Geriatric Outpatient Program team with the usual negative bias against the treatment of older patients, during the course of their experience they generally changed their attitude and became, if not positively oriented toward the treatment of these patients, at least less professionally nihilistic.

In San Francisco prior to 1963, approximately two-thirds of the patients over age sixty who were admitted to the San Francisco General Hospital psychiatric observation wards each year subsequently were committed to state mental hospitals. A geriatric screening unit established by the California Department of Mental Hygiene in association with the hospital in 1963 has made a remarkably successful effort to locate and utilize alternate placement facilities in the community for these elderly patients for whom commitment would otherwise be sought. A summary of the activities of this program, written by Miss Mary Lou Clark, Director of the Geriatric Screening Unit, is attached.*

In summary, the need for health services for the elderly is great, and the problems of this group are such that only a truly comprehensive health program can meet its needs. All levels of psychiatric care certainly need upgrading, from the long-term care of patients who grow old in the hospital to brief outpatient services. Coordination of the efforts of all resources and personnel is essential if adequate services are to be made easily accessible to the large group of elderly persons who are in many cases in really desperate need of help.

Sincerely,

ALEXANDER SIMON, M.D.

ITEM 11: LETTER FROM DONALD L. SPENCE, PH. D., STAFF SOCIOLOGIST, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO MEDICAL CENTER

November 27, 1968.

DEAR SENATOR SMATHERS: I am extremely sorry for the delay in responding to your inquiry of September 27. Dr. Feigenbaum and I have discussed your letter at some length, however, and feel that we do have some recommendations concerning the problem of medical student attitudes toward the geriatric patient.

Dr. Freigenbaum directs an outpatient program in geriatric psychiatry. His experience indicates that when students or trainees are exposed to this program their original negative attitudes are generally changed to a more positive stance with regard to the treatability of older people. This suggests two factors in the shaping of attitudes toward older patients. First, that some exposure to older patients is essential in any training program where the intent is to influence attitudes. But, probably more important in terms of the nature of the attitudes formed is the type of exposure. For a student to see an older patient properly

*Retained in committee files.

diagnosed and placed in a treatment program designed for his care is a far cry from what most of them see when in their training they are exposed to the "old peoples ward" in some public general hospital or to a hospital for chronic illness.

What this means is that early in their medical education, students should be instructed in the problems of gerontology in all its medical aspects. Later in their training when they are exposed to a variety of elderly patient situations, they will have the conceptual framework to understand how these situations fit into a broader picture. To accomplish this will require the training of persons to carry out this instruction. It will also be necessary to convince medical schools that this type of instruction is worthy of a significant place in an already overburdened curriculum. Ideally, this instruction should be taught in conjunction with existing courses in appropriate medical specialties. This, would require the re-orientation of the same individuals and professionals who are currently perpetuating the negative stereotypes. The problem, therefore, becomes one of the best strategy to produce the desired change in an ongoing, self-perpetuating situation.

Some change is already occurring. For example, there is a subcommittee of the Gerontological Society on training of medical students with respect to geriatrics. This subcommittee is currently headed, I believe, by Dr. Alfred H. Lawton of St. Petersburg, Florida. Also, the Western Interstate Commission for Higher Education had geriatric psychiatry as the content for one of its recent training sessions for psychiatrist teachers of practicing physicians. Another such program is now in the formative stages and is due to start in May or June of this year. The Committee on Aging and the American Psychiatric Association has made recommendations concerning the teaching of geriatric psychiatry for both medical students and residents in training. And, the very fact that your subcommittee exists and is concerned with the problem suggests the direction of change. Maintaining the impetus for change should be a primary objective.

Publicity, money, and programs are what is needed. Publicity in the right places is difficult to develop. For example, our article as published was rejected as inappropriate for the *Journal of Medical Education*. As for funding, you are undoubtedly aware that appropriations for training and research were cut this past year. And, in terms of operational programs, it is important to implement those which are the most appropriate to meet current needs. Your committee, is in a position to influence all three of these strategies.

Enclosed you will find a copy of our article as well as a background paper on the problem.[1] If we can be of service in any way please let us know.

Respectfully,

D. L. SPENCE, Ph. D.,
Staff Sociologist.

ITEM 12: LETTER FROM DR. HAROLD RICHTER STARK, LITTLEROCK, CALIFORNIA

NOVEMBER 22, 1968.

DEAR SENATOR WILLIAMS: I was happy to see an article by you in the November Geriatric Times regarding your work and interest in geriatrics. As you may note from my letterhead (F.A.G.S.) I am a specialist in geriatrics. Over a period of 20 years, I have attended many people in the old age bracket both in private practice and in various convalescent hospitals in southern California.

I recently had a heart attack and am recuperating at the present time in one such hospital, so I have had an opportunity now to observe as a practicing physician and as a patient some of the great problems of geriatric care in such hospitals.

Inasmuch as the Government is paying for much of this care in such institutions, I wonder if you would mind if I made a few comments which I hope may help you in the governmental phase of this work.

When a patient is placed in such an institution, it appears he is placed there for one of two reasons, or possibly both: that he has a health problem which may be minor or major and such placement is for the convenience of the doctor. Or it may be because the family feels unable to care for the patient and wishes to be unloaded of the burden.

It is obvious to me, and to you as well I am sure, that most of these convalescent hospitals are run by private individuals with the idea of profit in mind. Consequently, there are certain prerequisites for the management and for the patient.

---

[1] Retained in committee files.

It appears to me that the patient being placed in such an institution, if he is ill, should have the best of medical care, nursing care, food and general supervision.

I am convinced that in the present status of medicare that this is not always the case. Most doctors, in the first place, are allowed only one monthly visit per patient and are not particularly interested in geriatrics professionally. Such institutions become a dumping ground for those who are terminally ill, or a place where they can be cared for outside of the family.

The medical care, from the standpoint of the physician, is only partially successful. Communication with the doctor is difficult. Illnesses or medical emergencies are left to the discretion of the nursing staff or telephone conversations. I have personally noted that most of these difficulties may occur at night and the doctors are not available for consultation.

This places a responsibility on the judgment of the nursing staff. Most of this staff consists of licensed vocational nurses and medical aides—with the emphasis on the medical aides whose pay schedule is the minimum. Thus, only certain types of individuals can be procured to do this work and the nursing staff in general has no special preparation in the field of geriatrics. They know very little about the psychology and actual care of the older person, who is becoming greater in numbers each year.

It is my belief that these nurses and aides should be specially trained in courses in geriatrics and geriatric medicine. It is my personal belief, after observing the medical emergencies in such an institution which can occur in great numbers in one evening, that every convalescent hospital or nursing home of any size whatsoever should have a resident physician whose duties are to make medical rounds every morning and evening and to take care of any emergencies that arise during the night. It is my belief that such patients referred to a convalescent hospital by individual doctors should be placed under the care of such a resident physician so that the referring doctor no longer has any responsibility.

I feel that, if this is done, a higher quality of medical care can be established by each institution and that the Government of the United States will receive more for its money than at the present time under the present circumstances. Also, a program for our older people could be developed to which America could point with pride.

This resident physician could train the geriatric staff, supervise the diet, make judgment regarding the further disposition of the case at hand, possibly provide for occupational therapy and the necessary psychological counseling for these older people.

The problem that presents itself, however, is that most of these nursing homes are built by private organizations with profit in mind and it would probably be impossible for them to afford the services of such a resident physician.

It may be that there should be a Government subsidy and some sort of financial arrangement made with the Government of the United States to finance this.

You will note in the enclosed article* a survey made of the University of California Medical Center at San Francisco showing what the attitude of the young physician is in the field of geriatrics. I feel that very few physicians are interested sufficiently in the older patient, or that they do not have the proper time to devote to them, which constitutes an extremely grave problem, in my mind.

Thank you for your interest in the geriatric patient and in geriatrics. I hope that you will continue this great interest and perhaps solve this problem somehow; possibly, with a Government subsidy of hospitals or whatever is necessary to guarantee these older people the best of everything in the remaining years of their life.

Very sincerely,

H. R. STARK, M.D.

ITEM 13: STATEMENT OF BOYD THOMPSON, EXECUTIVE DIRECTOR, SAN JOAQUIN COUNTY MEDICAL SOCIETY, STOCKTON, CALIF.

The San Joaquin Foundation for Medical Care is an incorporated body under sponsorship of the San Joaquin County Medical Society. The specific and primary purposes for which this corporation is formed are to promote, develop, and encourage the distribution of medical services by its members to the people of San Joaquin and adjacent counties at a cost reasonable to both patient and physician; to preserve unto its members, the medical profession at large, and public, free-

*Retained in committee files.

dom of choice of both physician and patient; to guard and preserve the physician-patient relationship and its innumerable benefits; to protect the public health; to work and study in cooperation with the insurance industry and service plans that provide for periodic and realistic budgeting for medical care and to work with all segments of the community to develop best possible ways of financing and providing medical care.

The San Joaquin Foundation was established in 1954 and is now responsible directly or through insurance companies for insurance for half the population of the 5 counties it serves. The Foundation concept has spread to include 31 counties in California and is established in some counties of 7 other states.

The majority of the physicians of the San Joaquin Foundation for Medical Care take pride in the fact that their Medical Society is sponsoring through its economic arm, programs that give to their patients comprehensive medical care with predictable costs at premiums that are under controlled devices. They are particularly pleased by the fact that, due to the administrative relationships between the Foundation for Medical Care and the insurance companies, governmental agencies and others that purchase Foundation programs, it has been possible to improve the coverage for medical services, and allow for comprehensive coverage of all needed medical care services. By this we mean the inclusion of such important items as care of infants from birth to assure protection against the catastrophe of birth anomalies; the coverage of patients who are critically ill and need physician attendance over many hours; consultive services for all types of problems; the ease in which new modalities, such as the intensive care unit and cardiac unit, can be covered under our programs.

A few of the physicians are unhappy about our program in that they chafe under the strict quality control and fee control mechanisms. These physicians, for the most part, are in the minority and probably will be with us for a long period of time.

This technique has spread to other areas and in the areas to which it has spread, the physicians have welcomed it because it gave them a device with which they could compete with other administrative modalities whose aim was the destruction of the traditional physician-patient relationship. In areas of less sophistication where the insurance mechanism has not been developed to any great amount, this technique would be completely impalpable. It is necessary for conflict for this technique to develop because it takes conflict to bring awareness as to the problems and possible solutions to the problems by the medical profession.

Preventive measures are encouraged under the Foundation programs, and early diagnosis is more easily arrived at because of the increased freedom of using x-ray and laboratory devices on an out-patient basis. The financial barrier of seeking care is removed in that the patient is aware of the cost factors involved prior to seeking his medical care and most, if not all, is covered by his prepaid program. Other ingredients in the improvement of preventive measures is seen in the fact that as physicians become involved in delivery systems of medical care they also become involved with areas of need and take steps to correct this need.

Savings in Public Funds

Does it result in savings of public funds? The answer to this question is an unqualified "yes". This can be proven through the work done in the San Joaquin Foundation as well as by the Foundation for Medical Care in Kern and Fresno counties in California. In the brief time that these three counties have been involved in experiments relating to Title XVIII and Title XIX of Public Law 89–97, considerable savings have been documented without a decrease in the quality of care and, as a matter of fact, with the increase in the quality.

The utilization control and medical audit features of the program are acceptable to most of the physicians who participate in the program for the simple reason that they know, in general, medical audit is being carried out which does not affect them personally. The 10% of physicians whose claims are chronically in medical audit, obviously, are unhappy about the program and their unhappiness perhaps attests to the thoroughness of the audit.

We have been asked if we have encountered any federal or state statutes, regulations, or administrative policies which unnecessarily impede or inconvenience our organization in rendering medical services. To some degree the answer would have to be yes. State statutes are restrictive in developing methods of payment that vary from participating and nonparticipating physicians. They also are restrictive in that any program that is carried out under our strict medical audit in San Joaquin County must also be payable in areas where the audit

is not so strict. This has increased costs in certain instances and caused problems in reviewing out of area claims. Our local programs could be more inclusive if protective devices could be developed to increase co-insurance deductible features for out of area coverage.

Second, at the present time, there is no way where the Foundation can involve itself in reimbursing hospitals in that State statutes require that this be done on an insured basis and for this reason funds must be available to cover all contingencies. If change in the Law were made we could develop similar service contracts with hospitals and allow, perhaps, for more comprehensive coverage in hospitals.

ITEM 14: LETTER FROM DON VIAL, CHAIRMAN, CENTER FOR LABOR RESEARCH AND EDUCATION, INSTITUTE FOR INDUSTRIAL RELATIONS, UNIVERSITY OF CALIFORNIA, BERKELEY

November 22, 1968.

* * * * * * *

DEAR SENATOR WILLIAMS: First, I am enclosing a copy of a speech by Einar Mohn, Chairman of the California Council for Health Plan Alternatives, which was delivered before a recent convention of the California Hospital Association. Since I helped develop the address, I think it may be useful in responding to your questions.

As the speech indicates, the real crisis in health care is that while we are spending some 6% of GNP for health services, millions of Americans are still effectively removed from the essential services required to maintain good health. The government programs, including Medicare and Medicaid, have failed to relieve the crisis because they are primarily concerned with removing the financial barrier between the individual and so-called "mainstream health services" without adequately attacking the problem of organizing health care services to make them more effective. In this sense, these programs are like the negotiated programs which tend to increase demand beyond the present capacity of our health resources as they are presently organized and used. If the federal government is to make good on the promise of Medicare and Medicaid to bring more individuals into the mainstream of health care, then it must find ways of encouraging the reorganization of health services so that delivery systems are developed to overcome the kind of problems both underprivileged and many blue collar workers face in obtaining quality medical care.

QUASI PUBLIC HEALTH CENTERS

In the administration of Medicare, I would urge the federal government not only to encourage better organization of health services, but to actually sponsor new delivery systems in major metropolitan areas through the creation of quasi-public health centers so that realistic bench marks may be established for reimbursing the providers of health care services. In electric power generation, we have tried to keep alive the public power bench mark. In health care in California, we are moving in the opposite direction. MediCal has encouraged the conversion of county hospitals into community hospitals without the development of any new public delivery systems that can be used for bench mark purposes. We seem to be bent upon placing ourselves completely at the mercy of the providers, and what they determine to be "customary and usual charges."

In other words, I do not see any way of coming to grips with cost and quality problems in a framework that ignores the basic health care organizational issues. Mr. Mohn's address to the CHA places emphasis on the need for hospitals themselves to do something about keeping people well by taking a direct hand in fostering new ways of organizing outpatient services. I agree with him that hospitals must assume some of the responsibility for the over-use of hospital facilities when such over-use results from the failure of the community and health plans to make outpatient care accessable on a timely basis.

In this regard, the federal government should consider the extent to which hospitals and other health facilities are cooperating in implementing the federal comprehensive health planning law. In reimbursing health facilities for services rendered through Medicare and Medicaid, no allowances should be made for depreciation of facilities and equipment unless individual health facilities are in fact planning to provide services needed by the community and coordinating their plans through the comprehensive health planning mechanism of their community. Mr. Mohn supports this view point in his CHA address.

Preventive Health Service for Elderly

Finally, I would like to comment on the idea of providing preventive health services for the elderly. Of course, many of their health problems stem from the fact that they failed to receive preventive services when they were younger. The provision of such services may in fact be too late for many of them to suffer from chronic diseases that could have been prevented. Nevertheless, for those who's health can still be protected, I would suggest that the federal government establish a differential reimbursement rate for health facilities and physicians who participate in the establishment and operation of a community health screening facility for those covered by Medicare and Medicaid. This may be difficult to do, but I think it is worth the effort. Such a health screening facility should not only provide regular multiphasic health examinations for the aged, but should include a wide range of health education services designed to reach into the community and to help integrate medical care services that are now covered so that they may be used to preserve health. There is a great difference in my mind between adding health care screening on the one hand as another item on the medical "smorgasbord," and on the other, as a service that is organized to integrate for individuals the health services that are available to them in the community. I have serious reservations about multiphasic testing unless it is based on the integrated approach.

I offer these thoughts for what they may be worth, and regret that I have not had the time to prepare a statement for submission into the record. Thank you for giving me this opportunity to submit these comments.

Sincerely,

Don Vial, *Chairman.*

Exhibit A: Speech by Einar Mohn, Chairman of the California Council for Health Plan Alternatives, to the California Hospital Association

Introductory Remarks

Today, in this age of crises, we find it difficult to talk about health care without referring to a crisis in connection with skyrocketing medical costs. The statistics, indeed, are of crisis proportions. During the two year period, June 1966 to June 1968, when the general Consumer Price Index was rising by an inflationary 7%, the medical care index of the BLS rose 14%, twice as fast, and the index of hospital daily service charges rose 37%, over 5 times faster than the general Consumer Price Index. The projections for the future which we have heard many times are even gloomier . . .

Yet, we would be making a tragic mistake were we to focus only on costs, for this extraordinary rate of cost inflation in health care is merely a symptom of the real crisis.

The *real crisis* in health care is that while we are spending some $50 billion a year for health services in America (about 6% of GNP), millions of Americans are still effectively removed from the essential services required to maintain good health.

In a more immediate sense, the *real crisis* is that the billions being poured into the mainstream of health care to reach these millions are actually feeding the inflationary fires and providing very little in the way of incentives to finding more effective ways of organizing and delivering health services.

This, then, is the real crises—the sluggishness and unresponsiveness of our health care system to unmet needs, regardless of how much money we manage to pump into it.

We know this crisis only too well in the labor movement. We are up to our ears in it.

For years we have been "sweating out" of our employers, in lieu of wage increases, ever-larger amounts of money to purchase health care benefits for our members and their families through third party, group-purchases, arrangements. For years we have been pouring this money (now about $700 million annually in California) into the so-called mainstream and in the process, we have contributed more to the rate of health care inflation than to the improvement of the benefit structures of our programs. More importantly, quality considerations have consistently eluded us, and we have spent our dollars over the years without affecting a more efficient use of medical resources or better ways of organizing and delivering services to maintain the health of our members.

We have worked primarily through third-party intermediaries to come to grips with our mounting problems—and they have failed us. We are now prepared to abandon them, if necessary.

As we told the CHA committee that met with us recently to discuss our problems, the Council for Health Plan Alternatives seeks a fundamental reorganization of health care. Our object is to pool the collective bargaining power of a million and three-quarters organized workers in the state to insure the greatest return for our health dollar, to secure an effective voice for the consumer in providing and planning for health, and to establish the machinery for monitoring the cost and quality of health care services and preventing abuse.

In order to accomplish these far-reaching objectives, we have made the decision to become active participants in solving the problems in planning and organizing health care services. We have taken the steps necessary, as in the case of the CHP and the CMA, to establish direct lines of communications with the providers of health care services, rather than continuing to rely primarily on insurance companies and other vendors to act as our intermediaries. At the same time, we are not closing the door to constructive help from the insurance companies or other vendors.

We are under no delusion that the job we have cut out for ourselves is going to be easy to accomplish. For example, economists are prone to tell us, in connection with the current run-away inflation in health care, that we are bucking a classical situation where the demand for health services is running way ahead of the supply of resources needed to meet the demand. Inflation, we are told, is inevitable under these circumstances, and will continue until the supply side catches up with demand.

We wish it were possible to be even this optimistic. The prospects of supply catching up with demand doesn't even appear on the horizon at this time. We are in a sellers market in the health industry, and it's going to continue that way for a long time for some obvious reasons, the main one being that the health industry appears to be well sheltered from the pressures of demand to use resources in short supply more efficiently and effectively, while more resources are being developed. We do not see these classical economic pressures at work. In connection with hospitals specifically, we are inclined to believe, until proven false, what the Somers' pointed out in their book *Medicare and the Hospitals:*

"In no other realm of economic life today are payments guaranteed for costs that are neither controlled by competition nor regulated by public authority, and in which no incentive for economy can be discerned." (Somers and Somers, *Medicare and the Hospitals*, 1967, p. 192.)

Negotiated programs have also taken a great deal of the risk out of collections for hospitals, and for doctors and other providers as well. Doctors are undoubtedly even more immune from incentives to economy than hospitals.

Problems Faced by Providers

In a very real sense it can be said that the economic chips are on the side of the providers. But the Council knows things really aren't quite that bright on the provider's side either. The Government isn't adding its billions to the purchasing power stream for health care without attempting to exercise some responsibility to protect consumers from the forces working against them. And, as indicated, it is the intent of CCHPA, as an organization of group purchasers, to develop all the bargaining power it can pull together for the purpose of developing a direct buyer-seller relationship with providers of health services. Like the government, we have become very interested not only in removing financial barriers, but also in making sure that when negotiated dollars are spent, maximum pressure is exerted on providers to utilize resources as efficiently as possible, and to organize them so that our members obtain the right health service at the right time in the right place. We are going to try to use our dollars to get the quality we are paying for and to develop health care delivery systems that will maintain health as well as treat the sick. That is the thrust of government policy these days; it is our main thrust also.

The exercise of "power" these days has become something of a scare word, even though it is the basis of economic action in our free society. We use it in the sense that the Council is seeking to exercise power that goes with "consumer sovereignty" in our economy—the sovereignty that too often falls prey to producers and providers of goods and services. Just how much consumer power it will be necessary for the Council to attempt to muster will depend on the

response we receive to our pleas for help from the providers. We would much prefer to work with you on our mutual problems, rather than in opposition to policies and practices which we believe no longer have any validity.

Let me therefore explain how our Council members look at some of the responsibilities of hospitals.

COMING TO GRIPS WITH HOSPITAL COST AND QUALITY ISSUES

The staggering increase in hospital costs experiences over the long run, and the acceleration of the increases since Medicare and MediCal, is an urgent matter that group purchasers who are responsive to their members cannot ignore. Out-of-pocket costs of covered members are going up as fast as the value of hospital benefits declines. Yet we know what costs cannot be discussed in a vacuum without relating them to quality considerations, advancements in the health and medical sciences, and related technological changes. CCHPA is not looking for "bargain basement" health services. That is why we have asked CHA to make all the facts available that will help to explain the sharp rise in hospital charges since Medicare.

