CUTBACKS IN MEDICARE AND MEDICAID COVERAGE

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH OF THE ELDERLY

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-SECOND CONGRESS

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Part 3. Providence, R.I., Sept. 20, 1971

(Additional hearings anticipated, but not scheduled at time of this printing.)

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CUTBACKS IN MEDICARE AND MEDICAID COVERAGE

MONDAY, MAY 10, 1971

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

The subcommittee met at 10 a.m., pursuant to call, at 500 West Temple Street, Los Angeles, Calif., Senator Edmund S. Muskie (chairman) presiding.

Present: Senator Muskie.

Also present: William E. Oriol, staff director; David A. Affeldt, counsel; Kenneth Dameron, Jr., professional staff member; Dan Lewis, legislative assistant to Senator Muskie; Patricia Oriol, chief clerk; and Peggy Fecik, assistant chief clerk.

OPENING STATEMENT BY SENATOR MUSKIE, CHAIRMAN

Senator MUSKIE. The hearing will be in order.

To open these hearings this morning, I do have a brief statement in which I will try to outline what we hope to hear this morning and in subsequent hearings.

We are beginning this morning a series of hearings on the health crisis that confronts older Americans. During the year, we hope to explore various facets of the problem:

The high and rising costs of health care;

Some rigid Medicaid regulations that frequently prevent medical care from being effective or efficient;

An inadequate supply of medical and paramedical personnel; and

Outmoded health care institutions that cannot deliver a decent standard of health care.

EXAMINE IMPACT OF CUTBACKS TO SENIOR CITIZENS

The hearing today will focus upon the standards of health care that older Americans are receiving under the Medicare and Medi-Cal programs. Because of its high concentration of older Americans, southern California is an appropriate place to begin this study. We hope to exmaine carefully what impact recent cutbacks in the Medicare and Medi-Cal programs have had upon the lives of senior Americans. In order to obtain this information, we have invited health consumers, medical practitioners, and medical administrators to appear this morning.

Before we begin, I would like to outline briefly the problems which have created this health care crisis for millions of our elderly. Much of this recent data comes from a Working Paper written for the Subcommittee on Health of the Elderly by Mrs. Agnes Brewster, a health consultant who has been of great service to this committee in the past.*

Our elderly require greater health care than any other age group. Americans over 65 are twice as likely to have one or more chronic conditions than younger persons. They are in hospitals more frequently for longer stays caused by more serious illnesses. In 1970, the average stay in a hospital for an older American was 13 days.

Those who suffer most from illness—our elderly—can least afford to pay for health care. Persons 65 and over comprise about 10 percent of our population, but they account for nearly 20 percent of all persons in poverty. Over half of all persons 65 and older who live alone have annual incomes below $2,000.

And yet, the cost of health care for the elderly—despite Medicare and Medicaid—is rising:

In fiscal year 1970, the average health bill for a person 65 or older was $791, six times that of a youth, and three times that of people between 19 and 64 years old.

Medicare covers 43 percent of the total health care cost of the aged, leaving uncovered an amount larger than the total health bill for the average younger person.

Despite the valuable protection that Medicare and Medicaid affords, the older person must still pay annually $226 out-of-pocket for health care. This is more than double the out-of-pocket payments for those under 65.

Thus the elderly—with less than half the income of those under 65—themselves, pay twice as much for health services.

Even with Medicare and Medicaid, many elderly do not receive a decent level of health care.

What this means in human terms is that our elderly, even with our health care programs, must still spend a huge part of their limited income for health care. Many cannot afford it. Serious illness can mean destitution. The threat that major illness will wipe out a life's savings still haunts millions of older Americans.

This is a serious problem for older people who are poor, and is becoming a threat for all of those who retire and face major health problems.

Recent cost-cutting cutbacks and regulations have saved money, but at the price of denying urgently needed health care to our older citizens. By placing limits on care available and by increasing costs, we have merely decreased the health and the happiness of our older people. Too often the choice for them must be made between food or medicine.

Preventive Medicine Nearly Impossible

Untreated minor illnesses become major diseases. Canceled doctor visits and home care mean later expensive hospitalization. With health care primarily on an emergency-only basis, preventive medicine be-

*See appendix 1, p. 39, "Medicare, Medicaid and Cutbacks in California—a Working Paper."

comes near impossible. Without attention or drugs, many older Americans are forced to face the pain and terror of sickness alone.