In this connection we know wages alone could not begin to explain increases of the magnitude experienced. In fact, we have no tolerance whatsoever for the viewpoint that singles out rising labor costs in hospitals as the chief culprit. Apart from what appears to be the case that hospital charges are going up faster than unit labor costs, it should be recognized that labor costs are in fact going up in hospitals *because they should be going up.* It is intolerable to think that a nation spending $50 billion a year on health care should require, at the same time, a public subsidy from low-income hospital workers through the acceptance of substandard wages and conditions. From the viewpoint of thinking consumers, substandard wages and conditions are incompatible with the high quality of services demanded by consumers.

It's that simple to us. Hospitals can't score any public relations points by blaming low-income hospital workers and other underpaid persons, while ignoring a host of other considerations relating to the way services are planned and organized—considerations that vitally affect what the consumer is getting for his money.

What is important to the consumer in connection with hospital labor costs is how hospital administrators respond to the new set of economic considerations which come into play as labor costs go up. In a sellers market, like the one that exists for providers of health care services, the easiest and most irresponsible thing to do is simply pass the increases on to consumers. It would be considerably more responsible, although more troublesome, to explore ways of making offsetting adjustments, as for example:

—by introducing more efficient administrative practices.

—by introducing labor saving measures and finding ways of organizing work so that professionals and para-medical personnel are regularly employed at their highest skill levels, consistent with quality considerations.

—by abandoning under-utilized, high cost services which can be provided just as effectively and more efficiently in the community through other facilities.

To the extent that hospitals take the easier path of charging what the traffic will bear, while simultaneously denying consumers full access to financial data and information on how costs are allocated for rate setting purposes, they are simply helping to build a case against themselves for regulation as public utilities. It would be wise policy for hospitals to recognize that the days are limited in the future when they will be able to increase rates without being fully accountable to the public. Whether or not it comes through public utility regulations, group purchasers will increasingly demand accountability.

These observations are not intended to imply that we cannot see the inevitability of some substantial cost increases in the future, apart from the questions of wage costs. The Council can appreciate the fact that hospitals have historically been institutions for those who are seriously ill, and the fact that the cost of medical care has gone up as medical knowledge has advanced and as treatment procedures in hospitals have become more elaborate. It does not follow, however, that hospitals are now powerless to do anything about rising labor costs associated with medical progress.

As I have already indicated, CCHPA is also concerned about hospital costs in the context in which hospital services are organized in the community to meet the health needs of the community. Our over-riding concerns are (1) that hospital facilities and services of highest quality be *available* to all persons;

(2) that they be organized so that they are readily *accessible* to all persons; (3) that they be made available and accessible without wasteful duplication and undesirable proliferation of services; and (4) that hospital facilities and services be provided in balance with other health facilities and services to meet the total health needs of the population.

In short, CCHPA looks at hospitals costs in relation to how hospital services are organized in the community and how hospitals are used in the community. We see no hope for keeping hospital costs in check outside of a framework for effective planning of hospital and related facilities and services at the local and regional levels. Hospitals must not only accept the necessity of planning; they must actively participate in the voluntary planning process to help make it fully effective. Health planning is essentially a local and regional responsibility that simply cannot be passed upward to higher levels of government or community organization. Planning at the local level must be compatible. in its values and in its planning criteria, with planning at higher levels of community organization all the way up to the federal government.

Today, we know that the experience with voluntary health facilities and services planning in California has been very uneven and that it leaves a great deal to be desired. Much of the hospital planning has hardly gotten beyond the "bricks and mortar" stage. Well defined planning criteria are largely nonexistent. Wasteful duplication of facilities, equipment, and services is not the rare exception—it is still a common occurrence. More importantly, much of the hospital planning is going forward without adequate consideration being given to planning for other health facilities and services, such as extended care facilities, home health services, diagnostic centers and other out-patient services.

Hospitals have a special responsibility, not to try to dominate health facilities and services planning, but to participate in it and to put an end to costly duplication and undesirable proliferation of services wherever they exist. Too often decisions on expansion, renovation, the purchase of expensive equipment, and the addition of new services are made not on the basis of community needs—the availability, the accessability and the quality of the facilities and services to be provided—but on the basis of convenience to doctors who practice in the hospital and on the basis of their desire to have everything available to them in the hospital regardless of utilization experience or availability of services elsewhere in the community. Too often, also, hospitals have a tendency to want everything other hospitals have in the way of facilities, equipment and services, regardless of whether the community needs them.

Voluntary planning must stop this kind of wasteful and senseless competition. The inevitable rise in hospital costs related to advances in medical knowledge and the use of more complicated procedures is enough to be borne by consumers, without the toleration of wasteful practices. Voluntary planning, if is is to be effective in controlling costs, must make hospitals truly responsive to community needs, and at the same time strengthen the hand of hospitals so that they may withstand those pressures of doctors which may run contrary to community needs in the planning and development of hospital facilities and services. It follows that this can be achieved only if informed consumers are effectively involved in the planning process and become the domiant voice in the direction of the voluntary planning process.

CCHPA should be able to count on hospitals to take the lead among providers in developing the consumer role in the planning process. In recent years, we have come a long way in our acceptance of consumer participation. We have progressed from no representation to token representation, and now to the requirement that consumers be in the majority on all health planning bodies. This majority, however, too often functions as a facade for continued domination of the planning process by providers. We must find ways of moving beyond this facade.

In our effort to strengthen the concept of voluntary planning for hospital and related facilities and services, we must give special attention to breaking down the barriers that separate large groups of consumers from effective participation in the planning process, particularly in regard to the participation of minority and disadvantaged groups whose unmet health needs should be given high priority in the planning process. CCHPA urges your support in this effort.

We do not delude ourselves that the development of active consumer interest in the planning process can be achieved without a great exercise of responsibility on the part of consumers themselves and those who represent them as group purchasers, including organized labor. Apathy is not our only problem

Our foremost problem is overcoming ignorance concerning the planning process and its vital importance to cost and quality problems of interests to labor and other consumers. Because of the importance of consumer participation, the state, our universities, and providers should make a special effort to develop educational programs which will help all consumers involved in the planning process to identify health planning issues and problems as they relate to the total health needs of the population, especially the unmet needs of the underprivileged.

Planning Requires Broad Base

We have learned many additional lessons from our experience with health facilities and services planning in California during this decade. One of the most important is that the voluntary planning process cannot move forward unless existing facilities assume responsibility for planning their own future in reference to the health needs of the community. We have come to accept planning as a process—not some kind of master plan—a process which starts with how facilities perceive their roles in the community in which they are located. It is at this level that local and regional planning agencies can help existing facilities evaluate community needs and adapt their planning to those needs, without the duplication and proliferation of services and facilities that push up costs to the consumer.

The essence of such planning is not alone that it be done, but that the plans themselves should be made public through local and regional planning agencies along with all the supporting information used in developing them. Without this kind of planning and full disclosure of information, it is virtually impossible for consumers who sit on planning agencies to give direction to the planning process so that steps may be taken to take care of community needs that are unaccounted for in the planning of existing facilities.

One of the major responsibilities of the consumer in the planning process is not only to encourage innovations among existing facilities and to experiment with new ways of providing health services more effectively, but to make sure innovation and experimentation is stimulated in the community when the plans of existing facilities fall short of community needs or fail to come to grips with the problems encountered by consumers in obtaining quality health care.

In keeping with these expressed views, our Council members agree with the recommendation adopted recently by the State Hospital and Related Health Facilities and Services Planning Committee (the so-called "543" Committee) in its report to the state legislature. The recommendation, in part, reads as follows:

"In cooperation with regional and local health facilities and services planning groups, each health facility in California should develop both a current and a 5-year program for capital expenditure, for replacement, modernization, and expansion. Such programs should be kept up to date and on file with the local and regional planning agencies, through the development of continuing cooperative relationships between the facilities and the planning agencies. They should include a statement of the facility's responsibility to the community in at least the following areas: the people to be served; the area to be covered; the services to be provided; the facility's relationship with other facilities; and the timing and costs of implementing the program."

To repeat, it is crucial that these programs and all the information developed to support them be handled as public information. This means specifically that they should be available not only to the planners, but to the public at large, especially anyone initiating new facilities and those contemplating expenditures for the replacement, modernization and expansion of other health facilities and services.

We share the view that voluntarism seems to work best when government provides a few financial incentives in support of the process. In this connection the "543" Committee has suggested that in the administration of MediCal, the State Health and Welfare Agency should not include in its reimbursement formula for costs any allowance for depreciation to facilities that do not cooperate with regional and local planning agencies in the development and disclosure of their plans. We heartily agree with this viewpoint. But the Council would go further and suggest that facilities unwilling to assume their planning responsibilities toward the public, and unwilling to stand behind their planning with health planning groups, should not be allowed to participate in health care programs financed by the public. Labor organizations and other group purchasers would

do well to follow this lead in their payments to health facilities involved in their programs.

Some might argue that planning under these circumstances is hardly voluntary. It all depends upon how one looks at the concept of voluntarism in the kind of system we have developed in this country to defer the cost of health services. Private group purchasers and government programs have become the collection and disbursement agencies for the bulk of the population. Those facilities that want to go it alone ought to be willing to go it alone all the way.

For the fact of the matter remains that even under the most favorable planning circumstances, the cost of hospitalization can impose an unncessarily heavy burden on group purchase programs when hospitals are misused.

A number of studies have uncovered a disturbing amount of unnecessary utilization of hospitals under health care programs. To the consumer, the escalation of costs that results from over utilization of expensive facilities is no less a factor in the deterioration of the medical dollar that the rising costs of hospital and pesonal health services as such. In fact, the cost of over-utilization is perhaps more disturbing than other forms of medical inflation because it suggests that there may be something very wrong with the balance of benefits in health care programs.

It would be unfair, of course, to place all the blame on hospitals when unnecessary utilization occurs. After all, it is the doctor who controls admissions and who orders the services and determines the length of stays. He is the person who must assume final responsibility through the functioning of hospital review committees.

Yet, organized labor and other group purchasers cannot escape their share of the responsibility. Negotiated programs, like most voluntary health plans, emphasize hospital care at the expense of grossly inferior coverage of outpatient services. This imbalance in benefit structures distorts patterns of utilization of health services and undoubtedly lies behind a great deal of misuse or overuse of hospitals. Labor knows this, and is seeking the assistance of providers to correct the imbalance.

At the same time, however, we cannot overlook the misuse of hospitals that occurs because of the unavailability in the community of other facilities and services that could be used just as effectively, or more effectively, to take care of the patient's needs at a lower cost.

My reference is to the person whose stay in the hospital is stretched out, for example, because quality extended care facilities are not readily available; to the patient who winds up in a hospital because he does not have access to good home health services; and to others who find it difficult to obtain diagnostic services in the community without being hospitalized.

To the extent that this occurs, we must turn again to the hospitals, the doctors and others involved in the health planning process for relief. There no longer is any room for buck-passing, for the day of providing for hospital-based services in splendid isolation from all other facilities and services needed in the community is rapidly drawing to a close. The sheer magnitude of our growing health needs, and the pressures being exerted on existing health resources, make intolerable the waste associated with this kind of fragmented planning.

All of us—individual consumers, providers, vendors, and group purchasers—must come to grips with the basic issues confronting us concerning the organization of health services. Are we interested only in caring for the sick, or are we primarily interested in maintaining health?—Or shouldn't we be interested in both?

Hospitals have operated primairly as institutions for healing the sick. Does it follow that they should only be interested in doing a good job for people who get sick and need hospitalization, or should they be equally interested in keeping people well and out of hospitals?

There can be no choice for group purchasers of health care services. Organized labor is interested in both. We seek your assistance along with other providers to do both better.

FOCUS ON HEALTH

As a matter of national policy, the focus today in the health care field is currently on the development of comprehensive systems for delivering health services and maintaining health. Furthermore, planning for facilities and services under federal comprehensive planning is recognized only within the context of total health needs. Health facilities and services planning, in fact, must now be

effectively related to planning for personal health services, manpower development, and environmental health.

We hope hospital groups will accept this as a challenge to break new ground in the provision of services to the community. As recommended by the State "543" Committee, special attention needs to be given "to the development of new systems for delivering health services, especially to meet the needs of the underprivileged and those whose life styles are not compatible with the manner in which health services are currently organized and delivered."

Those of us involved in the work of the Council, as representatives of group purchasers of health services, would welcome the opportunity to develop new group service plans in cooperation with hospitals and others interested in expanding their out-patient services. We simply cannot ignore our 15 years of experience with negotiated programs, which has taught us that money alone does not assure good health care. We have learned the hard way that medical inflation, in part, is the product of irresponsibility of group purchasers who dump millions of dollars into the so-called mainstream without demanding a voice in how medical resources are used and organized. While our dollars have fed the inflationary fires, they have done preciously little to stimulate more efficient use of resources. We have bargained hard to remove the financial barriers to good medical care for the sick, but in the process we have largely forgotten about the needs of our members to stay healthy. Even more seriously, we have contributed to the growth and entrenchment of a system of delivering health services that is not only plagued by rigidities, but is basically incompatible with the level of health education and life styles for many in our population.

I am not only talking about the underprivileged for whom the promise of mainstream health care becomes a mockery without developing new medical delivery systems that penetrate their environment and the socio-economic problems that confront them in our urban society. I am also talking about many of our union members and their families in the so-called middle class of America who also have difficulty in using the prevailing delivery system, even when we try to remove the financial barriers.

It is true that in the development of our groups programs, we have talked a great deal about experimentation. In practice, however, we have done very little to make effective alternative programs available to our members and to others in the population who have become all but medically disenfranchised in a health-care sense.

A burning desire to change our ways lies behind the formation and the work of the Council. In a very real sense, the Council is the spontaneous product of years of frustration in dealing with vendors and other special interests whom we have allowed to engulf our islands of health plans and to decimate our bargaining power and ability to effect change—the necessary change that today can no longer be held back.

With the new focus on health, brought about by Medicare, the development of state and regional medical programs, and the requirement of comprehensive planning under federal law, we believe that the time for action is now.

We have served notice on the vendors that while we cannot do without health facilities and the professionals who provide health services through them, we *can* do without the vendors. We are therefore turning today more directly to the providers to deal with the staggering problems confronting group purchasers of health services.

Our surface focus may appear to be simply on controlling costs, but our real interest is on controlling costs by finding more effective ways of providing health services for people. The experimentation we desire may be more expensive when measured only in terms of providing medical care for the sick, but not in terms of maintaining health, which is our ultimate objective.

If hospitals today are prepared to take a fresh look at health maintenance problems, then we invite those interested to work cooperatively with the Council and interested doctors so that together we may begin some serious experimentation with new ways of relating the use of in-patient facilities to the development of out-patient services to lessen the need for hospitalization and help keep people well.

Immediately, the idea of hospital-linked out-patient clinics and neighborhood health centers comes to mind, based on the development of comprehensive prepaid group practice arrangements. We are very much interested in this approach, but we do not want to rule out experimentation with entirely new ways of bringing both solo and group practices into contact with out-patient services

that are specifically organized and designed to break down utilization barriers, to increase the level of health awareness, to provide for early detection of disease, and to promote more meaningful doctor-patient relationships on a continuing basis.

Some doctors, of course, may view such experimentation as a threat to solo practice arrangements, but it is too late to placate those who fear the competition of group practice arrangements. Group practice is every bit as professional as solo practice, and we know that quality can be good or bad in both. We are not out to destroy solo practice. Our goal is to provide a full range of alternatives available to group purchasers and to individual consumers, including alternatives that reach the individual who is clearly unable for any number of reasons to use the existing system effectively.

To those who still fear the Council's motives, we invite them to help us build into everything we do quality standards that are beyond reproach and beyond anything in operation today in the mainstream of health care.

In concluding, some of you may be wondering—why hospitals? Why should they be singled out to give special attention to the organization and provision of out-patient services? There is really no answer, except that hospitals traditionally have been the focus of medical care as it is practiced in this country. Doctors are brought together through hospitals at the most esteemed level of medical practice. Operating through their hospital committees, doctors have set high standards of performance for themselves while they are practicing in hospitals—standards which have no counterpart in their solo out-patient practice of medicine.

If hospitals can bring the best out of doctors when they are practicing in their institutions, then it is logical that hospitals should try to help bring the best out of them when they are providing health services outside the hospital, especially since the quality, scope and organization of out-patient services are vital factors affecting hospital admissions.

In any event, it appears to us that hospitals are slowly evolving into health centers, which we believe they should have been all along. It remains to be seen who will rise to the challenge and who will sit back; who will help to build a healthier state and nation, and who will try to hold onto those delivery systems and organizational concepts that are rapidly losing their viability and validity for increasing numbers in our society. We both have our work cut out for us.

ITEM 15: LETTER FROM PAUL D. WARD, EXECUTIVE DIRECTOR, CALIFORNIA COMMITTEE ON REGIONAL MEDICAL PROGRAMS, SAN FRANCISCO, CALIF.

October 15, 1968.

DEAR SENATOR WILLIAMS: Your Subcommittee has already received extensive testimony relative to the problems our elderly population encounters in obtaining health care. The hearings in California undoubtedly will reinforce testimony already received, but probably will produce no problems which have not already been brought out. Before dealing with specifics in regard to Regional Medical Programs, I would like to discuss briefly the major areas already brought before your Subcommittee.

HEALTH MANPOWER

The severe present and predicted future shortages of health professionals, particularly physicians, nurses, and dentists have created problems in obtaining medical care for all age groups. In fact, it is possible that the incentive fee structures of Medicare and Medicaid have increased the provision of services for the elderly in some communities to the point that good medical care, and particularly preventive medical services, for the younger age groups has diminished in availability. It is obvious that expanded or new governmental programs to pay for services rendered will not increase the capacity of the schools of medicine, nursing and dentistry. In fact, conversely, they may make it more rewarding for able instructors to stay out of teaching. Hence, it is imperative as coverage or benefits expand in governmental or insurance third party payment programs that equal emphasis be given to creation of additional educational facilities and incentives which will lead competent professionals to enter the teaching fields.

ALLIED HEALTH PERSONNEL

There has been wide discussion in the health field of developing new "subprofessional" or "allied health" personnel, or expanding the legitimate functions of lower level professionals in order to lessen the work load on physicians, nurses and others who are in short supply. In California recent joint agreements between the medical, nursing and hospital organizations as well as changes in the state law have expanded the legitimate functions of RNs and LVNs. While such actions are undoubtedly helpful in some instances, they do nothing to add to the absolute numbers of health care personnel available—they merely push some of the work down the line and create acute manpower problems at lower levels.

The only solution to the manpower problem is more training for more persons at all levels. Every resource should be utilized: teacher incentives, subsidized facilities, scholarships, loans, and outright subsidy of trainees. The health professions must be made available to qualified and interested applicants from all levels of our society, not merely to those qualified applicants who can afford the hight cost of such training.

PAYMENT FOR SERVICES

Much testimony has been presented to your subcommittee regarding the methods of payment for services, particularly through Medicare and Medicaid. The use of the fee-for-service approach, especially the physician profile, has been seriously attacked as provided for unbridled escalation of fees and incentives for over-utilization. It has also been described as deleterious to the development of group practice. Without doubt, the unscrupulous provider can profit unfairly under this—but he will find a way to do so under any system. He can gradually increase his fees and he can have patients return again and again for unnecessary visits.

I feel a note is indicated here to attempt once again to put to rest the misinformation that was widely publicized about the California Medi-Cal program, that 1200 physicians averaged over $70,000 each during the first year. The figure of 1200 represented that number of "vendor codes," most of these, in turn, representing physician groups. In one instance it was a group of 123 physicians. Investigation of those few solo practitioners who received large amounts of money revealed, in most instances, that the payments were justified. These were high volume doctors who worked long hours six and seven days a week in ghetto areas and who represented virtually the only medical services available to the residents.

While the fee-for-service system undoubtedly has its drawbacks and opportunities for abuse, one must consider the alternatives and their potential disadvantages. It is obvious from the testimony presented to the subcommittee that a clinic type approach with salaried physicians would not be very popular with anyone. Both professionals and elderly individuals testified about the long waiting periods and excessive travel requirements involved in clinic medicine. Yet there was some indication that a few preferred clinics and in some areas these were the only places care could be obtained.

The other alternative is the "capitation" method of payment. This means just what it says, a payment "per head" on a flat monthly or annual basis for providing all necessary professional services for a predetermined group of people. It provides a guaranteed income for the doctor regardless of how many or how few services he must provide. This method is not as foreign to American medicine or the American people as one might think. For years it has been a common method of providing well-child care in the private practice of pediatrics for the first two or three years of life. It is of course, the basis of the HIP, Kaiser and Ross Loos program as well as a number of other smaller family group practice plans. It is being developed on a private basis in some places through such organizations as American Medical Services in Los Angeles.

If properly used, the capitation method is a stimulus to the practice of preventive care—it is of obvious financial advantage to keep the patient well, and to discover disease in its early and less costly stages, than to wait until the patient is seriously ill. Conversely, there is a danger of under-utilization, a possible tendency to not see the patient often enough. Regrettably, the only conclusion one can read from this is that any method will require either external or internal review until the system adjusts to the new demands.

The other disadvantage, if it is such, of the capitation method is the possible violation of the principle of "free choice" of provider, which was written into the 1967 amendments to Title XIX. Obviously, the method gives a competi-

tive advantage to group practice, as more comprehensive services, it is argued, can be offered at presumably lower rates per person. Perhaps some objective conclusions in the organization of medical services, which are not in evidence now, should be a goal of government programs of health care for the aging. The overall patterns of care will not change rapidly but at least the change that is encouraged should be based on fact since no single type of organization fits all situations. The dilemma is to be able to encourage new approaches without isolating the individuals concerned from high quality care or making care so difficult to obtain that for all practicable purposes it does not exist.

DISTRIBUTION OF HEALTH SERVICES

The availability of medical care both for the elderly and the young in our population varies widely according to economic, cultural and ethnic characteristics of the patient population. Your subcommittee has heard much testimony on the diminishing numbers of physicians, dentists and others in the ghetto areas of our cities, taking place simultaneously with increases in the population and crowding of these areas. One attack on this problem is the dispersal of population through low-cost housing and urban development programs, and through long range changes in social acceptance of these groups outside the ghetto. These important, and in fact imperative, changes will be a long time in realization. In the meantime steps must be taken to bring services to these areas.

No amount of increase in total health manpower will help if some trained professionals do not locate in the areas of need. Every possible known and innovative method should be explored and tested in an effort to increase available services in these areas. Obviously, in spite of the widely publicized "opportunities to get rich" through Medicare and Medicaid, the financial incentives of these programs have not proved sufficient to reverse the trend of professionals to move out. Perhaps these programs have encouraged outward movement as a physician or dentist can now meet his income expectations in better neighborhoods without working as hard. We are watching the West Oakland experiment under U.S.P.H.S. auspices with great interest as it represents one way of attempting to solve this problem.

The Regional Medical Program, as you are aware, is not designed to increase the total amount of health services available. It must work with existing resources and without disturbing existing patterns of delivery of health care. RMP can (and to date largely has been designed to) increase the level of health care through increasing the availability of specialized medical services. However, in a limited manpower market, such efforts must necessarily be at the expense of basic health services. It was the quite obvious intent of Congress that RMP should not endeavor to create a whole new system of health care. In fact, perhaps the restrictions placed upon facilities and basic health care education make it virtually impossible for RMP to contribute materially to overall quantity of health care available.

From the standpoint of quality, RMP certainly is designed to effect improvements in the care of those persons afflicted with one of the categorical diseases or in imminent danger of becoming so afflicted. As indicated above, however, since we are "robbing Peter to pay Paul" we could end up reducing the quality of general health care available for the population as a whole. A cadre of highly trained physicians and nurses staffing a coronary care unit on a ratio of three professionals to one patient can well mean a shortage of personnel in the medical and surgical services of the same hospital.

RMP needs to be tied more closely to other programs, not just in health but in general socio-economic developments. Our relationships with Comprehensive Health Planning are loose at best and nonexistent in many areas, yet the two programs which share so many common goals should be moving in close coordination. I fear there is fault on both sides of this problem. RMP has drifted too much into control by medical schools or medical center officials and CHP too much into the hands of facilities-oriented planners. Both seem to function under the same basic philosophy, i.e., if they do their job well (increased and improved teaching or increased and improved buildings and equipment) more and better patient services will infallibly result. This is not necessarily true. Most patient care is still given by physicians in their private offices who are too busy to spend much time on postgraduate education. A few RMP projects, such as the Roseville Pilot Program in California, are attempting to get at this problem, but the bulk of the programs are still specialized training for specialists and are hospital or medical school based.

Perhaps RMP's greatest contribution eventually will come through the stimulation and support of preventive medical services. It is here that the greatest hope

lies for a healthier, happier population, future economies, and a partial solution to the manpower problem. The developers of the objectives for RMP in California have put great stress on multiphasic screening. Since it is a practical impossibility for every citizen to receive an annual physical examination by a physician, multiphasic screening must be extended in coverage and expanded in comprehensiveness for the discovery of early disease or, even better, precursor signs or symptoms. To date, in California, RMP has not financed multiphasic programs of significant comprehensiveness. One small project of limited scope is a part of the Roseville program. However, it is my feeling that multiphasic screening, broad in scope and coverage, along with other preventive medical programs has great promise and should be a prime RMP objective.

Finally, there has come to my attention the enclosed clipping from the San Francisco Chronicle describing the Hunters Point—Bayview Community Health Service. It brings to mind another subject which has received little attention until recently, that is the inability to understand, and therefore to effectively utilize. existing systems of medical care on the part of the elderly and culturally deprived citizens of our nation. Under the "mainstream" and "free choice" concepts of the public medical care programs of Medicare and Medicaid, government employees have been strickly prohibited from directing, or advising beneficiaries, to seek appropriate sources of care for their problems. These programs have been bill-paying mechanisms only. The result has been hapless shopping around, referral and counter referral, outright solicitation on the part of some questionable providers, some provision of unnecessary services, significant waste of valuable professional time, and often deleterious fragmentation of care for many persons. This San Francisco experiment is an attempt to provide what has just recently appeared in the jargon of health as a "patient advocate" or "health ombudsman."

Plans for the Northeast Medcial Center in San Francisco's Chinatown are being developed very much along the lines of the Hunters Point project, but are in a far more embryonic stage. A decision has not yet been made, for example, whether funding should be sought through DHEW or OEO channels. The main intent of the center, once in operation, will be to find and encourage individuals of all ages who are not now properly cared for in the basically Chinese and Italian population of the area to see doctors reguarly and, in the fashionable phrase, get them back in "the mainstream of medicine."

RMP is currently developing many programs to provide superlative care for the seriously ill person. However, the first line of defense against serious illness and disability rests on the capability of the system to provide elementary general health services. It is there, when the patient presents himself for relatively less significant problems, that the first elevated blood pressure can be detected, that cigarette smoking habits can be noted and discussed, or that early increased blood or urine sugar levels can be found. Hence, it appears to me that programs such as Hunter's Point in San Francisco have as much implication for RMP as the highly skilled services of a speech therapist working with a man who has had his larynx removed. If a full scale attack is to be mounted on heart disease, cancer and stroke, people must be assisted in utilizing appropriately the first line medical services already available.

This has been a somewhat lengthy reply to your letter. If I had to reduce it to one statement I think I would say that the elderly are only one segment of complex of groups in our population that are medically underprivileged and that a great deal more vision has to be exercised in a total attack on the health care problems of our entire population than that shown to date, progressive and visionary as it has been.

Sincerely,

PAUL D. WARD, *Executive Director.*

[Enclosures].

EXHIBIT A: ARTICLE FROM THE SAN FRANCISCO CHRONICLE, "SPREADING THE MEDICAL WORD IN HUNTERS POINT"

[From the San Francisco Chronicle, Oct. 9, 1968]

SPREADING THE MEDICAL WORD IN HUNTERS POINT

(By David Perlman, science correspondent)

Somewhere out in the Hunters Point-Bayview part of town there's an old man. handicapped by a stroke, who sits in his room alone—more a psychological cripple than a physical one.

There are kids out there with decaying teeth—not because their parents don't care, but because they are too unsophisticated to know where to find dental help.

Infants are being born prematurely to malnourished mothers—not because food is so scarce, but because the pathway to adequate prenatal medical care and diet instruction is an unfamiliar one. The fact that public funds exist to pay the bills may even be unknown.

Attack

These are the sorts of problems that will be attacked from now on by a new federally financed program designed to change the basic life-style—and with it the health—of thousands of low-income families.

The program, which begins this month, is called the Hunters Point-Bayview Community Health Service. It is armed with a $705,000 grant from the Public Health Service, and it is projected to continue for the next five years at a total cost of $5 million.

Details of the project were discussed yesterday by Dr. Arthur H. Coleman, its director, at a press conference at the service's new headquarters at 5815 Third street.

Impediments

As Dr. Coleman noted, the problem for people in the project area is not that medical care is poor—it's excellent, in fact. But far too many potential patients—particularly black patients—have profound psychological and social impediments to seeking care at all.

So the new community service will not actually provide medical treatment. Rather, it will deploy four health teams of public health nurses, social workers and "social health technicians" to encourage families to use private medical and dental offices in the traditional "free choice" manner of more affluent families.

Job

Where patients are eligible for Medi-Cal or Medicare or welfare services, the health teams will show them how to qualify. The health teams also will offer psychological help and nutrition instruction. In many cases the community service will help pay bills that aren't covered by insurance or Medi-Cal.

Of interest to the Public Health Service will be an evaluation of the program year by year. For it actually represents a major departure from other medical projects in low-income areas.

In San Francisco, for example, the Poverty Program is now financing a Mission Neighborhood Health Center, where salaried physicians actually provide comprehensive care in a full-fledged medical facility.

Dual

"It is our feeling," said Dr. Coleman, "that the neighborhood center or clinic is a dual system of medical care—a special center for poor people. We hope to show that we can provide first-class care for our patients through the same kind of private medicine that all other sections of the population receive."

EXHIBIT B: RELATIONSHIP OF THE HEALTH POWER STRUCTURE TO REGIONAL ACTIVITIES

(By Paul D. Ward, delivered at RMP Coordinators' Conference, Arlington, Va., Sept. 30, 1968)

When I accepted this assignment to speak to you on this subject, I did so with some trepidation. To many of my associates in this program the need to acknowledge the existence of "pressure groups," "power blocks," "special interest groups," or whatever you may desire to call them is in itself a deplorable factor. One sometimes gets the feeling that those who do engage in the art of obtaining consensus from various pressure groups for any given goal are indeed practicing some form of Satanism. It is like being the father of Rosemary's baby without ever having known Rosemary. The only solace I take in all of this is to note that when the connotation of evil is applied to any grouping, it is always the other man's organization that is evil. We only belong to good groups to protect ourselves from the advances of those other groups. Anyone who admits seeing some good in the vast majority of the groups, and who tries to mold portions of their efforts together in order to obtain a working consensus in which progress toward a given goal can be made, becomes contaminated with the "other man's" evil. Further, to openly admit that you are a broker in pressure groups is to admit

that you are a member of none—in effect isolated—and sitting as if naked atop a beehive, not knowing whether you're about to be seduced by the queen bee or attacked by her suitors. That is why there is some danger, at least to me, in this topic of discussion, "and I must add I feel must as Lincoln must have felt as he was being ridden out of a small southern town on a rail after the Emancipation Proclamation: "If it wasn't for the honor of it all, I'd just as soon walk."

To those of you who would practice the art of obtaining consensus and keep quiet about it, there is little danger. In fact, at times it can be quite rewarding if you can find a way to silently give yourself credit for that which has been accomplished in the names of others. I fear, however, that like all voluntary collective efforts in the social field, observable progress toward a given humane goal is all, and should be all, the reward we should expect. The legislative framework, the Congressional committee imperatives and the guidelines offer a unique opportunity to determine on a broad national scale whether or not the components of the health power structure can work together voluntarily for the general good of the public. It may not be virgin territory upon which we are treading, but at least it is wild enough to make life interesting.

Legal Mandates

What are the specific mandates set forth by the law and Congress that we are obligated to observe insofar as the health power structure is concerned? It seems to me that there are at least three main postulations that we must be aware of. The first is the wording of the law itself. Sec. 903 states that grants under this section may be made only if the advisory group includes "practicing physicians, hospital administrators, representatives from appropriate medical societies, voluntary health agencies and representatives of other organizations." Secondly, Sec. 904 which covers operational grants states that they may be made only if "recommended by the advisory group" as described in Sec. 903. This type of language gave virtually unique recognition in the legislation itself to the regional health power structure. This recognition in effect took the form of the right to veto.

Thirdly, Congress went even further in its subsequent reports on the program. It used the term "voluntary partnership" when referring to research centers, practicing physicians and community hospitals, indicating a co-equal status. Hearings this year brought out the very deep concern on the part of Congress that components of the health power structure may not be involved uniformly in all regions to the degree Congress intended. Some sentiment on the part of the national health power structure tended to support this position although it was pointed out that the problems were sporadic in nature.

At this point in time, Congress seems determined that there be a co-equal involvement of components of the health power structure, not only in the design of the program but in its operational surveillance as well.

How does one determine what constitutes the health power structure? In this case the law is unusually clear. It identifies medical center officials, hospital administrators, practicing physicians, representatives from "appropriate" medical societies, "appropriate" voluntary health agencies, and other organizations, institutions and agencies *concerned* with activities in RMP plus *informed* public members. The statute uses key modifiers, in effect, to identify the power structure that legally must be involved in the decision making processes of the program.

Unlike the typical legislation which establishes citizens advisory committees, this act specifies that certain specific kinds of representatives *must*, not may, be included on the advisory committee. It generally follows that at least Congress looked upon these classifications as the primary power structure involved.

From a practical point of view there may be others, but they are not legally specified. As an example, at least one governor unofficially proclaimed his state a region and apparently his remarks carried some weight. At least one state legislature caused a shotgun marriage between RMP and Community Health Planning and seemingly those involved took note of this act. Whether the marriage has been consummated only the principals can attest.

Although these extra-legal forces are important, time does not permit their discussion here except to mention the fact that eventually we will have to deal with public health power blocks such as those interested in O.E.O. facilities, model cities programs, Medi-Care and Medicaid, Crippled Children programs, health planning councils and Community Health Planning, among others.

INTENT OF CONGRESS

Some interesting conclusions can be drawn from the unique language used by Congress to establish RMP. First, the program was described as a "partnership" implying an equal role in the decision making process by the partners involved. The only mechanism provided in the act for exercising this role was the advisory group which must advise on and approve the actions of the region. Later, Congress used the term "oversee."

Secondly, the term "medical center official" was used in place of a "representative of medical centers." An official is one with the authority to commit his organization or institution to a given course of action.

Thirdly, it spoke specifically of "hospital administrators," not representatives of hospitals. This again implied a specific level of authority and function within the hospital world. If further implies that this person or persons would have the authority to speak for others in his category.

Fourthly, the act specifies both "practicing physicians" and representatives of "appropriate medical societies." The modifier "practicing" would simply differentiate this physician from those who might be in administrative or other capacities. But the modifier "appropriate" would seem to have more specific connotations. From the legislative history we must assume that this was to be a person with the authority to speak for organized medicine in the region. Even without the benefit of the legislative history, "appropriate" logically would refer to the organization that historically has had the greatest policy impact on medical practice, the most significant legal impact, and geographically covers the area concerned. In the vast majority of the cases, "appropriate" could only mean the state medical society. There are situations when in multi-state regions more than one state society must be represented and there is at least one instance in which the state society may be described as slightly bifurcated but there can be little doubt as to the general appropriateness of state societies.

Fifthly, the same modifier, "appropriate," is used to describe voluntary health agency representatives, as members of the legal advisory group. Again, the structure, function, and coverage of each voluntary health agency would determine the appropriateness—that is, whether it should be the statewide organization that is involved, or some other level.

But, from a practical point of view, it would seem that RMP would want to associate itself with the voluntary health agencies at the point in the agency's structure where the major policy decisions are made. This point differs to some extent among the voluntary agencies from state to state. It is evident that to take full advantage of the relationship with the voluntary agency, RMP has to be plugged in at the decision making point, the point at which new programs are designed, objectives set, data accumulated and stored, financial determinations made and general organizational policy established and executed.

In most cases, this appears to be the state-wide organization. Not to involve the voluntary associations at the policy making point will result in much duplicative effort and the lack of ability to fully utilize all of their existing resources on a coordinated basis. More important, perhaps, is the difficulty in obtaining a definite commitment for support of RMP objectives if this relationship does not exist at the policy making and management level. Agreement on issues without the authority to commit support, funds or resources is as worthless as pursuing the vote of citizens of Washington, D.C. for a Virginia election.

Even though representatives may be chosen from the "appropriate" body—that is, chosen from the level within organized medicine, the hospital association and the voluntary health agencies where the vital decisions are made and the policy is set—there is more that must be done if progress is to be made. It amounts to giving the partners a sense of confidence that their role in the program will not be subverted. This is especially difficult because the relationships that have existed in the past between these partners have been extremely limited and even then, some were viewed with suspicion.

Some times those of us who live with the programs tend to forget that a massive amount of planning activity has been thrust upon the health leadership. This activity seldom is based on long established, firm relationships; thus, there is bound to be some uncertainty. This uncertainty requires a profuse amount of reassurance and reconciliation to keep the new partnership in-

tact. Let us recognize that this partnership is voluntary, something even less secure than a commonlaw marriage, and until there are abundant children in the form of successful operational projects, it may be hard to keep the faith.

Role of Regional Coordinator

Because of this, I believe it is the Regional Coordinator's role to know intimately the decision making mechanisms of the health power groups primarily involved in his region. Not only must he understand the mechanics of their decision process, but he has to have a fairly good knowledge of the people involved and what causes them to take the positions that they do. He has to have some assurances that the representatives of the various power groups have the authority to speak for the decision making apparatus within their own organization. He has to have some assurance that the power group's organizational framework will back up their representative in controversial matters. If the representative's authority is limited, as it is almost certain to be, the Coordinator should know these limits and compensate for them.

The Coordinator is further obligated to back up the representative with his own group by personally providing information and assurances to the decision making bodies within the representative's group on matters of controversy. In most cases, this will mean routine appearances before the executive councils of the state hospital association, the state medical society, the various voluntary health organizations and medical center groups. It means, above all, that he has to be prepared to negotiate differences in as amicable an environment as passion will allow.

There are other problems within the health power structure that face the more complex region. Although they may not directly affect each of us, at least to the same degree, they nevertheless may have a very profound effect upon the reaction that Congress has to the program. To date, Congress has indicated an unusually favorable reaction, but this reaction could reverse itself if these problems are not dealt with properly and soon. In my own self defense, I have not mentioned California, and I do not intend to, but let me quote from an article written by a man for whom I have the greatest respect, George James, M.D., Dean of Mt. Sinai School of Medicine, New York. It appeared in "New York Medicine," April 1968. I quote without his permission:

Regional Medical Programs

"What problems are associated with Regional Medical Programs and how is New York City going about resolving them? New York City has a particularly difficult problem. Those of you have been associated with the review process of the heart, stroke and cancer program in Washington have noticed that it is very easy for a state with a single state medical school, a single state health department, and relatively few really vital agencies to organize for a regional program. This is true for some of our Midwestern states where the entire process is very simple with a single state governor, a single state legislature, a single state health department, a single state university with most of the doctors in the state being alumni of the state university. All of this makes for a very simple arrangement.

"In New York City we have seven medical schools; we have a large number of additional sophisticated agencies and institutions. This makes for quite a bit of trouble. It creates major problems for intercommunication among groups which have not been notable for their ability to communicate before. Now, in addition to this, New York City has very great needs, and they are very visible needs. If there are any of you who feel incapable of adequately recognizing these needs, there are at least three dozen agencies in the state that will be very happy to point them out. There is great citizen demand for services."

Dr. James stated the problem of the complex community clearly and briefly. It is not as easy to isolate, understand describe the decision making process in the areas where the most people are, where the most voters are, where the most Congressmen come from. This poses a far greater problem than most of us realize if you stop to think where the mass of our health problems exist and who votes the dollars in support of the program.

As Coordinators and as individuals interested in the health of this nation, we face our greatest challenge during the next two years. We are faced with marshalling the health resources of the metropolitan areas which contain our most

complex problems in terms of relationships. We have to seek a greater understanding on the part of all the health power structure that this program, which all of the leadership seems to prefer, may be significantly modified if momentum is not gained in the highly complex urban areas.

At this point in the program if a speaker raises problems, he ought to have some pat solutions to them. Frankly, I do not, except to say that we should proceed as we have been, with more of our energies focused on the urban problems. We should not lose sight of the fact that although there have been problems of relationships, they have been relatively minor compared to other programs of this magnitude and especially programs as unique in approach as this one.

It does seem to me that in facing these problems the main challenge to the Coordinators over the next few months will be to maintain the integrity of the program. If the partnership concept is lost—that is, if it becomes predominately a medical society program or a hospital program or a medical center program in place of a balanced program between the partners—then its lustre and innovativeness will be lost. We can develop models and pilot projects until we are inundated with the reports involved, but they won't mean a thing unless they are accepted by the total health manpower through their involvement from the ground up. Obviously, there is a price to be paid for involvement, enlarged staffs for the schools, easier access to continued learning for the professional person, and improved service facilities for the institutions. The test will be the amount of dividends that are paid to the people in terms of better health care.

California II

Funded Operational Projects

Coronary care training—Area I (San Francisco)

Objectives.—Will develop and establish a confederation of Coronary Care Units throughout northwestern California. Training will be provided for nurses and physicians in patient care and for nurse educators and nurse administrators. Supportive programs will be coronary care conferences; a reference information center and newsletter; and consultation on unit design, management, and specific care problems.

Roseville pilot program

Objectives.—Will be a living laboratory for development of programs in continuing physician education, inservice training for paramedical personnel, multiphasic screening, community information and education, tumor board consultation, and cerebrovascular disease and CNS malignancy diagnosis and evaluation. Applicable to entire area.

A training program for physicians in coronary care—Area IV (Cedars-Sinai)

Objectives.—To provide training programs for physicians who will occupy positions as directors or associate directors of Coronary Care Units in community hospitals and who will ultimately provide leadership in cardiology at the community level. A basic training course will be given, followed by continuing education and consultative services, and seminars and workshops for continuing liaison between the medical center and community hospitals.

Watts-Willowbrook postgraduate education

Objectives.—Joint proposal of University of California at Los Angeles and University of Southern California Medical Schools, the County of Los Angeles, the Charles Drew Medical Society, and the Community of Watts-Willowbrook. A combination planning-operational proposal. This project will coordinate the establishment of a Watts-Willowbrook district Regional Medical Program with the development of a postgraduate medical school.

RMP medical TV network—A center for the continuing education of health care professionals using television and other audiovisual materials

Objectives.—Based on the ULCA campus: the project will support medical programs via the Medical Television Network (MTN). Partially funded by a PHS contract (expires June 30, 1968) MTN began as a pilot program. Seventy participating institutions in 6 counties and 6 producing institutions. A community enterprise; all programs are officially approved for credit by American Academy of General Practice.

Program for training physicians and nurses in coronary care techniques

Objectives.—The pogram will begin with a central training center at the Los Angeles County Hospital and two cooperating hospitals (Good Samitarian and St. Vincent's). This central program will provide a base to initiate training for the entire region and will be expanded to include 6 additional hospitals in the second year.

Training of physicians in intensive care for small hospitals (pilot program, Pacific Medical Center)

Objectives.—A pilot project (one year only) designed to train physicians in skills, as applicable in a small general hospital, in order to provide intensive care to patients with acute myocardial infarction. (Designed for hospitals *not* covered under Project #1).

Hypertension—Area I—University of California, San Francisco—Northwest California

Objectives.—Demonstration training program for medical and allied health personnel in ten (10) community hospitals for referral and followup of hypertensive patients. Includes computerized registries.

Pediatric pulmonary—Area VIII

Objectives.—Irvine Pediatric Pulmonary Demonstration Center. Center will demonstrate the proper diagnosis and treatment of children with respiratory problems; to investigate the relation of pediatric pulmonary disease to chronic conditions of later life.

ITEM 16: QUESTIONS SUBMITTED BY THE CHAIRMAN TO CASPAR W. WEINBERGER, DIRECTOR OF FINANCE, STATE OF CALIFORNIA, SACRAMENTO, CALIF.

1. The American Medical Association News of August 28, 1968, carried a story indicating that the cost of Medi-Cal for the past fiscal year was $208.1 million, about one-third less than originally predicted. Is this a correct statement? May the Subcommittee have a statement on the reasons for this reduction in anticipated cost?

Answer.—The correct figure for the State of California General Fund estimated cost of Medi-Cal for the fiscal year 1967–1968, as approved by the Legislature in May, 1968, was $232.7 million. This was a reduction in the original estimate of the cost, which was $305 million. This estimate ($305 million) was revised in December of 1967 to $274 million. Reasons for the decline in cost were a decline in utilization of certain services, specifically including dentistry, and the effect of more strict utilization controls imposed as a means of trying to reduce the total cost of the program. The medically needy caseload also showed a slower rate of increase during the second year of operation of the program than had been anticipated based on first-year utilization.

2. How many persons past 65 have been served by the Medi-Cal program since it was established? What kind of treatment have they received? Do you have estimates of average costs for the elderly as compared to other age groups?

Answer.—The total number of persons 65 and over who were eligible for Medi-Cal benefits was 410,900. Based upon an expanded one per cent (1%) sampling of Medi-Cal recipients for the fiscal year 1966–1967, we believe that 337,000, or 82.5 per cent of this number, received some benefits from Medi-Cal during that fiscal year. The categories "Physicians" and "Drugs" constituted the largest type of treatment received. Of this 65 and older group, almost 10 per cent received nursing home services each month. Unfortunately, our average cost per eligible for those people 65 years and older cannot be used to compare utilization and costs between other age groups, because our data do not include Medicare services and costs.

APPENDIX 3

REPORT ON MEDI-CAL PROGRAM, BY CALIFORNIA DEPARTMENT OF JUSTICE AND RESPONSE BY NURSING HOME ASSOCIATION

ITEM 1: LETTER FROM CHARLES A. O'BRIEN, CHIEF DEPUTY ATTORNEY GENERAL, DEPARTMENT OF JUSTICE, STATE OF CALIFORNIA; TO SENATOR HARRISON A. WILLIAMS, JR., CHAIRMAN, SPECIAL COMMITTEE ON AGING, U.S. SENATE

DECEMBER 12, 1968.

DEAR SENATOR WILLIAMS: Our office reported that *minimally* eight million dollars is being bilked annually from the Medi-Cal Program by medical practitioners. A copy of the report supporting our findings is attached for inclusion in your transcript.

As we indicated in our report, we believe that such cheating seriously injures both the program and the public. Since the release of our report, we have learned that similar problems are occurring in other states. One official told us that we could remove the cover from our report, replace it with the name of his state, and re-issue it with no other changes.

Our investigation found that Medi-Cal abuses have a particular impact in terms of nursing homes and long-term case facilities. Medicare provides greater reimbursement to nursing homes than Medi-Cal. Therefore, the potential for transferring a nursing home patient from Medi-Cal to Medicare may determine the patient's admittance to a nursing home. Special arrangements between hospitals and nursing homes exist solely for the purpose of maximizing government payments to nursing homes. We also found nursing homes requiring under-the-table payments before admitting patients.

A major problem is the sheer "bigness" of the program. Efforts to manage the program through the Blue Shield office in San Francisco and the Blue Cross offices in Los Angeles and Oakland have obviously created enormous difficulties which are thoroughly discussed in our report. Special consideration should be given to localizing the administration of this program. Smaller regional administrative units might reduce the management of the program to a scale which may be encompassed by the mind of man. At the present time, Blue Shield receives 80,000 claims a day at its main office in San Francisco. This obviously presents a burden which even the most advanced computer cannot handle in terms of both processing the claims and effectively weeding out frauds.

Aside from conquering the immensity of the program through some effort at localization, another broader concept may also be seen in the problems which we have uncovered. A major contributor to these problems was the pressure on the State of California to take advantage of the funds made available by the federal government through Title Nineteen. Better coordination between local governments, the state and the federal government would certainly have resulted in a better program. As we note in our report, peril accompanies prosperity when federal funding rushes the states into adopting hastily conceived programs.

We emphasize in our report that none of our comments are intended to derogate the Medi-Cal Program. We consider it essential. Our sole goal is to improve this program. We hope that this report will aid you in your efforts. We will be happy to supply any further information which you may require.

Sincerely,

CHARLES A. O'BRIEN,
Chief Deputy Attorney General.

[Enclosure]

EXHIBIT A: REPORT ON MEDI-CAL PROGRAM BY THE CALIFORNIA DEPARTMENT OF JUSTICE, NOVEMBER 6, 1968

February 5, 1968.

Memorandum to: Herbert Davis, Deputy Attorney General, Los Angeles.
From: Charles A. O'Brien, Chief Deputy Attorney General.
Subject: Medi-Cal investigation.

This office continues to receive information concerning widespread abuses of the state's Medi-Cal Program. These alleged abuses include fraud, kickbacks, inflated charges and double-billing by persons providing services under the program.

We have held two meetings in San Francisco to explore this problem and have concluded that it merits investigation. Since the bulk of the Medi-Cal expenditures are in Southern California, any investigation should properly be directed from the Los Angeles office. It is assigned to you, as head of our Health Plan Registration Unit.

In conducting this investigation, our aim should be to improve—not to impede—this program. Medi-Cal is an essential state program, which is allegedly being hampered by fraud and mismanagement. Our primary effort should be to determine the extent of fraud—if any—and the possible remedies, either through criminal prosecution or administrative action. We should also be prepared to make recommendations to improve the management of the program, if our investigation discloses areas requiring improvement.

CHARLES A. O'BRIEN,
Chief Deputy Attorney General.

November 6, 1968.

Memorandum to: Charles A. O'Brien, Chief Deputy Attorney General.
From: Office of the Attorney General, Herbert Davis, Los Angeles.
Subject: Report of Medi-Cal investigation.

INTRODUCTION

On February 5, 1968, the Attorney General ordered an investigation of the California Medical Assistance Program (Medi-Cal).

The investigation was based upon information received in this office from numerous persons which indicated extensive fraudulent activities and other abuses by persons participating in the Medi-Cal Program.

The Medi-Cal Program commenced on March 1, 1966. For the fiscal year ending June 30, 1967, Medi-Cal paid approximately $600,000,000 to 70,000 vendors who provided services to 1.5 million persons eligible to receive benefits under the program. It is estimated that Medi-Cal will spend around $800,000,000 in the current fiscal year.

Of the money spent under the Medi-Cal Program, approximately fifty per cent is paid by the federal government with the state and counties contributing the remainder of such funds.

Our investigation indicates that illegal and unethical activities of persons providing services under Medi-Cal are siphoning millions of dollars annually from the program. Poor administration of the program has contributed to further needless expenditure of money by Medi-Cal.

The vast scope of the program precludes any precise estimate of the total amount of funds paid out due to poor administration of the program, outright fraudulent activities and the excessive providing of services.

Our investigation leads us to conclude that six to eight million dollars annually is being drained from the program by illegal and unethical activities of various professionals involved in Medi-Cal. This would not include funds paid out in error and as a result of faulty administration.

The primary abuses of the program involve submission of false claims, kickbacks, and overservicing.

In February 1967, Governor Reagan appointed a Task Force to review the administration of the Medi-Cal Program. This committee recommended changes which would allegedly save Medi-Cal $90,000,000 annually.

The Office of Health Care Services, which administers Medi-Cal, estimates a total of 2.5 million dollars in overpayments have been made to individual practitioners since the inception of the program. For the fiscal year ending June 30, 1968, vendors *voluntarily* returned 1.5 million dollars in overpayments. Thousands of dollars in overpayments are still voluntarily being returned each month.

In addition to the violations of the laws and regulations of Medi-Cal by the vendors, the investigation disclosed that an effective enforcement program to discover, investigate and deter such activities does not exist.

The complex nature of Medi-Cal and the large numbers of participants—both vendors and recipients of health care services—prohibited a thorough investigation by the Department of Justice into the conduct of each individual vendor suspected of engaging in unlawful or unethical activities. The investigation was therefore conducted primarily to determine the nature of abuses being engaged in under the program.

This report does not attempt a complete "white paper" on the Medi-Cal Program. It does attempt to identify the problems and supply new guidelines—especially in the area of enforcement—which will result in savings for the taxpayers by curtailing the current amount of abuse.

In preparing this report we recognized the problems confronted by Health Care Services in administering a program which was hastily conceived and implemented. The necessary planning and research needed for the effective operation of the worthy goal of the Medi-Cal Program unfortunately did not accompany the initial enactment of the program. This is certainly not the fault of Health Care Services.

There is a lesson here for both the state and federal governments. The enactment of federal legislation which requires immediate response from the states to take advantage of federal funding is laden with peril, as well as with token prosperity. Unprepared and without sufficient analysis, the states are rushed into formulating programs which are both essential and ill-considered. There should be an effort by both federal and state governments to transform such programs into more meaningful and fruitful cooperative actions.

SUMMARY OF RECOMMENDATIONS

1. Establish an Effective Investigating Unit.
2. Improve Procedures to Expedite Suspension Proceedings.
3. Publicize Existence and Actions of Investigating Unit.
4. Establish Liaison with Professional Licensing Boards.
5. Improve Communication Between Organizations Participating in the Administration of the Program.
6. New Regulations.
7. Review Procedure of Processing Claims.
8. Improve Use of Computers.
9. Review Claims on a Local Basis.
10. Post Examination of Claims.
11. Controlling the Cost of Drugs.
12. Scope of Benefits.
13. Third Party Liability.
14. Purchase of Appliances.

THE INVESTIGATION

I. Background

Medi-Cal became effective on March 1, 1966. The program was placed under the supervision of the Health and Welfare Agency which established the Office of Health Care Services (HCS) to administer the program.

Prior to Medi-Cal's enactment, the State of California provided health care services to indigents through a variety of different programs known as Public Assistance Medical Care and Medical Assistance to the Aged. These programs were administered by the various counties in the state. Administration of these programs involved determining eligibility of recipients, authorizing vendors to provide health care services and receiving, reviewing and processing claims of vendors for payment. (Some counties contracted with California Physicians' Service to assist them in administering the program.) Professional consultants were used by the counties to assist in reviewing claims and to authorize requests to provide services.

Medi-Cal was passed in response to Title 19 of the Social Security Law which provided that the federal government would share on a 50–50 basis in the cost of California's new program including services then being financed entirely by the state or county. This permitted the unification of all major governmental health care systems which provided care for the indigents into a single system financed by the state, counties and federal government.

The state contracted with California Physicians' Service (Blue Shield) and Hospital Service of California and Hospital Service of Southern California (Blue Cross) to act as fiscal intermediary agents. As a result of these contracts the processing of claims for payment was largely shifted from the counties to Blue Shield and Blue Cross, although county consultants were still retained to grant requests for prior authorization.

Blue Shield is responsible for processing claims of individual vendors (*e.g.*, physicians, dentists, etc.). All claims are processed by Blue Shield in their San Francisco office.

Blue Cross is responsible for processing claims of institutional vendors (*e.g.*, nursing homes, hospitals, etc.). Claims in Northern California are processed in Oakland. Claims in Southern California are processed in Los Angeles.

II. Vendor Abuses

The investigation revealed that vendors are engaging in unlawful activities and are also bilking the program by providing excessive services to beneficiaries.

(1) *Unlawful Activities.*—The methods by which vendors participating in Medi-Cal engage in unlawful activities can be classified into two main categories: Submission of false claims and kickbacks.

(a) *Submission of false claims.*—This occurs when vendors request payment for services which they have never rendered or falsify information on claims (e.g., knowingly request excessive reimbursement). The submission of a false claim for payment is a felony. (Penal Code section 72.) The acceptance of payment upon a false claim would also constitute the crime of theft.

(b) *Kickbacks.*—Vendors violate Medi-Cal regulations when they agree to give or accept kickbacks—money or other forms of unearned consideration—in return for the opportunity to provide services to Medi-Cal beneficiaries. Such activity is a ground for suspension from the program. Depending upon the type of vendor it might also be grounds for a criminal prosecution or disciplinary action against his license.

(2) *Overservicing.*—While some vendors have cheated Medi-Cal by engaging in unlawful activities, others have taken advantage of the program by providing excessive and unnecessary services for the primary purpose of obtaining greater reimbursement under the program. Overservicing is grounds for suspending a vendor from participating in the Medi-Cal Program.

Discussed herein are various types of abuses by vendors which were found to be prevalent under the program. In describing these abuses we recognize that they may in fact be engaged in by only a small number of providers. Nevertheless, the extent to which they do occur and the millions of dollars drained from the program by such activities merit their exposure to the public and to appropriate public agencies.

A. Nursing Homes

There are approximately 1,000 nursing homes licensed by the State of California. This class of vendors receives approximately $140,000,000 a year for providing services under the Medi-Cal Program. Except for hospitals this is the largest portion of Medi-Cal funds paid to any single class of vendors.

The maximum fee paid to nursing homes for caring for a Medi-Cal beneficiary is $14 a day. This fee is based on a formula which determines the homes' "cost of operation."

The investigation revealed that nursing homes are engaging in numerous activities which violate the laws and regulations governing Medi-Cal.

(1) *Many nursing homes require beneficiaries or their relatives to pay money "under the table" to secure admission of the beneficiary into the home.* Such payments are often required not just upon the initial admission of the beneficiary but also for each month the beneficiary is kept in the home.

A Medi-Cal regulation provides that vendors under the program shall not, in addition to being reimbursed from Medi-Cal, collect or demand reimbursement from beneficiaries or from other persons on behalf of beneficiaries.

(2) Medi-Cal beneficiaries in nursing homes receive $15.00 per month from the county for incidental expenses (e.g., cigarettes, candy, etc.). In many homes this money is maintained by the nursing home on behalf of the beneficiary.

The investigation has disclosed that some nursing homes misappropriate this incidental expense money which they maintain on behalf of beneficiaries. In one case, for example, it was found that a nursing home was in possession of some $2,000 which belonged to persons who either died or who were discharged from the home.

(3) *Several nursing homes have been found to be submitting claims to Medi-Cal for services rendered to patients who either died or who had been discharged from the home prior to the period covered in the billing.* One home, for example, received $3,000 for rendering services to patients who had in fact died prior to the date of the alleged services.

(4) *Another abuse which was found relates to the receipt of duplicate payments by nursing homes.* This can occur in situations where the fiscal agent accidentally makes the duplicate payment or where the nursing home submits a duplicate payment hoping to be paid twice. In either situation the unethical vendor retains the duplicate payment without notifying the fiscal agent.

We have already noted that HCS itself estimates that approximately 2.5 million dollars in overpayments have been made to all types of vendors.

Duplicate payments also occur where a nursing home has patients who are eligible to receive benefits from both Medi-Cal and Medicare. While Medi-Cal is only supposed to pay that amount which Medicare does not cover, the submission of duplicate claims under both welfare programs often results in the nursing homes getting paid in full from both Medi-Cal and Medicare. One nursing home, for example, received a duplicate payment of approximately $50,000 by billing in this manner.

Nursing homes may also receive duplicate payment in another manner. A home is reimbursed by Medi-Cal for providing a service, yet it also bills and receives payment for this same service from the patient or his relatives. Many persons receiving Medi-Cal benefits do not know that the services they are billed for have already been paid by Medi-Cal.

(5) *The investigation revealed that it is common practice for nursing homes to require vendors with whom they deal to give kickbacks in order to provide their services to persons in the nursing home.*

In some instances the kickbacks ranged as high as 35% of the fee received by the vendor.

Kickbacks are prohibited by Medi-Cal regulations. Nevertheless, it is a common practice for vendors such as pharmacists, therapists, X-ray technicians and laboratory clinics to give kickbacks in order to obtain business from nursing homes.

(6) *Nursing homes often provide services to their residents which are greatly in excess of the services actually needed. Such overservicing is cause for dropping a nursing home from the Medi-Cal program.*

(a) Our investigation indicated that some nursing homes order drugs far in excess of the quantities required by their residents. This situation can occur since physicians often prescribe continuous medication for persons in the homes and the homes determine when to order the medication. For example, one nursing home had a patient who was to take three pills a day. A prescription of 100 pills would have lasted an entire month. The home, however, ordered three prescriptions, each for 100 pills, during this one month.

The temptation of this abuse is enhanced in those situations where there is either common ownership between a nursing home and pharmacy or some kickback arrangement betwen the home and a pharmacy. Common interests in nursing homes and pharmacies are, in fact, becoming more prevalent under the welfare program.

(b) Another method by which excessive services are provided is where nursing homes have arrangements with vendors such as physicians, dentists, optometrists, podiatrists, etc., which permit them to examine persons in the home whether or not their services are required or requested.

Indications of "mass examinations" by such vendors have been observed by county consultants throughout the state in the course of their processing requests for prior authorization. Persons in the home seldom object to such examination since they are not usually required to pay for such services.

(c) Information has been obtained which indicates yet a third method by which excessive services are provided by nursing homes. This relates to the situation where a nursing home attempts to "qualify" Medi-Cal patients for Medicare. Since nursing homes receive greater reimbursement for persons who are eligible for Medicare than they do for persons eligible for Medi-Cal it is to their benefit to have a patient classified as a Medicare patient.

To be eligible for Medicare benefits while in a nursing home the patient must have been hospitalized for a period of three days. A former administrator of a nursing home has alleged that some nursing homes have an arrangement with hospitals whereby Medi-Cal patients are transferred from the home to the hospital for a period of three days and then returned to the home.

The nursing home benefits by this arrangement since it receives reimbursement at the greater rate from Medicare when the patient is returned to the home. The hospital benefits because it is reimbursed for providing services to the patient which usually include laboratory tests, x-rays, etc. (Under such an arrangement the nursing home or hospital usually has a physician who authorizes the patient to be hospitalized.)

This type of activity not only provides services to a patient which were not needed nor requested, but the question of "eligibility" may determine whether a nursing home will accept a Medi-Cal patient into the home.

* * *

In addition to effecting services provided under Medi-Cal, the unlawful activities of nursing homes also effect services provided under the federal program of Medicare. The activities described also result in a needless expenditure of funds under that program. Indeed, the scope of such unlawful activities was a matter of inquiry before a congressional subcommittee on Long Term Care in 1965. Testimony given before this subcommittee indicated that many of the activities we have described concerning nursing homes are prevalent throughout the nation.

B. Hospitals

The largest share of Medi-Cal funds, approximately $220,000,000 is received by hospitals. Of this amount, $120,000,000 goes to county hospitals. The remainder goes to private and non-profit hospitals.

We concentrated our investigation of hospitals on the profit making variety. There have been no indications that the abuses we are studying are prevalent in public and non-profit institutions.

Generally, we discovered that many of the abuses which we have seen in nursing homes occur equally in hospitals. Such abuses include overservicing, kickbacks and double billing.

These Medi-Cal abuses seem to be predominant in physician-owned hospitals. Since there are no significant differences in the patterns of abuse in nursing homes and hospitals, we will not offer extensive examples of hospital problems.

Our comments on nursing homes clearly indicate the Medi-Cal problems which may be found in hospitals. An audit of just seven hospitals, for example, between March and August 1968, resulted in a recovery of $136,000 by Blue Cross.

C. Physicians

Medi-Cal pays around $95,000,000 a year to 18,000 physicians who participate in the program.

(1) *The primary fraudulent activity engaged in by physicians as disclosed by the investigation has been submitting claims for services which were not in fact rendered by the physicians.*

One area in particular where this type of activity occurs relates to physicians submitting claims for having examined patients in nursing homes, although such examinations were not in fact performed.

Due to problems which hamper investigative activities into fraudulent activities (discussed *infra*) the investigation was unable to determine the extent to which this type of conduct occurs.

(2) *Overservicing is the major problem concerning physicians in the Medi-Cal Program.* This involves services which are not necessary for a patient's well being, but which are provided primarily for the purpose of obtaining additional fees under the Medi-Cal Program.

(a) Examples of activities involving such overservicing include unnecessary examinations, office visits, laboratory tests, x-rays, injections and surgical procedures.

(b) The placement of persons in nursing homes whose physical condition does not require such extensive care is another form of overservicing.

In Los Angeles County alone during a one-year period of time some 1300 persons were requested to leave nursing homes by county consultants because their physical condition no longer required such extensive care.

(c) Many nursing homes have "house physicians". These are physicians who have an arrangement with nursing homes whereby they take care of the persons in the home. By having a "captive audience" the physician is able to realize a significant amount of income regardless of the actual need of the individual residents.

Under this type of arrangement however a physician may often compromise his professional judgment to the point where he relies upon recommendations made by the nursing home itself as to services to be given to the patient.

For example, our investigation revealed incidents where physicians signed blank prescriptions which were given to them by the nursing home and which were subsequently completed by the home itself. In one instance, a physician thought he was signing a prescription for a drug when in fact it was filled in by a nursing home for a wheel chair for a patient who was ambulatory. In another case, 75 blank prescriptions signed by a doctor were found in a nursing home. Review of claims by consultants have also given rise to suspicion that it is the nursing home which prepares the forms describing the physicial condition of persons who seek admission into the home. The "house physicians" sign such forms although they, in fact, have not examined the patients.

The determination of whether a physician is providing excessive services is one which usually requires the judgment of other physicians. Claims of physicians are processed for payment by Blue Shield. Blue Shield maintains a Utilization Committee which began functioning in February 1967. One major purpose of this committee is to discover physicians who overutilize the program.

As will be seen later in this report, the current method of reviewing claims submitted by physicians does not maximize the discovery of abuses. Nevertheless, as of September 30, 1968, the Utilization Committee had discovered approximately 1000 physicians who had engaged in overutilization. As a result the committee either recovered or made adjustments in the doctors' claims to the extent that Medi-Cal realized a savings of approximately one half million dollars.

In addition to the Utilization Committee, physicians who act as advisors for Blue Shield at the county level have saved the program approximately $2,000,000 in just the first six months of this year based upon their review of claims submitted by physicians.

The question of overservicing also arises when doctors receive huge fees from the welfare program. Over 3 million dollars in payments have been made to just 35 physicians in a period of one year, with payments ranging from $70,000 to $131,000 each. Investigation disclosed overservicing by many of these physicians.

Physicians with a financial interest in pharmacies, laboratories and hospitals are also presented with the opportunity of subjecting Medi-Cal beneficiaries to these services although they may not be required for medical reasons. For example, of four hospitals whose claims are under constant review by Blue Cross to determine if excessive services are being provided, all four are owned by physicians.

One blatant example of unnecessary services in a physician-owned hospital concerns a patient who was hospitalized for sixteen days. Ten blood tests, many of them identical, were taken each day the patient was hospitalized. Of the 160 tests taken, not one revealed an abnormal finding. Multiple X-rays of the chest, skull and cervical spine were also taken although here again no abnormality was ever revealed. This type of overservicing was similarly provided to many other patients in this same hospital.

D. Pharmacists

There are approximately 4,900 pharmacies in the State of California. For the fiscal year ending June 30, 1967, pharmacies participating in Medi-Cal received 40 million dollars from the program.

Until recently, the formula used to reimburse pharmacies for drugs they dispensed was the cost of the drug, plus 50% of the cost, plus a fee of $1.15. Thus, if a drug cost $1, the pharmacy would receive $1 plus 50 cents plus $1.15, for a total of $2.65.

Under a recent regulation this was changed to the cost of the drug, plus a professional fee of $2.30 per prescription.

The investigation has revealed numerous ways in which pharmacies are engaging in activities which violate the laws and regulations governing Medi-Cal.

(1) HCS publishes a drug formulary which contains instructions as to the manner in which pharmacies are to determine the cost of their drugs when billing the Medi-Cal Program.

Pharmacists are instructed not to charge the state a price which is in excess of the price charged to the public for the same drug. Based upon investiga-

tions made both before and since the enactment of Medi-Cal, it appears that a large number of pharmacies are violating this instruction.

This conclusion is based on the fact that prior to Medi-Cal, Los Angeles County (which contains approximately 45% of the pharmacies in the state) maintained a staff of investigators who would make periodic visits to pharmacies to determine if the county was being charged a higher price than the public for the same drugs. This spot-check revealed that a vast majority of the pharmacies visited were, in fact, selling identical drugs at a lower price to the public than to the welfare program.

With the enactment of Medi-Cal, the staff used by Los Angeles County to do such field audits ceased to exist and HCS does not have personnel who check on pharmacies in this manner. It is therefore highly unlikely that the practice of excessive billing ended with the enactment of the Medi-Cal Program. Indeed, spot-checks which have been made on pharmacies since Medi-Cal revealed that a majority of the pharmacies visited are still charging prices to the state which are in excess of those charged to the public.

There is a special problem involving the difference in drug prices charged to public agencies and private individuals. This involves private health programs which may pay less for drugs than the public welfare program. For example, the United Auto Workers is negotiating a contract under which Blue Shield would cover the expense of drugs purchased by members of the union. Under the proposed contract, the UAW Program would pay less for drugs than the state welfare program.

(2) *The drugs formulary instructs the pharmacist to dispense the lowest cost item which he has in stock provided that it meets the requirements of the practitioner as shown in the prescription. Many pharmacies are not complying with this instruction.* For example, in situations where an inexpensive generic drug could have been dispensed, the patient has been given an expensive brand name drug which resulted in greater reimbursement to the pharmacy under the formula previously described.

Many drugs have both a brand and generic name. A brand name is always more expensive than the generic name drug. Often, the brand name is as much as two or three times more expensive.

Examples of the difference in price can be seen by a comparison of the cost of some leading brand name drugs with the cost of comparable generic drugs.

BRAND NAME		COMPARABLE GENERIC	
Achromycin caps (250 mg.):		Tetracycline caps (250 mg.):	
100	$11.22	100	$4.20
Peritrate tabs (10 mg.):		Pentaerythritol tetranitrate tabs (10 mg.):	
100	2.50	100	.65
1,000	22.50	1,000	3.00
Seconal sodium (1½ gr.):		Secobarbital sodium (1½ gr.):	
100	2.16	100	1.25
1,000	19.92	1,000	8.80
Tedral tabs:		Theophylline, ephedrine and phenobarbital tabs:	
100	3.18	100	.60
1,000	28.60	1,000	4.65
Noctec caps (7½ gr.): 100	4.20	Chloral hydrate caps (7½ gr.):	
		100	1.75

(3) *Visits to nursing homes, hospitals, sanitariums and homes of patients revealed that some pharmacies give patients a generic drug but bill the state as though the brand name drug had been dispensed.* Under the formula for reimbursement the excessive expenditure made by Medi-Cal due to such false claims can amount to a significant amount of money.

(4) *The investigation revealed that pharmacies often purchase drugs in large quantities but bill Medi-Cal at a cost premised upon a minimum quantity purchase. This results in the pharmacy receiving more than its actual cost for the drug dispensed.* Furthermore, Medi-Cal not only pays out excessive money for the cost of the drug, but the excessive expenditure is compounded when this higher cost is used in applying the formula for reimbursement.

Under the formula for reimbursement, a pharmacist is supposed to bill Medi-Cal for his "cost" of the drug dispensed. The drug formulary prescribes that the

pharmacist shall apply the maximum allowable wholesale cost or his actual cost, whichever is lower in calculating the cost of the drug dispensed.

Most pharmacies buy certain drugs in large quantity (e.g., on a thousand lot or gallon basis) so that the cost per hundred or per pint of the drug is cheaper than if purchased in a quantity of hundreds or pints.

Drugs purchased on a minimum quantity basis are more expensive than drugs purchased in large quantities.

The difference in cost when buying small quantities as compared to large quantities can be illustrated by the following examples:

Name of drug	Cost for 100	Cost for 100 on purchase of 1,000	Percent of difference
Lanoxin tabs, 25 mg	$1.14	$0.80	47
Nembutal	2.16	1.62	32
Butisol sodium tabs, ½ gr	2.15	1.84	13

An audit of a single pharmacy's prescriptions paid by the state during a two-month period revealed that the pharmacy overstated its cost of drugs at an average of 38 cents per prescription. During the year, this pharmacy submitted 14,000 prescriptions to Medi-Cal. Applying the excessive cost of 38 cents per prescription, the state may have overpaid this one pharmacy some $5,300 for the year.

(5) It is permissible in California for a pharmacist to fill a prescription which has been authorized by a physician over the telephone. Whenever a pharmacist gets a request from a person other than a physician for a prescription, it is the duty and responsibility of the pharmacist to contact the physician prior to issuing the drug.

Analysis of prescriptions submitted for payment by pharmacies disclosed several situations which indicate that the drugs were probably not authorized by the physician and sometimes never dispensed by the pharmacy. Examples of such situations are described below.

(a) *Some pharmacies needlessly dispense multiple prescriptions of the same drug to the same patient over a short period of time.* Examination of such prescriptions revealed that if the drug was taken as directed, there was no need to dispense the quantity of drugs indicated on the prescriptions submitted for payment.

For example, a pharmacy might submit for reimbursement to Medi-Cal four prescriptions written for the same patient during a thirty-day period of time. Each prescription was for 30 pills of the same drug or a total of 120 pills. If the pills were taken as directed in the prescription (e.g., 1 pill twice a day), 60 pills would be been sufficient for the entire month.

This situation also occurs when nursing homes order prescription medicines. In such circumstances, pharmacies often prepare multiple prescriptions to meet the quantity ordered rather than writing a single prescription. Since pharmacies were reimbursed on a basis of cost, plus 50% of cost, plus $1.15 fee per prescription, they were able to obtain greater reimbursement by writing several prescriptions for small quantities of a drug rather than writing one prescription for a larger quantity.

(b) *Some pharmacies dispense an excessive number of prescriptions for a particular patient or family on one day, or within a relatively short period of time.*

In one case, 15 prescriptions were dispensed to a single family on a given day. The family consisted of a husband, wife and three children. The 15 prescriptions involved only three different medicines. An identical prescription for each member of the family was written for each of the three medicines. (E.g., each member of the family got a prescription for 4 ounces of the same cough medicine; each member of the family got a prescription for 2 ounces of the same antibiotic.)

(c) *Misuse of "preprinted" prescriptions is another problem revealed by the investigation.* A preprint is a prescription form which is already printed to contain such information as the name of the patient, name of drug, quantity of drug, directions for use, name of doctor and name of pharmacy. Pharmacies prepare these prescription forms without any request from a physician for such a prescription. Allegedly, they are prepared to improve service to regular customers.

Actual misuse or temptation to misuse such preprints is patently obvious. A successful criminal prosecution was brought against a pharmacist who used pre-

printed prescription forms to submit false claims. This pharmacist had never dispensed the drugs indicated on the preprinted forms which he submitted for payment.

In most of the examples mentioned an examination of prescriptions indicated that they were in fact written by the pharmacist as telephone prescriptions. Inquiries were made to physicians whose names appeared on suspicious prescriptions. A majority of the physicians who responded stated that they did not authorize the issuance of the prescriptions.

(6) Nursing homes usually order all the drugs required by persons residing in the homes. This often amounts to the purchase of a few thousand dollars worth of drugs per month. *The investigation revealed that many pharmacies are giving kickbacks to nursing homes in order to obtain their business. One pharmacy has even sent letters to nursing homes offering to give discounts for their business.*

A Medi-Cal regulation specifically prohibits a vendor from offering an unearned rebate, refund, discount or other unearned consideration as compensation for the referral of business under the Medi-Cal Program.

* * *

Several pharmacies are currently under separate investigations for engaging in the types of activities we have been discussing. One such investigation has resulted in the filing of a criminal complaint against a pharmacist who requested payments for prescriptions never dispensed.

Although the investigation could not determine the exact amount of money the state is spending due to abuses by pharmacies it is significant to note that an audit of only 39 stores has resulted in a recovery of approximately $132,000. Under the present system these audits arise out of complaints. Complaints involving around 70 other stores have not yet been investigated.

It is estimated by experienced investigators that if routine audits were *initiated* by Medi-Cal the amount of recovery would probably exceed $500,000 a year.

E. Dentists

Dentists who participate under the program receive about $12,000,000 a year from Medi-Cal.

Unlike physicians who perform whatever services they deem necessary, dentists are required to get prior authorization from dental consultants for any plan of treatment which would exceed $35. Also, unlike physicians, reimbursement to dentists is fixed by a schedule of fees depending upon the dental procedure performed.

Investigation disclosed the following fraudulent activities by dentists.

(1) *In order to avoid getting prior authorization, dentists have submitted separate bills, each under $35, directly to Blue Shield for payment of services rendered to a particular patient.* The total sum of the bills, however, clearly revealed that the entire single plan of treatment did exceed $35 and should have been submitted for prior authorization.

(2) *Submitting false claims.* This type of abuse can occur when a dentist seeks payment where he has performed no services. It can also occur where a dentist submits a bill for having performed a specific dental procedure entitling him to a certain reimbursement when in fact he did a different procedure for which he should have received a smaller sum of money.

In one instance, a dentist falsified his claims by putting down the wrong procedure number for his dental work thereby obtaining $60 more than he was entitled to receive on each claim.

(3) *Overservicing also exists in the field of dentistry.*

(a) *Dentists are providing dentures or other prosthetic work under Medi-Cal which would not be provided under normal circumstances.* Such services are being performed primarily because reimbursement can be obtained under the Medi-Cal Program. In one county, twenty percent of the requests for prior authorization are denied because the consultants deem that the proposed dental work is unnecessary.

(b) Examination by dentists of patients in nursing homes is a special area where overservicing exists. Dental consultants throughout the state agree that dental work performed in nursing homes presents a large area of potential abuse.

In one county, more than fifty percent of all requests for prior authorization submitted by a dentist for patients in one nursing home were rejected on the ground that the treatment requested would not be beneficial to the patient. Even where authorization to perform work is denied, however, the dentists are still

entitled to receive their fee for making routine examinations, although these examinations are not always requested nor needed.

(c) Just as suspicion of overservicing is raised when large fees are paid to physicians, the same is equally true when big fees are received by dentists. Eleven dentists received close to one million dollars in fees in the year 1967. The activities of many of these dentists are, in fact, suspect by dental consultants at the county level.

F. Optometrists

Expenditures under Medi-Cal to optometrists are approximately $8.000,000 a year. Optometrists need prior authorization before they can provide lenses or frames to a beneficiary under the program. However, no such authorization is required for an optometrist to perform a routine eye examination.

(1) *Fraudulent activities by optometrists have primarily involved requesting prior authorization to provide appliances based upon the submission of false information.*

The extent to which optometrists submit false information in requesting prior authorization is indicated by the fact that one county rejects approximately one third of the requests received for prior authorization to provide lenses and frames to patients in nursing homes. Many of these rejections were based on the ground that the information supplied was false.

In one case, for example, an optometrist requested approval for a pair of expensive prescription sun glasses for a patient. Investigation disclosed that the patient was blind. In other cases requests stated that the patients were in possession of old glasses which were in poor condition. Investigation revealed that the patients were in fact in possession of new glasses which they received within six months prior to the latest request.

(2) *Optometrists were also found to be providing materials which do not meet the quality specified by the regulations.* Several optometrists suspected of providing inferior quality materials are now under investigation.

(3) *Optometrists overutilize the Medi-Cal Program by providing unnecessary examinations and by providing lenses and frames which are not needed by the beneficiary.*

Once again, investigation disclosed that review of requests for authorization received from optometrists concerning patients in nursing homes are often rejected on the ground that the glasses requested will not be of benefit to the patient.

In several cases, for example, requests stated that the patient was "active, alert and expressed a need and desire for improved vision." Examination of the patients by the optometric consultant however revealed that their physical condition was such that communication with them was difficult, if not impossible, and that the glasses would not be of benefit to the patients.

Another manner of overservicing exists where optometrists replace lenses and also request replacement of frames which are still in good condition.

CONCLUSION

In mentioning various types of fraudulent activities and acts of overservicing which are occurring we have only attempted to show some of the more shocking and extravagant abuses. We have not exhausted all of the methods by which every class of vendor can take advantage of the program. Nor have we related every case which is under investigation. Instances of fraud and overservicing, for example, could also be given for vendors such as hearing aid dealers, podiatrists and ambulance services.

In some cases the abuses mentioned may be prevalent among a specific class of vendor. In other cases only a small percentage of the class of vendors involved may be engaging in a particular type of abuse.

The one fact which is certain however is that the abuses mentioned are occurring and have resulted in millions of dollars being needlessly spent since the commencement of the program. Moreover, unless immediate efforts are made to curtail these activities it is likely they will grow in scope and cost to the program.

Our attention is now directed to the type of enforcement which has existed under the Medi-Cal Program for the purpose of discovering and preventing abuses and whether whether the program of enforcement has been effective in these areas.

III. Enforcement of Laws and Regulations

We have concluded from the investigation that an effective enforcement program to discover and investigate vendors who are taking advantage of the program does not exist.

Medi-Cal became effective March 1, 1966. It was not until twenty-one months later in December 1967 that HCS hired any trained investigators and then only two men were hired for the whole state.

Whether it was the myraid of problems encountered in getting the Medi-Cal Program operating, or a belief that potential abuses were not significant or would be adequately discovered by the fiscal intermediary agents, the fact is that an effective investigative unit was not initially established and does not exist today.

Since the commencement of Medi-Cal in March, 1966, only twenty-one vendors have been suspended from the program. These few suspensions, in light of the substantial amount of abuses revealed by the investigation, vividly reflect the inadequate enforcement of the program.

Two main problems confront attempts to seek compliance with the laws and regulations governing Medi-Cal.

(1) *There is a lack of an effective system to discover those vendors who are engaging in fraudulent activities and overservicing.*

(2) *Even after vendors become suspect, proper investigation into the matter is difficult, if not impossible, due to a number of internal problems.*

A. Discovery of Abuses

Most abuses are discovered in the course of the fiscal agents processing claims submitted for payment or consultants passing upon requests for prior authorization.

(1) *Professional Consultants*

The professional consultants in counties throughout the state must give prior authorization before the services of many individual vendors can be provided (*e.g.*, dentists, optometrists, podiatrists, etc.) and part of their responsibility is to discover abuses by such vendors.

Professional consultants had a similar responsibility under the welfare program prior to the enactment of Medi-Cal. Prior to Medi-Cal, however, the consultants would not only get requests for prior authorization, but they would also receive and approve claims for payment after services had been performed enabling them to maintain complete patient and vendor folders. This system permitted comparisons of services rendered wih approved requests, and verification of prices charged. By doing so, the consultants were able to detect overservicing and fraudulent activities such as billing for services not rendered, or billing at an exorbitant price.

Under Medi-Cal, the consultants only receive requests for prior authorization. The claims for payment of services rendered go directly to Blue Shield with no copies of the billing going to the consultants. *It was the unanimous opinion of consultants with whom we spoke throughout the state that the failure to provide them with billing information has greatly diminished their ability to discover abuses.*

In Los Angeles County, for example, the dental consultants were able to either recover from dentists or to adjust requests for authorization to the extent that the welfare program was able to "save" over a million dollars a year prior to the enactment of Medi-Cal. However, since they are no longer receiving claims submitted by dentists for services rendered, they have been unable to maintain complete files and to achieve such savings under the Medi-Cal Program. This county still retains a "bad boy" list of dentists, many of whom receive large fees from the program, whose claims they believe merit careful scrutiny which is not being given under the current method of review.

(2) *Blue Shield*

Blue Shield, with certain exceptions, receives 70,000 claims a day from individual vendors throughout the state. Since consultants at the county level must give prior authorization before many vendors can provide services, Blue Shield's main concern is to process this huge number of claims for payment. In doing so, the main review is to see if the service and the fee set forth on the claim is allowed under the program. Discovery of abuses by such review is primarily limited to claims submitted by physicians and pharmacists, whose claims are not subject to prior authorization.

Efforts to discover fraudulent activities and acts of overservicing are made by personnel who are trained to examine claims to see if they are justified.

(a) *Without maintaining a patient or vendor folder, and by examining claims on an individual rather than group basis, many of the abuses by physicians will not be discovered by the present method of review.*

Assume for example that a physician intends to take advantage of the program by requiring a patient to make unnecessary visits to his office. Since the individual claims submitted to Blue Shield for each office visit would appear proper and be processed for payment, the chances of discovering this type of abuse is remote upon a review of claims on an individual basis. This abuse is more likely to be discovered if a number of claims submitted by this physician were reviewed at the same time, or if a patient or vendor file was maintained. Due to the volume of documents involved in reviewing claims of physicians throughout the state, such files are not presently maintained.

As previously noted, the review of claims by the Utilization Committee and county-level advisors to Blue Shield recovered approximately four and one half million dollars in one year from physicians who were providing excessive services. This figure alone is a commentary on the extent of abuse occurring under the program by just one class of vendor. Furthermore, this figure relates only to those excessive activities which have in fact been discovered.

While this type of review has achieved some success in discovering acts of overservicing by physicians, it has not been able to discover numerous other abuses we have mentioned are being engaged in by other vendors. One indication of this is that while Blue Shield has taken action on over 1,000 cases involving Medi-Cal, only 18 cases were deemed significant enough to be sent to HCS with recommendations for suspension.

The Utilization Committee has recently commenced reviewing claims of physicians after they have been paid. This "post-audit" is done by establishing various parameters. This involves determining services or procedures which indicate overservicing and obtaining, by means of computer, the names of physicians who exceed the "norm" in regard to the performance of such procedures. The selection of one such parameter, for example, resulted in the review of some 20 physicians who performed a certain surgical procedure. Most of the physicians reviewed were found to have performed excessive services in regard to this particular procedure. This method in reviewing claims is too new to be evaluated at this time, although it offers certain advantages which will be discussed later in the report.

(b) The results of the method used in examining claims submitted by pharmacists presents even a better illustration of the inadequacy of the current method of review. We have already mentioned the numerous ways in which pharmacists are known to be abusing the program. *Prior to our investigation, action had been taken against only one pharmacist since the enactment of Medi-Cal.*

One reason few pharmacists have been investigated is that the review of individual prescriptions submitted for payment will not usually reveal a pattern of abuse. *To effectively discover abuses numerous prescriptions of a pharmacist should be analyzed at the same time.*

At our request a former pharmaceutical consultant was asked to select at random from Blue Shield's files prescriptions which had been submitted for payment and to analyze them for possible abuses. His examination of claims in this manner developed facts giving rise to several questions as to the propriety of the activities of several pharmacies. Set forth below are some examples of the suspicious activities detected by this type of examination.

(i) One pharmacy submitted 15 prescriptions, all of which were given to one family in a single day. Five of the prescriptions were identical, each being for four ounces of the same cough medicine.

(ii) A pharmacy dispensed in a period of 33 days 300 pills to a single patient. If taken as directed (one pill three times a day) 100 pills would have sufficed for the entire period.

(iii) One pharmacy employing one pharmacist dispensed 290 Medi-Cal prescriptions in a single day. These prescriptions amounted to his being reimbursed $1,190. Many of these prescriptions were preprinted. Around fifty percent of these prescriptions were written by two physicians, one of whom sees 75 to 100 patients a day and prescribes 100 to 125 prescriptions a day. For comparison purposes, a major chain drugstore employing seven pharmacists in a thirteen hour day writes an average of 300 presriptions a day.

While legitimate reasons could exist to explain the above patterns, the examples illustrate how this type of examination at least reveals activities which may justify additional investigation.

(3) *Blue Cross*

Blue Cross receives 5,000 claims a day from institutional vendors such as nusring homes and hospitals.

(a) Claims for nursing homes are submitted monthly and primarily set forth the names of the persons in the home during the period for which payment is requested. Reimbursement to a home is based on a fixed rate determined by its "cost of operation."

Since county consultants have authorized the admission of pesrons into homes, the examination of claims for nursing homes by Blue Cross is basically limited to determine if the appropriate amount of money is being paid. It is therefore highly unlikely that in the processing of such claims Blue Cross will detect the many types of abuses which we have mentioned as being engaged in by nursing homes.

A review of claims, for example, will not determine if nursing homes have submitted false claims, misappropriated patients' money, required kickbacks, or received duplicate payments.

Knowledge of such abuses can only effectively be discovered through periodic audits of nursing homes. Such audits have not been taking place.

The combination of lack of audits and the inadequacy of claims review has offered little deterrence to those nursing homes which are tempted to take advantage of the Medi-Cal Program since any unlawful or unethical activities are not likely to be discovered.

(b) The major reviewed performed by Blue Cross relates to claims submitted by hospitals. Examination of such claims is primarily directed toward determining if excessive services were provided. Such claims contain information relating to the diagnosis of patients and the treatment provided to them.

The majority of expenditures to hospitals are made to county and nonprofit hospitals. Discovery of excessive services has been associated primarily with profit-making hospitals.

The examination of claims to discover excessive services is performed by persons trained to detect this abuse. The review of such claims was initiated around November, 1967, with a staff of just two persons. This staff has now been increased to six. Two physicians who work part time for Blue Cross also review questionable claims of hospitals under the Medi-Cal Program (as well as claims submitted to Blue Cross under other government and private contracts).

In the limited time that this review has been going on, abuses have been discovered resulting in a savings of $136,000 to the Medi-Cal Program.

B. Investigative Activities

Although the present review system makes it difficult to discover abuses, HCS investigators have opened cases for investigation to determine if a vendor might be engaging in unlawful practices.

The difficulty in discovering abuses has been exceeded only by the inability of investigators and consultants to obtain essential information from HCS and the fiscal agents to pursue investigations on specific cases.

Several factors hamper investigative activities.

(1) To prove that a vendor is abusing the Medi-Cal program so that appropriate action may be taken—be it administrative suspension or criminal action—it is essential to examine documents submitted by the vendor. In the event of a hearing or trial, witnesses will also be needed to testify. Since we are often dealing with elderly people—whose health and memory are a legitimate matter of concern—time is of the essence if any investigation is to be successful.

The fiscal intermediary agents maintain possession of most documents which are pertinent and necessary to any investigation such as claims for services rendered, records of payments made, etc.

Our investigation disclosed that investigators and consultants have not been successful in their attempts to obtain documents and other information from the HCS and the fiscal agents for the purpose of pursuing investigations. The inability to obtain such information within a reasonable period of time not only makes cases moot because of the passage of time, but has the effect of discouring the efforts of persons charged with the responsibility of discovering abuses and performing investigations.

One vivid example of the frustration encountered is illustrated by tracing a request made to Blue Shield in September 1967 by the dental consultants in

one county. Documents were requested on 15 dentists whose activities were suspicious. As time elapsed without receiving the information, additional letters were written to both Blue Shield and HCS requesting the documents. In December 1967, the consultants were advised of the person to whom the request should be directed. The request was again made to this individual. As of this date, the information has still not been received.

Numerous other examples could be cited where investigators and consultants had to literally wait months before receiving answers to inquiries or documents which were requested. In many instances no responses at all were ever received.

The failure to provide documents may indicate a lack of cooperation and communication between HCS and the fiscal agents, or a lack of interest and concern by these organizations as to the importance of such investigations.

If, for example, requests for documents are not being sent to the proper persons both the fiscal agents and HCS have been aware of the problem long enough to have taken corrective action. If the number of requests for information are too great to enable expeditious replies to all requests, priority should be given to those matters involving investigations.

The delay in sending documents may be due to the fact that the fiscal agents microfilm documents which they process for payment. In using this procedure it may require some time to locate the proper microfilm and make the necessary copies. This office, for example, requested from Blue Shield documents concerning the activities of one vendor for a period of three months. Giving this matter top priority it still required 235 man hours and three weeks to provide this information at a cost of $800. While this may explain a reasonable delay, it does not justify the failure wihch has usually been encountered by those persons who have requested documents and other information.

Whatever the reason, the inability of investigators and consultants to obtain documents and other information presents a serious problem and is precluding effective investigation.

In commenting on this problem, it is important to note that Blue Shield has made every effort to cooperate with this office in providing documents which we requested and has often furnished such documents within a reasonable period of time. This would indicate that the ability to provide documents is not the basis for the lack of success which has been experienced by others.

(2) HCS is responsible for administering the Medi-Cal Program. Blue Shield and Blue Cross have contracts to act as fiscal intermediary agents on behalf of the state.

These organizations have a mutual goal and interest in seeing that the Medi-Cal Program is efficiently administered and that abuses by vendors are held to a minimum.

Our investigation reveals, however, that the coordination, cooperation and communication which one would expect to exist between HCS, Blue Cross and Blue Shield does not prevail.

(a) We have already mentioned the inability of an investigator to obtain information from the fiscal agents.

(b) Another example of this lack of communication is seen by the problem of determining which organization will investigate cases. We previously mentioned that Blue Shield has a Utilization Committee which attempts to discover cases of overservicing. There has not been a clear understanding however as to which cases involve fraud and should therefore be referred to HCS.

(c) Problems in the coordination of activities are further manifested by situations where Blue Shield has referred cases to HCS but HCS has no record of receiving the cases. Also, when cases are sent to HCS by Blue Shield recommending either further investigation or suspension of the vendor this is often the last that Blue Shield ever hears of the matter. Recommendations to suspend physicians are made by "peer" committees which exist within county medical societies. Serious frustration on the part of these committees has resulted from the failure of HCS to either take any action or to sustain such recommendations. In regard to cases received from Blue Shield, HCS claims that they are usually not properly reported so that rather than being able to continue investigating cases which are referred, it is necessary for them to start the investigation from scratch. This often results in duplicating work which has already been done by Blue Shield but not properly reported.

(d) Another area of lack of communication or coordination of activities relates to our previous discussion of abuses. We have seen that the activities of certain vendors may tend to overlap with activities of other vendors. Discovery of over-

servicing by hospitals or nursing homes, for example, may often give rise upon further inquiry to overservicing by physicians, pharmacists and other vendors. Our investigation disclosed, however, that where abuses have been discovered by one fiscal agent which indicate that other vendors whose claims are reviewed by the other fiscal agent should be investigated there has been a failure to adequately inform either HCS or the fiscal agent of potential investigations which might prove fruitful.

(3) "Investigation Units" exist in the offices of HCS, Blue Shield and the Department of Social Services of Los Angeles County. Although the three units all have basically the same objectives there has been no supervision or coordination of their activities so that often one unit does not know what the other is doing. Thus, one unit might commence an investigation against a vendor who is already under investigation by another unit, or who has been investigated and cleared by another unit. *This duplication of investigative efforts constitutes a serious problem with its resultant unnecessary expenditures and inefficient investigations.*

(4) *A major weakness in the investigative program of HCS has been the lack of adequate personnel.*

(a) Ten field investigators are employed by the Utilization Committee of Blue Shield. Their primary area of concern relates to investigating cases of overservicing by physicians which are handled by administrative action.

There are three investigators on the payroll of Los Angeles County, which county accounts for approximately 45% of the money expended under the program.

HCS employs just two investigators to cover the entire state. These investigators' primary responsibility is in the area of criminal fraud.

It therefore seems that the number of investigators decreases in proportion to the importance and geographic scope of the investigative activities.

Each investigator for HCS has approximately 100 cases. Most investigations require interviews with numerous persons and examination of many documents just to determine if a complaint has merit. Therefore, the investigative "staff" of one in southern California and one in northern California is unable to pursue more than a handful of cases at a time.

(b) The lack of an adequate investigative staff has meant that far too few actions have been brought against vendors who have been cheating the program. Failure to bring such actions precludes Medi-Cal from recovering or offsetting monies to which it may be entitled from such vendors and also enables them to continue participating in the program without much fear of detection. *Since there is no noticeable evidence of an investigative program—and hence no threat of criminal prosecution, suspension from Medi-Cal or disciplinary action against a practitioner's license—the current investigative program offers no deterrent to those vendors who may consider taking advantage of the program.*

(c) *In discussing the lack of an adequate investigative staff, it should be noted that the basic equipment and staff necessary for the effective performance of an investigator has not been provided by HCS.* Lack of portable tape recorders for use in the field when doing interviews and secretarial help to prepare reports and summaries of interviews are just two illustrations of the handicaps under which investigators must presently work. The investigator for HCS in southern California, for example, does not even have someone to answer his telephone when he is not in his office.

Other examples could be stated which would illustrate the problems involved in discovering and pursuing investigations. The matters mentioned above, however, amply demonstrate the dire need to review the procedures now being used to determine what appropriate steps should be taken to increase the effectiveness of enforcing the program.

IV. General Administration of Program

In the course of the investigation information was obtained concerning problems which exist in the general administration of the Medi-Cal Program. *Many of Medi-Cal's administrative problems indirectly contribute to the abuses which are occurring under the program.*

In relating such problems we are aware that Medi-Cal is only two years old and still experiencing growing pains. Many problems could not have been anticipated (e.g., Medi-Cal must conform to constant changes in regulations established by the federal government) or are inherent in the administration of any program this size. Indeed, efforts have already been made to remedy many of the problems which will be mentioned.

(A) *Communication and Coordination*

1. Reference has been made to the difficulty which exists in coordinating the activities of HCS and the fiscal agents in regard to investigating vendors who may be abusing the program.

a. *There is also a need for greater communication between HCS and the fiscal agents as to the general administration of the program.* HCS and the fiscal agents have not established an effective means of communication to enable HCS to keep abreast of problems confronting the intermediaries in the performance of their duties. For example, frequent changes by HCS in the type of information desired from the fiscal agents have often been made without consultation with the fiscal agents as to the feasibility and cost of making such changes.

b. *Blue Cross has not performed audits to determine the accuracy of fees being paid to nursing homes and hospitals.*

The amount of payment received by nursing homes and hospitals is determined by a formula which ascertains the "cost of operation" of such institutions. One responsibility of Blue Cross as the fiscal agent for processing claims of nursing homes and hospitals is to perform audits of such institutions to determine if their "cost of operation" justifies the fees they are receiving from Medi-Cal. As previously mentioned, only by doing audits of nursing homes can there be effective discovery of the abuses some homes are engaging in under the program.

Lack of direction from HCS and its failure to formulate policies have contributed significantly to Blue Cross' failure to perform audits until recently. The results of these recent audits reveal that Medi-Cal has been making excessive payments to nursing homes.

As one example, a recent audit by Blue Cross determined that one chain of eight nursing homes has received in excess of $380,000 from Medi-Cal. Other audits which are now in process are disclosing that the majority of institutions audited have also received excessive payments from Medi-Cal.

Audits of hospitals have also recently been commenced by public accounting firms under contract with Blue Cross.

c. *The problem of communication also extends into the relationship which HCS has with the counties throughout the state.*

(i) There are 58 counties in the State of California. Most of these process Medi-Cal claims for prior authorization. *In general there has been a failure on the part of HCS to effectively communicate with these counties for the purpose of discussing problems concerning their duties and the manner in which the laws of Medi-Cal should be applied.*

One example of this lack of communication is illustrated by a form which was recently used throughout the state for authorization to admit or retain persons in nursing homes. The form was prepared by HCS without consulting most of the medical consultants who had to determine from the information on the form if the request should be granted. Various county consultants contend that the form should have contained additional information to assist them in making their decisions.

This problem is also seen in the dissemination of a new form which is used in requesting authorization from county consultants to extend the period of time that Medi-Cal beneficiaries can remain in a hospital. This new form was not only devised without the advice of county consultants, but was also distributed to hospitals without prior notification to local consultants.

Another example reflecting lack of communication is illustrated by the fact that for several months consultants for one county were directing correspondence to a division chief at HCS who no longer held his post. County consultants were never notified of the change in the division chief.

(ii) *"Communication" between HCS and the counties is also weak in regard to the amount of discretion and responsibility county consultants can exercise on matters not specifically covered by any law or regulation.* Needless to say, a multitude of problems arise in various counties for which there is no specific answer provided in any law or regulation governing the program. In such instances, the consultants have a choice of either acting upon their own discretion or requesting direction from HCS. The failure of HCS to respond promptly to requests for advice often results in no action at all being taken by the counties. The failure to clearly advise the counties as to areas of discretionary responsibility has resulted in counties taking inconsistent positions on matters where there should be uniformity.

(iii) *HCS has also issued directives which were inconsistent with existing laws and regulations governing the Medi-Cal Program.* The current time lag in cor-

recting such inconsistencies—often weeks—would be eliminated by more effective lines of communication.

(B) *Evasion of Regulations*

Certain "loopholes" exist in the laws and regulations governing Medi-Cal which enable vendors to engage in activities which are contrary to the intent and language of the law.

1. *Through a simple subterfuge, physicians who are suspended from the program may continue to receive Medi-Cal payments.*

Persons participating as vendors in the Medi-Cal Program possess a vendor number. Usually this number is the same as the professional license number possessed by the vendor. When the vendor is a physician, however, and practices as a member of a group or clinic a vendor number is also assigned to the group or clinic.

As a result, physicians who have been suspended from the program for over-servicing or fraud are able to continue treating Medi-Cal patients and to receive payment for their services by submitting their claims under their group or clinic vendor number. This results in the physician being able to evade the purpose of the suspension which is to remove him as a participant in the Medi-Cal Program.

2. The regulations also provide that a physical therapist shall not receive payment for rendering more than six treatments to a patient without having obtained a new prescription from a physician authorizing further treatments. Home health agencies, another type of vendor under the program, are also allowed to provide physical therapy to Medi-Cal patients.

Unlike the individual physical therapist, no limitation has been placed on the amount of payments which can be made to a home health agency for providing physical therapy. As a result, it is common for physical therapists to have an arrangement with home health agencies whereby the latter will submit claims for services rendered by the physical therapists as though the service was rendered by the home health agency itself. In effect the home health agency is merely acting as a billing service for the therapist and receives a fee from the therapist for doing so. *Under this arrangement with home health agencies the individual therapists are able to evade the limitation which the Medi-Cal Regulations impose upon them.*

(C) *Determining "Cost" of Drugs*

We have seen that some pharmacies inflate their fees by overstating the cost of the drugs they dispense.

HCS publishes a drug formulary which basically provides that "cost" is intended to be the acquisition cost of the drug. (The formulary defines "cost" as being the lower of the maximum allowable wholesale cost or the actual cost to the pharmacist. The former price refers to a few drugs in the formulary on which there is placed a maximum allowable wholesale cost.)

A new drug formulary has recently been published. "Cost" has again been defined in the same manner. However, appearing under the caption "Billing Instructions" in the new formulary is a section which provides, in part, that the wholesale cost for the *standard package* of the drug dispensed shall be used in determining the cost of the drug to the pharmacy. A "standard package" is defined as 100's, pints, or pounds or the available size that is closest to said packages.

In providing that "cost" should be figured at the wholesale cost of a "standard package" this section ignores the acquisition cost of the drug. Hence, it gives the pharmacy the advantage of obtaining drugs at a cheaper price by purchasing in large quantities without passing this saving along to Medi-Cal. *The effect of this new Medi-Cal instruction is to allow reimbursement to the pharmacy for more than its actual cost in purchasing the drug.*

In the past several years a great increase has occurred in the cost of drugs under the welfare program. In 1967 the number of welfare prescriptions filled on a nationwide basis was 26.4% greater than the year before. In California the increase in welfare prescriptions over the same period of time was 37.4%. California also led the nation in both the number of welfare prescriptions filled in 1967 and the amount of dollar volume paid out for prescriptions in that year.

The number of welfare prescriptions and their cost for the current fiscal year have both been estimated as being higher than in the past year. It is now anticipated that as a result of the billing instruction in the new drug formulary the cost of drugs will be even greater than predicted.

Although previously mentioned, it is again significant to note that under the new welfare program in California the amount of money reimbursed to phar-

macies will be greater than the reimbursement provided under private negotiated contracts.

(D) *Purchase of Appliances*

Appliances such as wheelchairs, crutches and beds are purchased by both the state for persons eligible for Medi-Cal and by counties for persons who are on welfare but not under the Medi-Cal Program.

1. In Los Angeles County alone Medi-Cal purchases over $250,000 worth of appliances a year. However, whereas Los Angeles County has entered into contracts with suppliers of such appliances to purchase them at a discount the state has no such agreements and purchases identical appliances at a full retail price. *The effect is that the Medi-Cal is paying more money (often as much as twenty percent more) than the county for identical medical appliances.*

2. When Medi-Cal does purchase an appliance, the patient retains title to it. This means that when there is no longer any need for the appliance, because of death or otherwise, the patient or his family retains possession of the appliance.

Prior to Medi-Cal, Los Angeles County developed a procedure whereby appliances could be reobtained, serviced and stored so as to be available for future use by another welfare patient. No procedure for Medi-Cal to reobtain medical appliances—after it gives them to patients—exists under the current program.

(E) Beneficiaries under the Medi-Cal Program who passess certain assets are supposed to pay a portion of the cost of the services they receive.

1. The counties have the responsibility of ascertaining the liability of the patient. *There has been a general failure by the counties in assuring that the financial liability of patients for Medi-Cal treatment is being paid.*

If the patient's liability is not fulfilled, Medi-Cal ends up paying the vendor money which should have been paid by the patient. One county which is concentrating its efforts in this area has recovered from Medi-Cal patients approximately $20,000 in a period of one year.

2. The state also has a right of subrogation where there may be a third party liability to a Medi-Cal patient. *Failure to ascertain cases where subrogation might exist and to pursue such cases is also depriving Medi-Cal of a potential recovery of money.*

(F) *The failure by the counties and HCS to maintain current records of beneficiary eligibility has also been a source of many problems in administering the program.*

1. One problem of constant irritation has been the making of duplicate payments to vendors. This often occurs where an initial claim is rejected because the patient is not found to be eligible for benefits. Upon further inquiry, however, the patient is deemed eligible and a second claim is submitted. *This problem with eligibility records has often resulted in payments being made upon both claims.*

2. *The failure by the counties and HCS to maintain current records on eligibility has also caused the rejection of claims which should have been paid and the payment of claims which should have been rejected.* By not keeping records current inquiries as to eligibility have also resulted in undue delay in rendering services and paying vendors.

(G) *Processing Claims*

Mention has been made that the fiscal agents are responsible for processing claims of vendors. A closer look at their activities is necessary in considering the overall administration of the Medi-Cal Program.

Blue Shield receives 70,000 claims a day to process. These claims are intially reviewed for completeness of form and legibility. They are then examined on an individual claims basis by people trained to determine if the vendor has billed the proper amount for the services and if the services seem reasonable. If the claims seem proper they are forwarded to be microfilmed and to be paid.

Each claim is reviewed for the purpose of preparing it for data processing. This function actually requires some employees to cross out information requested on the forms provided by the state, but which is not needed for the processing of the claim. (E.g., telephone number of vendor.) Other employees have the task of printing names of vendors which are not legible on the claims submitted.

Blue Cross processes some 5,000 claims a day from institutional vendors. They, too, use trained personnel who review claims primarily to determine if the services and amount of claim is proper. These claims are also processed to prepare them for data processing.

Both fiscal agents utilize computers to a great extent. Among other things, the computers are supposed to be used for the purpose of determining who has been paid, amounts which have been paid, and kicking out requests for duplicate pay-

ment. The effectiveness of any computer is dependent upon how it is programmed and the accuracy of information it is given.

1. *There have been numerous instances where vendors have received double and triple payment for services they have rendered.*

Preliminary investigation has disclosed that one hospital, for example, has received duplicate payments involving some 59 different patients amounting to $17,000 in overpayments.

a. Various reasons exist for such duplicate payments. In the case of the hospital it was found that employees of the fiscal agent insert a diagnostic code on the claim received from the hospital. The code is determined by the diagnosis set forth on the claim. If a duplicate claim is submitted a different employee might interpret the same diagnosis in such a way so as to insert a different code number on the claim. Due to the difference in code numbers the computer will not detect the duplicate claim and payment will be made upon both claims.

b. Another means in which duplicate payments can occur is where a vendor initially submits a claim for $1,000 which shows that the patient's liability for such services is $100. The claim would thus request a net payment to the vendor of $900. If it was subsequently determined that the patient's liability should have been $200 a duplicate claim might be submitted by the vendor requesting $800. Due to the difference in the net amount claimed the computer would once again be unable to detect the duplicate claim and again it is probable that payments of both $800 and $900 would be made to the vendor.

2. *There also have been cases where the computers have not properly recorded where vendors have or have not been paid.* This type of error often results in inquiries being made by the vendors resulting in additional time and expense in ascertaining if payment has been made.

The inability of the fiscal agents to accurately advise investigators and consultants who request information as to whether vendors have been paid creates further delay and interference in the pursuit of investigations. Investigation disclosed, for example, that upon inquiry as to whether specific vendors have been paid the fiscal agent replied in the negative although such vendors had in fact received payment.

3. *The current system of processing claims has not only resulted in making duplicate payments to vendors who have rendered services to patients, but errors in the program have also caused checks to be sent to persons who have never provided services to Medi-Cal patients.*

It is difficult to estimate the amount of money which Medi-Cal has mistakenly paid out as a result of the errors we have mentioned. At the outset of the report we noted that as of June 30, 1967, one and a half million dollars in overpayments were voluntarily refunded by vendors. HCS estimates that another one million dollars in overpayments are still outstanding. Unless the vendor is honest and voluntarily notifies the fiscal agents of such duplicate payments it is unlikely that they would be discovered under the current auditing procedures.

Both fiscal agents have expressed the desire and need for better computer operations which would assist them in the performance of their duties in processing claims for payment.

RECOMMENDATIONS

The responsibility imposed upon HCS to administer the Medi-Cal Program is not one to be envied. Massive problems have confronted HCS from the initial day the program began operating and many of them still exist today.

Since the operation of the Medi-Cal Program is under constant review by both HCS and the California Legislature we offer herein suggestions concerning certain areas in the program which may be of some benefit to those agencies which are looking for ways to improve the program.

Many of the matters mentioned in this report have been discussed with HCS which has already begun to take steps to remedy some of the weaknesss found in the program.

1. Establish an Effective Investigating Unit

(a) One problem which has been mentioned in regard to the enforcement of the program has been the difficulty in discovering vendors who have taken advantage of the program. Similar difficulty exists in finding those recipients of Medi-Cal who also take advantage of the program.

We have noted that under the current system investigators are employed by HCS, Los Angeles County and the fiscal agents. Failure to coordinate their

activities has resulted not only in duplication of work and needless expenditure of money, but has produced far too few cases against persons abusing the program.

HCS investigations have produced few proceedings against vendors. This lack of suspensions and criminal or other disciplinary actions has been caused in great part by the inordinate amount of time which expires between the commencement and the conclusion of investigations. Because of the time lag evidence becomes stale and, in some cases, the witnesses have died. The latter, of course, is a particular problem in the field of medical investigations.

It is therefore recommended that a single investigative unit be established, consisting of at least ten men, under the supervision of one person who would have the responsibility of assigning cases and coordinating investigative activities.

The investigators should be experienced or trained to efficiently perform investigations into the various types of abuses mentioned in this report. Since Los Angeles County receives approximately forty-five percent of the money spent in the welfare program the majority of investigators should be located in the Los Angeles area.

The recommendation of a single investigative unit is not intended to preclude consideration of a proposed arrangement whereby the fiscal agents would have their own investigators.

(b) The investigative staff should be provided with adequate equipment and secretarial help to assist them to perform their duties in an efficient manner.

(c) This report has discussed the various means by which vendors have been taking advantage of the program. It is recommended that with use of this knowledge a manual be prepared to set forth basic procedures which should be followed by investigators when doing audits and investigations of specific types of vendors.

(d) Investigations now occur as the result of complaints which may be received. It is suggested that consideration be given to having investigators perform routine audits and investigations without the necessity of receiving a complaint. Such routine investigations would be especially effective in discovering abuses among such vendors as pharmacies and nursing homes and in acting as a deterrent to those who might otherwise consider abusing the program.

(e) The inability of investigators to obtain information from the fiscal agents has hampered effective investigation. Procedures should therefore be established whereby investigators can request and obtain within a reasonable period of time information which is needed for investigations.

(f) Both fiscal agents when processing claims attempt to discover providers who may be engaging in fraud or providing excessive services.

Effective liaison should be established between the investigative unit and the fiscal agents so that they may be apprised of the activities of each other.

2. Improve Procedures to Expedite Suspension Proceedings

If our recommendations for investigations are followed, there should be a vast improvement in the ability of the investigators to expedite cases and, where appropriate, to recommend disciplinary proceedings. While recommendations for criminal or disciplinary action would be referred to agencies other than HCS, in most instances the suspension of the vendor from the program would also be appropriate. This emphasizes the need for improving HCS suspension proceedings.

In the past, HCS' method in acting on suspensions from the program has proven unsatisfactory from the standpoint of both procedure and results.

It is therefore recommended that HCS take steps to improve the manner in which it handles proceedings to determine if a vendor should be suspended. Two possible sources to which HCS may look for advice in this matter are the Attorney General's Office and the Office of Administrative Procedure since both these offices have extensive experience in the processing of administrative hearings.

3. Publicize Existence and Actions of Investigative Unit

It is recommended that the existence of the investigative unit be made known to the public and to persons providing and receiving benefits under the program.

This would encourage information and complaints from the public and would also deter abuses.

The establishment of an effective unit should also result in an increase in the number of criminal actions, suspensions, and disciplinary actions taken against

persons participating in the program. Here again, it is recommended that such actions be publicized as a deterrant to abuses.

4. Establish Liaison with Professional Licensing Boards

Most of the persons providing services under Medi-Cal, such as physicians, dentists and optometrists are licensed by a professional board within the Department of Professional and Vocational Standards. Many of the abusive activities engaged in by vendors under the welfare program would also constitute a violation of the regulations established by their licensing boards.

Since it is the desire of both HCS and such licensing boards to discover and take appropriate action against such vendors, it is recommended that HCS establish an effective liaison with the relevant professional boards. By doing so, HCS not only will bring to the attention of such boards the activities of their licentiates which may warrant disciplinary action, but HCS may also be able to obtain additional investigative help through use of the staff of investigators employed by such boards.

5. Improve Communication Between Organizations Participating in the Administration of the Program

This report has revealed that the lack of communication between HCS, the fiscal agents and the counties has been a major impediment to the effective administration of the program.

It is therefore recommended that HCS should take appropriate steps to improve the communication and cooperation between these agencies.

One suggestion would be to hold periodic meetings with the professional county consultants and the fiscal agents to provide the opportunity to exchange views on improving program administration. Professional consultants, for example, from their review of thousands of claims might be a good source from which to obtain information to improve the program to assure the providing of *necessary* health services. Such meetings would also clarify such matters as when discretion is to be exercised by counties when processing claims. Meetings with the fiscal agents could be used to keep HCS abreast of the problems in processing claims and advised of new electronic data processing techniques to meet present and anticipated problems.

6. New Regulations

Consideration should be given to enacting new regulations which would implement the enforcement of the program.

(a) Improved communication with the counties and fiscal agents might prove to be one source of determining additional regulations which may be appropriate.

(b) At the present time vendors are not required to maintain any specific records or documents in regard to services they have provided. For example, nursing homes are not required to maintain records which would show the various services rendered to their patients. We have seen from this report that a major area of fraudulent billing concerns services provided to persons in nursing homes.

It is therefore suggested that consideration be given to the enactment of a regulation which would specify the types of records that must be maintained by vendors and which requires them to retain such records for a reasonable period of time. One possible effect of such a regulation might be to expedite investigations by enabling investigators to examine documents in the possession of vendors thereby removing the delay now encountered when records must be obtained from the fiscal agents.

(c) Mention has been made of at least two "loopholes" in the program which allows physical therepists to bill through nursing homes and suspended physicians to bill through a group practice to circumvent existing regulations.

Regulations should be enacted to prevent such circumvention.

7. Review Procedure of Processing Claims

Blue Shield employs some 350 persons to process 70,000 claims a day. Blue Cross employs approximately 70 persons to process 5,000 claims a day.

The procedures used by these fiscal agents should be periodically reviewed to see if their system of processing claims can be expedited and the cost lowered.

(a) In light of the large number of claims processed each day, the elimination of any one unnecessary step might result in a significant savings of money.

As an example, claim forms provided by HCS request information which is not needed in the processing of claims. In fact, persons reviewing claims actually cross out such information to avoid errors in preparation of data processing.

Other persons who review claims do so for the limited purpose of printing the name of the vendor on those claims where the name is not legible.

The expense of providing new forms which only contain required information or the identification of the vendor; or the providing of preprinted identification cards to vendors and recipients of benefits, might be one means to expedite and lower the cost of processing claims.

(b) Reference was made in the report to the fact that the fiscal agents microfilm the claims they process. The large number of claims processed may well make it necessary to do so since it enables thousands of records to be stored on microfilm in a single file drawer.

Since the use of microfilm however is one factor in the delay in providing information to investigators, efforts should be made to establish a procedure whereby information can be made more readily available to investigators.

8. Improve Use of Computers

Computers are presently used by both fiscal agents in the reviewing and processing of claims. Efforts should be made to improve control procedures and the programming of computers to assist them in their handling of claims.

Improved procedures in the computer program should eliminate errors such as making payments to persons who do not participate in the program and in making duplicate payments.

Since Medi-Cal pays a fixed fee to many vendors for specific procedures and services which are usually listed by code number on claim forms, consideration should be given to the feasibility of programming computers to make use of this information. By doing so, such errors as excessive payments and payments for services not authorized should be eliminated. The success of such programming might also reduce the need to employ persons who now manually perform these tasks.

Another area in which improved techniques of the computer system might be of value is in providing information to investigators and to vendors who request information on the status of claims. The inability to accurately determine who has been paid is one cause of the needless expenditure of money under the program.

It is important to mention that, prior to considering methods to improve the use of computers, HCS and the fiscal agents should attempt to anticipate the type of information and statistics which would be of value in the future to both the administration and the legislature as they seek to improve the Medi-Cal Program.

9. Review of Claims on a Local Basis

Pior to Medi-Cal the county welfare departments had the responsibility of receiving, reviewing and paying claims of persons providing services under the welfare program. That responsibility has now been shifted to the fiscal agents which process claims from vendors all over the state, although professional consultants employed by the counties still pass upon requests for prior authorization.

In the opinion of most persons interviewed, the current method of review has greatly diminished the ability of both the county consultants and the fiscal agents to discover vendors abusing the program and has reduced the amount of money saved by the discovery of such abuses.

It is therefore recommended that consideration be given to returning to a system where claims are reviewed on a local basis rather than out of the one office of Blue Shield and the two offices of Blue Cross. Indeed, to some extent this type of review is being employed under the current system.

Blue Shield, for example, subcontracts with various county medical foundations whereby said foundations perform the task of receiving and reviewing claims of physicians in their county. There is also a pilot project going on in San Joaquin County where the county medical foundation is performing the task of receiving and reviewing claims submitted by most vendors. Evaluation of this project should be of considerable help in determining the feasibility of again having local review.

One advantage of a local review is that it is usually performed by persons who are more familiar with the practice in a given area and with vendors whose reputation might justify their claims being closely scrutinized.

Another advantage is that local review allows for maintenance of better records. For example, San Joaquin County Medical Foundation in the pilot project has been able to maintain a patient folder upon which it records all services which the patient receives from any type of vendor. This has enabled the foundation to

discover situations where vendors, or the patient himself, has been taking advantage of the program. The foundation is currently working on a method of establishing a profile on vendors participating in the program as another means of discovering abuses being engaged in by vendors. Also, the foundation has been able to program computers to provide greater information than that which is now available in the processing of claims by Blue Shield and Blue Cross on a statewide basis. This too has been a means of enabling greater detection of abuses under the program.

While a return to reviewing claims on a local basis might present problems such as central control of payment of checks and maintenance of statistics, the concept of local review appears to merit further attention.

Another interesting experiment in the pilot project in San Joaquin is that the county foundation is processing claims of physicians on a "prepaid" basis. A fixed amount of money has been given to the foundation to cover the services provided by physicians in the county.

If the funds provided are not adequate the loss is incurred by the member physicians in the foundation. If successful, use of a prepaid system should be studied and evaluated to see if it would be appropriate in other areas in the state.

10. Post-examination of Claims

Reference was briefly made in the report to the fact that the Utilization Committe of Blue Shield recently began checking claims by doing a "post-examination" of claims.

Careful evaluation of the success in discovering abuses should be given to this method of examining claims. If proven successful, consideration should be given to establishing some type of post-examination for other types of vendors.

Several advantages appear to be offered under this system.

First, a review of claims by this method is done on a "group basis" which we have seen is preferable to the examination of claims on an "individual claim" basis.

Secondly, by taking advantage of information which can be obtained from computers it enables those who review claims to take the initiative in checking on vendors who engage in services that are considered likely to be abusing the program. By use of computers, for example, it is possible to establish profiles of vendors who receive the greatest reimbursement for specific procedures.

If successful as a method of discovering abuses the use of post-examination of claims might achieve additional savings by eliminating the need and cost of hiring persons who now perform duties which would be unnecessary in the processing of claims.

Finally, the use of a post-examination would probably be successful in regaining money from vendors who have abused the program. Since vendors who do abuse the program usually perform services to which they are legitimately entitled to receive payment, it would be possible to withhold money due the vendor for legitimate claims as an offset for the money which he wrongfully obtained.

One example of the success resulting from a post audit review of claims is illustrated by an investigation made into the activities of twenty physicians who performed an unusual number of surgical operations for umbilical hernias in children under five. Of the cases so far reviewed, the determination has been made that the operations performed by many of these physicians were in fact unnecessary.

11. Controlling the Cost of Drugs

We have discussed at length the potential increase in costs which may accompany the new method under which pharmacies have been instructed to ascertain their "cost" of drugs for the purpose of billing the Medi-Cal Program.

If the intent of the administration is to reimburse pharmacies for the true cost of drugs they dispense and then to pay them a fixed professional fee for their services, the billing instructions in the new drug formulary does not achieve this goal. If pharmacies are to be paid in a manner which fixes their cost on the purchase of a minimum quantity of drugs it is recommended that this method of reimbursement be carefully evaluated to determine its effect on the anticipated cost of the drug program.

The new drug formulary also deletes a number of drugs upon which there was previously placed a maximum cost which could be charged to the welfare program. If the effect of deleting these drugs results in a significant increase in the cost to Medi-Cal to provide such drugs, consideration should be given not only

to reinstating a maximum cost on these drugs but also to the merit of imposing similar maximum costs on other drugs. Imposing a maximum cost on drugs apparently has not had the effect of preventing such drugs from being made available to patients in the program so that such action does not prevent patients from receiving proper care.

In connection with the cost of drugs, suggestions have been made that a fair price could be established for all drugs in the formulary thereby establishing a definite fee schedule for drugs.

As in the case of any other specific service being paid based on a fee schedule, improved computer programming of such information could expedite the payment of such claims and eliminate the errors which have been found in the amount of money being paid and even in the payment of drugs and other medical supplies which are not authorized under the program.

Another means of controlling the drug cost of the program which has been suggested is to establish "Medi-Cal Pharmacies" throughout the state. This would require patients to go to one of the numerous pharmacies which would contract with the state to service persons in the program.

12. Scope of Benefits

It is the opinion of many persons directly involved in administering the Medi-Cal Program that Medi-Cal patients are receiving health care services which are far greater than services which a non-welfare patient would either anticipate or demand.

The opportunity to provide and receive such services has created a tempting area of abuse by both vendors and recipients of benefits.

It is therefore recommended that consideration be given to the question of whether changes could be made to assure persons on welfare of proper medical treatment without providing the opportunity to abuse the program.

To illustrate this problem, we mentioned in the report that the investigation disclosed that thousands of persons are now residing in nursing homes although their physical conditions do not warrant such extensive care. One major reason for this situation results from Medi-Cal's failure to provide benefits to persons in facilities other than nursing homes (e.g., board and care homes, rest rooms, etc.).

Family pressure upon physicians to keep persons in nursing homes since they would not get reimbursed if in other types of facilities is just one reason why so many persons are found in nursing homes although their physical conditions do not merit such care.

If reduced Medi-Cal payments were made to facilities providing less extensive care than nursing homes, the end result might to be effectuate a savings in the total Medi-Cal Program. Furthermore, a program which would remove thousands of persons from nursing homes who do not need such care would also create vacancies for persons who do require such care but are unable to receive it due to lack of space in the homes.

13. Third Party Liability

Although provisions exist in the law for Medi-Cal to recover its expenditures, if there is third party liability involved, the program has been very lax in pursuing this avenue to reduce the cost of the program.

It is therefore recommended that procedures be established to allow Medi-Cal to avail itself of this source of revenue.

Similarly, the methods now used to determine if the recipients of benefits are paying their share of liability under the program should be reviewed since the failure to do so needlessly increases the cost of the program.

14. Purchase of Appliances

Consideration should be given to determining if the state could contract with vendors of appliances (e.g., wheelchairs, crutches, etc.) whereby there is an agreement to purchase such appliances at a discount. Also, study should be given to the question of whether a savings would result if a procedure was established whereby the state or the vendor of the appliance could reobtain, service and store the appliance from patients who no longer required them, which appliances could then be used for other patients.

These matters should be reviewed to determine not only if they are feasible from a money savings point of view but if they can be accomplished in compliance with federal laws under which Medi-Cal operates.

CONCLUSION

The recommendations set forth herein are not intended to exhaust all problem areas in the Medi-Cal Program which require attention.

These recommendations are intended to correct the weaknesses in the administration of the program which contribute especially to cheating by persons participating in the program.

The abuses and weaknesses pointed out in the report are serious in nature and do merit further attention by the appropriate bodies which can take steps to improve the administration of the program and achieve immense savings of money without diminishing the quality of the services being offered to persons under the program.

As you requested, this report will be provided to law enforcement agencies to improve surveillance of outright criminal activity in the Medi-Cal Program.

HERBERT DAVIS,
Deputy Attorney General.

ITEM 2: STATEMENT ON ATTORNEY GENERAL'S REPORT MADE BEFORE THE JOINT COMMITTEE ON MEDI-CAL ADMINISTRATION ON NOVEMBER 13, 1968, BY THE CALIFORNIA ASSOCIATION OF NURSING HOMES, SANITARIUMS, REST HOMES, AND HOMES FOR THE AGED, INC.

EXHIBIT

On November 6, 1968, the Attorney General of the State of California released a document which purported to be a report on the findings of a nine-month investigation of the Medi-Cal program.

This document displays an unconscionable misfeasance and malfeasance in an office of public trust. That such an unethical and unprofessional report should be issued from the office of the Attorney General can only serve to demonstrate that political motives have taken control of a public office that presumably is pledged to protect and defend against unwarranted prosecution and presecution, as it is to seek out and punish individual criminals.

The report is replete with false accusations against a body of health care professionals who are dedicated to the highest ideals of service. The document is loaded with generalities, vague statements, uneducated guesses, passive wording, and displays a shocking lack of knowledge on the part of the attorney general's personnel, of the professional relationships in the health care field they seek to explore.

To use the prestige of the high office of Attorney General to publish such a document, to hold a press conference, and to release this scurrilous report for public consumption is inexcusable conduct. To attempt to destroy the public confidence in an industry that is dedicated to serve them, and to attempt to do so with a document based on hearsay, unconfirmed statements and isolated instances is reprehensible, and is grounds for a legislative investigation of the office of California's Attorney General.

The following review of excerpts of the Attorney General's report will support this contention.

REPORT ON MEDI-CAL INVESTIGATIONS

Verbatim quotes from the Attorney General's report follow: Comments from the California Association of Nursing Homes are identified as such and follow each quote from the report.

Excerpt:

"Our investigation indicates that illegal and unethical activities of persons providing services under Medi-Cal are siphoning millions of dollars annually from the program. Poor administration of the program has contributed to . . . ."

Comment—if there are illegal activities, as charged, why has not the attorney general's office moved to prosecute?

Comment—how can anything be termed unethical without first identifying the details of the applicable ethics?

Comment—if poor administration exists, then some effort should be made to improve it. Insinuations and condemnatory language directed toward the entire industry is not the solution.

Excerpt:

"The vast scope of the program precludes any precise estimate of the total amount of funds paid out due to poor administration . . . ."

Comment—the attorney general admits it is a rather poor report based on a very inconclusive investigation.

Excerpt:

"Our investigation leads us to conclude . . . ."

Comment—conclusion only, unsupported by documentation.

Excerpt:

"In February 1967, Governor Reagan appointed a task force to review the administration of the Medi-Cal program. This committee recommended changes which would allegedly save Medi-Cal $90,000,000 annually."

Comment—not being a part of the findings of the investigation, this is obviously a politically inspired statement which seeks to discredit the administration which is of a different political party than the attorney general.

Excerpt:

"The complex nature of Medi-Cal and the large number of participants—both vendor and recipients of health care services—prohibited a thorough investigation by the Department of Justice . . . ."

Comment—so, only a casual investigation was made. And, it was done without the help of the several interested professional associations that had volunteered help.

Excerpt:

". . . we recognize the problems confronted by Health Care Services in administering a program which was hastily conceived and implemented."

Comment—one of the few unquestionable statements in the report.

Excerpt:

"There is a lesson here for both the state and federal governments. The enactment of federal legislation which requires immediate response from the states to take advantage of federal funding is laden with peril, as well as with token prosperity. Unprepared and without sufficient analysis, the states are rushed into formulating programs which are both essential and ill-considered. There should be an effort by both federal and state governments to transform such programs into more meaningful and fruitful cooperative actions."

Comment—is it the place of the offce of the Attorney General to issue philosophical editorials?

It is here suggested that all governmental agencies should seek the help of professionals "to transform such programs into more meaningful and fruitful cooperative actions".

Excerpt:

"The investigation revealed that vendors are engaging in unlawful activities and are bilking the program. . . ."

Comment—such condemnatory and inflamatory language is not necessary and is unbecoming the office of California's attorney general. The case should be stated in simple, straightforward terms without editorilizing or expressions of bias.

Excerpt:

"Vendors violate Medi-Cal regulations when they agree to give or accept kickbacks—money or other unearned consideration—in return. . . ."

Comment—the report should have defined 'unearned considerations'.

Excerpt:

"In describing these abuses we recognize that they may in fact be engaged in by only a small number of providers."

Comment—this statement is not consistent with the many insinuations, accusations and allegations that appear throughout the report.

Excerpt:

". . . the millions of dollars drained from the program by such activities merit their exposure to the public and. . . ."

Comment—the function of the attorney general's office is not one of seeking publicity. Why such an effort at this time?

Excerpt:

"There are approximately 1,000 nursing homes licensed by the State of California. . . ."

Comment—if this investigation had been as complete and thorough as the attorney general's office would have us believe, the investigators certainly would have discovered that there are approximately 1,160 homes licensed by the Department of Public Health and another 90 (approximately) licensed by the Department of Mental Hygiene.

Excerpt:

"The investigation revealed that nursing homes are engaging in numerous activities which violate the laws and regulations governing Medi-Cal."

Comment—if this is more than an allegation, there should be some citations issued and prosecutions instigated. And—how many are described by the word 'numerous'.

Excerpt:

"Medi-Cal beneficiaries in nursing homes receive $15 per month from the county for incidental expenses. In many homes this money is maintained by the nursing home on behalf of the beneficiary.

The investigation has disclosed that some nursing homes misappropriate expense money which they maintain on behalf of beneficiaries."

Comment—the funds are retained—not maintained—for the patient by the nursing home administration which has posted a bond for handling such personal funds. Did investigators determine that there had been any claims filed against these bonds?

Also, just what quantities are indicated by such words as 'many' and 'some'?

Excerpt:

"In one case, for example, it was found that a nursing home was in possession of some $2,000 which belonged to persons who either died or who were discharged from the homes."

Comment—is this the only case discovered by the investigation?

One such case out of more than 1,250 possibilities is much above the record of any other profession in the matters of poor judgment, questionable practices or plain ignorance.

Excerpt:

"(4) *Another abuse which was found relates to the receipt of duplicate payments by nursing homes.* This can occur in situations where the fiscal agent accidentally makes the duplicate payment or where the nursing home submits a duplicate payment hoping to be paid twice. In either situation the unethical vendor retains the duplicate payment without notifying the fiscal agent."

Comment—this passive statement is evidently based on conjecture and surmise. The investigator acknowledges the probability of an accidental happening. However, the report proceeds to damn an entire profession for one imagined happening.

Excerpt:

"We have already noted that HCS itself estimates that approximately 2.5 million dollars in overpayments have been made to all types of vendors."

Comment—admittedly, this is purely an estimate; no basis is supplied to explain it. Although the amount of 2.5 million dollars is here identified as overpayment to all types of vendors, elsewhere in this report the amount is identified as overpayment to nursing homes alone.

Excerpt:

"Duplicate payments also occur where a nursing home has patients who are eligible to receive benefits from both Medi-Cal and Medicare. While Medi-Cal is only supposed to pay that amount which Medicare does not cover, the submission of duplicate claims under both welfare programs often results in the nursing home, for example receiving a duplicate payment of approximately $50,000 by billing in this manner."

Comment—this just simply is not so. Again, how often is 'often'? Was there only one nursing home that could be charged with "billing in this manner"? One out of how many? Was there proof of intent to defraud?

Excerpt:

"Nursing homes may also receive payment in another manner. A home is reimbursed by Medi-Cal for providing a service, yet it also bills and receives payment for this same service from the patient or his relatives."

Comment—with shared liability (Group II), the nursing home must bill both the intermediary and the patient. The patient (family) is given official notice of shared payment.

Again, how many is indicated by the word "many"?

Excerpt:

"The investigation revealed that it is common practice for nursing homes to. . . ."

Comment—if it is common practice then can it be objectionable? (By definition, anything 'common' is shared or approved by all; belongs or pertains to the public at large.)

Actually, this comment is made to show the bias in the Attorney General's office in using words to insinuate the scope of investigation was far greater than the report itself openly admits. Such a broadly sweeping charge and general allegation without any supporting evidence is reprehensible.

Excerpt:

". . . . . it is common practice for vendors such as pharmacists, therapists, X-ray technicians and laboratory clinics to give kickbacks in order to obtain business from nursing homes."

Comment—such a broad, all-inclusive indictment should be supported by some documentation. Again, the investigator is careless with language by stating that (if true) the one thing he attempts to condemn is known and accepted by all.

Excerpt:

"(6) *Nursing homes often provide services to their residents which are greatly in excess of the services actually needed. Such overservicing is cause for dropping a nursing home from the Medi-Cal program.*"

Comment—all services of a nursing home are ordered by the patient's own physician. In this erroneous statement, the investigator should have explained how a nursing home can 'overservice' a patient. Actually, this paragraph displays the appalling ignorance of the investigating staff in the basic relationship of the physician-patient-provider of service.

Excerpt:

"(a) Our investigation indicated that some nursing homes order drugs far in excess of the quantities required by their residents. This situation can occur since physicians often prescribe continuous medication for persons in the homes and the homes determine when to order the medication."

Comment—during a nine-month investigation, the attorney general's representatives did not discover that nursing homes do not order drugs. This is done by the physician who also specifies the quantities required by the patient. A nursing home chart is a requisition—not a prescription. A pharmacist is legally and professionally required to verify and obtain prescriptions from the doctor.

Excerpt:

"(b) Another method by which excessive services are provided is where nursing homes have arrangements with vendors such as physicians, dentists, optometrists, podiatrists, etc.,, which permit them to examine persons in the home whether or not their services are required or requested."

Comment—all such services are ordered by the physician. This is an assertion without foundation.

Excerpt:

"Indications of 'mass examinations' by such vendors have been observed by county consultants throughout the state in the course of their processing requests for prior authorization. Persons in the home seldom object to such examination since they are not usually required to pay for such services."

Comment—this is an attempt at a sweeping indictment against all 58 counties in California; which is patently ridiculous. If "county consultants throughout the state" observed all these things, why wasn't something done about it? The final sentence is both fatuous and absurd. The fact is all such "examinations" are ordered or appropved by the patient's attending physician.

Excerpt:

"(c) Information has been obtained which indicates yet a third method by which excessive services are provided by nursing homes. This relates to the situation where a nursing home attempts to 'qualify' Medi-Cal patients for Medicare. Since nursing homes receive greater reimbursement for persons who are eligible for Medicare than they do for persons eligible for Medi-Cal it is to their benefit to have a patient classified as a Medicare patient."

Comment—this statement again demonstrates the fact that the investigators did not have sufficient knowledge to qualify them for this study. The fact is that both Medi-Cal and Medicare are cost reimbursement programs. If the Attorney General in this paragraph is admitting that Medi-Cal reimbursement is less than the reasonable cost required by law then it is acceptable as such. However, a simple statement to this fact would be more appropriate than the round-about verbiage in the report.

Excerpt:

"A former administrator of a nursing home has alleged that some nursing homes have an arrangement with hospitals whereby Medi-Cal patients are transferred from the home to the hospital for a period of three days and then returned to the home."

Comment—the investigators strive mightily to make a point based on the allegations of a former administrator, hinting at an unspecified 'arrangement'. Among other things, one may wonder why their source is now a *former* administrator. The fact is that all transfers of a patient from a nursing home to a hospital are ordered or approved by the patient's attending physician (except in the possible case of an emergency).

Excerpt:

"The nursing home benefits by this arrangement since it receives reimbursement at the greater rate from Medicare when the patient is returned to the home. The hospital benefits because it is reimbursed for providing services to the patient which usually include laboratory tests, x-rays, etc. (Under such an arrangement the nursing home or hospital usually has a physician who authorizes the patient to be hospitalized.)"

Comment—in stating that Medicare reimburses at a greater rate than Medi-Cal, are the investigators calling attention to the fact that Medi-Cal rates are less than reasonable cost?

In the parenthesized sentence, the investigators are again displaying a great lack of knowledge of their subject. There is always an attending physician—not *usually.*

Excerpt:

"This type of activity not only provides services to a patient which were not needed nor requested, but the question of 'eligibility' may determine whether a nursing home will accept a Medi-Cal patient into the home."

Comment—a patient does not request services; the doctor does. This statement makes an absurd assumption; that such an unlikely and illegal action is approved by the nursing home administrator, the hospital management, several doctors, a utilization review team, a medical staff (audit committee), and the fiscal intermediary. This is idiotic. Further, with reference to "eligibility" we assume that this is another reference to Medi-Cal reimbursement being less than reasonable cost. Veiled as it is we accept it as such.

Excerpt:

"In addition to effecting services provided under Medi-Cal, the unlawful activities of nursing homes also effect services provided under the federal program of Medicare. The activities described also result in a needless expenditure of funds under that program. Indeed, the scope of such unlawful activities was a matter of inquiry before a congressional subcommittee on Long Term Care in 1965. Testimony given before this subcommittee indicated that many of the activities we have described concerning nursing homes are prevalent throughout the nation."

Comment—in addition to using the words 'effecting' and 'effect' when it is obvious that they meant to use 'affecting' and 'affect', and drawing on events that took place before the time of Medicare (the 1965 Long Term Care inquiry), the writers of this paragraph have lost themselves in polysyllabic hash that is as incompetent as it is irrelevant and immaterial. The true meaning of this paragraph is that the report itself documents the appalling ignorance and incompetency of the investigatory staff in stating conclusions on Medicare with reference to a congressional report prepared *prior* to the enactment of Medicare.

Excerpt:

"We concentrated our investigation of hospitals on the profit making variety. There have been no indications that the abuses we are studying are prevalent in public and non-profit institutions."

Comment—why do the investigators make this discriminatory statement; they must have discovered that administrative controls apply to all types.

If no investigation was made, how do they know that there is no indication of abuses in public and non-profit facilities.

Excerpt:

"These Medi-Cal abuses seem to be predominant in physician-owned hospitals. Since there are no significant differences in the patterns of abuse in nursing homes and hospitals, we will not offer extensive examples of hospital problems."

Comment—Conjecture again. The investigators state that abuses *seem* to be more prevalent in one type of facility. This sort of statement is inadmissible in any court of law.

If there is 'no significant difference' in the patterns of abuse in nursing homes and hospitals, why, then, did the investigators choose to persecute the nursing homes? They have already established that hospitals are the bigger spenders, yet they make nursing homes the target of their unfounded accusations. This is rank discrimination.

Excerpt:

"Our comments on nursing homes clearly indicate the Medi-Cal problems which may be found in hospitals. An audit of just seven hospitals, for example, between March and August 1968, resulted in a recovery of $136,000 by Blue Cross."

Comment—this is a msleading statement; comments of the investigators have not clearly indicated anything; in saying that something 'may' be found is inadmissible; an audit of seven hospitals out of more than 600 is not conclusive.

Question: how can the study of one class of institution (nursing homes) lend to any conclusion, 'clearly' or not, about another class of institution (hospitals), or put another way, how can the study of oranges lead to a conclusion concerning apples?

Question: with reference to the audit result why does the report always draw the wrong conclusion? That is, if there has been overpayment the purpose of audit is for recovery of the money. Thus, if audit results in repayment the audit is working as intended.

Excerpt:

"One area in particular where this type of activity occurs relates to physicians submitting claims for having examined patients in nursing homes, although such examinations were not in fact performed."

Comment—why do the investigators insist on singularly pointing out nursing homes even when talking about an alleged abuse that has nothing to do with a nursing home? In this statement the investigator is talking about physicians, but drags in nursing homes to share the misleading accusation.

Excerpt:

"Due to problems which hamper investigative activities into fraudulent activities (discussed *infra*) the investigation was unable to determine the extent to which this type of conduct occurs."

Comment—the investigators, themselves, admit this is a poor report.

Excerpt:

"(b) The placement of persons in nursing homes whose physical condition does not require such extensive care is another form of overservicing."

Comment—the report should state that this is an abuse due to the actions of a physician rather than—again—implying that nursing homes are at fault.

Excerpt:

"In Los Angeles County alone during a one-year period of time some 1,300 persons were requested to leave nursing homes by county consultants because their physical condition no longer required such extensive care."

Comment—this indicates that the Medi-Cal consultant is functioning according to regulations—therefore, conclusion is entirely erroneous.

Excerpt:

"Many nursing homes have 'house physicians'. These are physicians who have an arrangement with nursing homes whereby they take care of the persons in the home. By having a 'captive audience' the physician is able to realize a significant amount of income regardless of the actual need of the individual resident."

Comment—once again, while delineating an accusation directed at physicians, the investigators feel called upon to mention nursing homes. Had they investigated hospitals, which they admittedly did not, they might have found that doctors have even more direct relations with the acute care facilities through an organized medical staff.

The use of the word 'arrangement' in this context suggests something never defined in a straightforward manner; a sly type of aspersion.

The statement that many—how many is that—have house doctors is ridiculous and misleading.

Excerpt:

"For example, our investigation revealed incidents where physicians signed blank prescriptions which were given to them by the nursing home and which were subsequently completed by the home itself. In one instance, a physician thought he was signing a prescription for a drug when in fact it was filled in by a nursing home for a wheel chair for a patient who was ambulatory. In another case, 75 blank prescriptions signed by a doctor were found in a nursing home. Review of claims by consultants have also given rise to suspicion that it is the nursing home which prepares the forms describing the physical condition of persons who seek admission into the home. The 'house physicians' sign such forms although they, in fact, have not examined the patients."

Comment—the investigator fails to identify exactly who in the nursing home is the object of his criticism. He, instead, refers to the nursing home as if it was a living, active entity.

If it was determined that a doctor actually signed 75 blank prescription forms, he should have been prosecuted. Is it not the responsibility of the attorney general's office to enforce the laws. What has been done about this case other than talk about it and, again, calumniate the nursing homes by blaming them for the laxity of the legally responsible party.

Excerpt:

"One blatant example of unnecessary services in a physician-owned hospital concerns a patient who was hospitalized for sixteen days. Ten blood tests, many of them identical, were taken each day the patient was hospitalized. Of the 160 tests taken, not one revealed an abnormal finding. Multiple x-rays of the chest, skull and cervical spine were also taken although here again no abnormality was ever revealed. This type of overservicing was similarly provided to many other patients in this same hospital."

Comment—on one example the attorney general's investigator tries to build a case. Such a detailed statement justifies an equally detailed rebuttal.

Frequently, even the most extensive testing fails to reveal laboratory findings which are reactive or diagnostic. The patient may, neverthless, be critically ill upon clinical examination and presentation of symptoms. An attorney is not qualified to criticize the doctors' processes, for the doctor is trying to find out why the patient is ill. Even in these hyperscientific times, there are old and newly identified clinical disorders that can—and do—make a patient very ill and still defy a laboratory finding.

If the attorney general's office is going to be so presumptuous as to be critical of a physician's methodology, then any opinions should be supported with specific laboratory (investigative) reports that will lend credence to his clinical diagnosis.

Excerpt:

"(1) HCS publishes a drug formulary which contains instructions as to the manner in which pharmacies are to determine the cost of their drugs when billing the Medi-Cal Program."

Comment—to determine the cost of drugs, it is suggested that pharmacies look at the appropriate invoice. This sort of statement again suggests the absolute lack of knowledge on the part of the investigators.

Excerpt:

"It is therefore highly unlikely that the practice of excessive billing ended with the enactment of the Medi-Cal Program."

Comment—the use of the expression "highly unlikely" is an editorial conclusion unsupported by fact.

Excerpt:

"(3) *Visits to nursing homes, hospitals, sanitariums and homes of patients revealed that some pharmacies give patients a generic drug but bill the state as though the brand name drug had been dispensed.* Under the formula for reimbursement the excessive expenditure made by Medi-Cal due to such false claims can amount to a significant amount of money."

Comment—during their nine months of investigation, did the attorney general's investigators determine the difference between nursing homes and sanitariums? They must have determined a significant difference that induced them to identify them individually. Actually, this is a matter of highly imprecise terminology, but, again, displays the lack of knowledge of the Attorney General's staff.

Excerpt:

"(5) It is permissible in California for a pharmacist to fill a prescription which has been authorized by a physician over the telephone. Whenever a pharmacist gets a request from a person other than a physician for a prescription, it is the duty and responsibility of the pharmacist to contact the physician prior to issuing the drug."

Comment—rather than erroneously condemning nursing homes, proprietary hospitals and doctors earlier in this report, why did not the investigators acknowledge this bit of fact on pages 11(6), 12(b), 16 and elsewhere?

Excerpt:

"(a) *Some pharmacies needlessly dispense multiple prescriptions of the same drug to the same patient over a short period of time.*"

Comment—all prescriptions are dispensed in accordance with a doctor's written orders. How does the attorney general's office determine this medical judgement? Actually, this statement "charges" the pharmacist for doing what the law requires of him.

Excerpt:

"This situation also occurs when nursing homes order prescription medicines."

Comment—nursing homes do not order drugs—physicians are solely responsible for this.

Excerpt:

"One pharmacy has even sent letters to nursing homes offering to give discounts for their business."

Comment—in nine months of investigation, one culpable pharmacy was discovered, and the investigators feel they must ask nursing homes to share the blame.

Excerpt:

"Although the investigation could not determine the exact amount of money the state is spending due to abuses by pharmacies it is significant to note that an audit of only 39 stores was resulted in the recovery of approximately $132,000."

Comment—This is less than eight-tenths of one percent; hardly a valid sample. Yet the attorney general's office insists this is a complete investigation. Again, the wrong conclusion—if audit results in recovery that is what it's supposed to do.

Excerpt:

"Even where authorization to perform work is denied, however, the dentists are still entitled to receive their fees for making routine examinations, although these examinations are not always requested nor needed."

Comment—if this investigation was as thorough as we have been asked to believe, then the investigators should have discovered that oral hygiene exams are required by Medicare. Again, medical judgement by an attorney?

Excerpt:

". . . . to provide lenses and frames to patients in nursing homes."

Comment—would the investigators have us believe that only nursing homes have patients requiring the attentions of optometrists? Did they ignore all other types of facilities in their eagerness to indict the long-term health care profession?

Excerpt:

"In one case, for example, an optometrist requested approval for a pair of expensive prescription sunglasses for a patient. Investigation disclosed that the patient was blind."

Comment—had the investigation been a thorough one, it might have been discovered that a patient may be legally blind and still have enough vision to require care and protection. And—this is one case in how many?

Excerpt:

"Instances of fraud and overservicing, for example, could also be given for vendors such as hearing aid dealers, podiatrists and ambulance services."

Comment—if the investigators do, indeed, have what they consider to be factual evidence involving these services, why are they not supplied. There was no hesitation in impugning the motives of other vendors with no supportable evidence in any considerable amount.

Excerpt:

"In some cases the abuses mentioned may be prevalent among a specific class of vendor. In other cases only a small percentage of the class of vendors involved may be engaging in a particular type of abuse."

Comment—The investigators proceed to becloud their own issue by declining to identify which type of vendor they are maligning the most. The second sentence should be amplified as it is most inconsistent with the entire report.

Excerpt:

"Most abuses are discovered in the course of the fiscal agents processing claims submitted for payment or consultants passing upon requests for prior authorization."

Comment—being denied something does not constitute an abuse; it is exactly the opposite. The function of the fiscal agents and the county consultants is not understood by the Attorney General is the true meaning of this paragraph in the report.

Excerpt:

"Whatever their reason, the inability of investigators and consultants to obtain documents and other information presents a serious problem and is precluding effective investigation."

Comment—after admitting this, the investigators have the audacity to issue this "ineffective" report.

Excerpt:

"There has not been a clear understanding however as to which cases involve fraud and should therefore be referred to HCS."

Comment—in view of the reasonably well stated laws and regulations and the fact that the attorney general's staff is supposed to contain legal experts, this statement only adds to the obfuscation of the report.

Excerpt:

"Discovery of overservicing by hospitals or nursing homes, for example, may often give rise upon further inquiry by physicians, pharmacists and other vendors. Our investigation disclosed, however, that where abuses have been discovered by one fiscal agent which indicate that other vendors whose claims are reviewed by other fiscal agents should be investigated there has been a failure to adequately inform either HCS or the fiscal agent of potential investigations which might prove fruitful."

Comment—these 77 words constitute one of the most generalized, irresponsible statements ever contrived. It serves to characterize the entire report.

Excerpt:

"As one example, a recent audit by Blue Cross determined that one chain of eight nursing homes has received $380,000 from Medi-Cal."

Comment—Another example of the confusion which exists in this document. The report implies that a payment of "in excess of $380,000 from Medi-Cal" to a chain of eight nursing homes is an abuse of the program. The period of time over which the amount was paid was not specified. Using this example, the following extrapolations can be made: The average size of nursing homes in California is 57 beds, so we may assume these eight nursing homes comprise 456 beds. We also know that approximately 65% of the nursing home beds in California are being "purchased" by the Medi-Cal program. Also giving the statewide occupancy figure of 90%, the approximate number of beds occupied by Medi-Cal patients is 266.76. If the period (not specified in the report) is one year, there would be a total of 97,367.4 Medi-Cal patient days. If one were to further assume a $10.00 per patient day rate for those facilities (maximum rate is $14.00), total payment to that chain would on this average basis be $973,674.00. Certainly, $380,000 is not excessive. This example illustrates how vague, confusing, poorly documented and unintelligible the report is. The report relies on implication and innuendo to make its points. However, since the entire report is so carelessly written, it may be that the report intended to say that on audit this chain of eight nursing homes was revealed to have received $380,000 more than it was entitled to under the program. If that is the case then the obvious conclusion is that the audit system is working, which does not seem to be understood by the Attorney General.

Excerpt:

"For example, nursing homes are not required to maintain records which would show the various services rendered to their patients. We have seen from this report that a major area of fraudulent billing concerns services provided to persons in nursing homes."

Comment—the statement made in the first sentence points out an appalling ignorance of existing laws and regulations on the part of the attorney general's staff. Such medical records are required by law and must be retained for a minimum of 7 years.

The second sentence is tantamount to libel of an entire industry; a statement based on erroneous conclusions, no evidence and pure guesswork. We demand a retraction from the attorney general's office. Furthermore, we demand an investigation by the legislature of what system in the Attorney General's office permits such untruthfully repugnant statements in a publicly released document.

Excerpt:

"It is therefore suggested that consideration be given to the enactment of regulations which would specify the types of records that must be maintained by vendors and which requires them to retain such records for a reasonable period of time. One possible effect of such a regulation might be to expedite investigations by enabling investigators to examine documents in the possession of vendors thereby removing the delay now encountered when records must be obtained from the fiscal agents."

Comment—the first sentence again displays the incompetence of the attorney general's staff. There already is a law to this effect.

As for the second statement, these records are available if the investigators knew where to look.

Excerpt

"7. *Review Procedure of Processing Claims*

"Blue Shield employs some 350 persons to process 70,000 claims a day. Blue Cross employs approximately 70 persons to process 5,000 claims a day.

"The procedures used by these fiscal agents should be periodically reviewed to see if their system of processing claims can be expedited and the cost lowered."

Comment—if the attorney general's figures are correct, Blue Shield personnel must process claims at the rate of 200 per man-day; 25 each hour, or approximately 2 minutes per claim, and Blue Cross employees must adjudicate 710 claims each man-day; approximately 88 per hour, or one every 40 seconds.

One wonders if the attorney general's personnel, in suggesting that claims processing be expedited, are claiming to be office systems engineers.

Excerpt:

"a) In light of the large number of claims processed each day, the elimination of any one unnecessary step might result in a significant savings of money."

Comment—the attorney general's office now presumes to be a management consultant to the various state administrative agencies. Is the attorney general's staff instructed to spend investigative efforts to reach such determinations? Again, the validity of the entire report is questioned when it "reaches" for this type of a conclusion.

Excerpt:

"In the opinion of most persons interviewed. . . ."

Comment—how many were interviewed—who were they—were they knowledgable in the field of health care? And, is such a significant document as this is represented to be acceptable when, in part, it is based on opinions?

Excerpt:

"The recommendations set forth herein are not intended to exhaust all problem areas in the Medi-Cal Program which require attention."

Comment—in making this disclaimer a part of the summation, the attorney general's office implies realization of the inept nature of this report.

○