When this Nation adopted Medicare and Medicaid, it made a commitment toward providing adequate health care to those who spent their lives building America. We began turning a dream into reality—that all our older citizens could live their years with the best health care available and without the fear of financial ruin caused by serious illness. These programs were not a complete answer, but they were a solid foundation upon which we could build.

Now we seem to be turning back upon our commitment, and instead of pushing forward towards better health care, we are dismantling our first efforts. We are turning our backs upon older Americans, forcing them to face illness and pain alone.

This is not the way a great Nation should treat a generation that helped make it great. It is not generous. It is not fair. It is not decent. Every person over 65 should receive the health care he needs.

So our objective for these hearings this morning is to find ways to make good health care a right and not a privilege. [Applause.] For this purpose, we have assembled here this morning a panel of elderly consumers of health care.

But, before I introduce the panel, I have a communication from your senator from California—Senator John V. Tunney—who, unfortunately, could not be here today. And, without objection, it will be inserted in the record at this point.

STATEMENT OF SENATOR JOHN V. TUNNEY

I came to the Congress during the mid-1960's when new and bold steps were taken toward improving the health and well-being of the Nation's older population and of its poor. Programs like Medicare and Medicaid, when enacted, were truly monumental legislative milestones in the social history of the United States. Each program marked an important change in public policy regarding the value of health as a good in itself, and each program was a beginning step in the direction of adequate health care for all Americans, not for just the fortunate few who were able to expend massive amounts of money. No older person, no poor person, we declared, should be denied needed medical care for want of the resources with which to purchase it. With the advances in medical science that can extend a fuller life and eliminate some of the ill-health accompanying aging, we must advance in our extension of health services to our senior citizens allowing the maximum possibilities of good health.

There are now ominous signs appearing which seem to suggest that all which was gained for the poor and elderly may soon be lost under the guise of "economy."

To begin with, I was most alarmed when I learned that the Governor of my State proposed substantially to reduce the scope of medical protection now afforded needy persons in California. In addition to proposing cutbacks regarding eligibility for medical assistance, the Governor and his administration also announced that the poor would be required to carry certain costs of hospital care, nursing home care, physicians' visits and prescription drugs. Such a program would again force many needy people to go without necessary health services because the costs would be prohibitive, or they would be left financially incapacitated because of the outlay of funds for major illnesses.

When Congress enacted Medicaid, it sought to assure that the poor would not assume the entire burden of so-called "economy drives" proposed by administrations like the one in California. Cost-sharing was forbidden in the case of those who were categorically poor and cost-sharing for the medically needy had to be reasonably related to the resources of the medically indigent person. It is commendable for the Governor to talk about "economy drives," but it is absolutely intolerable that these drives be directed at the people least able to absorb the

costs. We need to cut "inflation" in many areas, but not in the services so vital to the quality of human life.

I also find that the Nixon administration will permit the State to impose new costs on the poor, if its recommendations regarding Medicaid now before the Congress are agreed to. As if this weren't enough, the Nixon Administration has also proposed substantial cutbacks in the scope of insurance protection afforded older persons under the Medicare program. Under present law, beneficiaries are entitled to 60 free days of hospital care, after satisfying an initial deductible amount, during each benefit period. The Administration has proposed that this number of cost-free days of hospital care be reduced to only 14 and that a coinsurance amount of $7.50 a day be imposed on older people between the 15th and 60th days of care. In addition, older people have been deprived of essential convalescent care and rehabilitation after major illnesses due to an arbitrary and questionable definition of Medicare coverage policies. For example, heart and stroke victims who are usually covered for emergency treatment often find that they are denied protections against costs for the health personnel, facilities and service—not decreases.

The administration also proposed to increase the Part B, or Supplementary Medical Insurance deductible, as the fees of physicians rise in future years.

It is my intention to oppose vigorously any sham of this sort on older Americans, and I urge my colleagues in the Senate to do the same. We must redefine the avenues for adequate health care, and we must talk about increases in health personnel, facilities and services—not decreases.

Senator MUSKIE. I would like to introduce our first panel, Mrs. Lila Keiser of Morro Bay to my right. Mr. Juan Montaño of Los Angeles. Third from my right is Mrs. Doris Jackson who is replacing a witness who could not be here today—Mr. Porter Hunter of Los Angeles. As an interpreter—Mrs. Alicia Noriega.

It is a pleasure to welcome you here this morning, and I will ask you now to present your stories in your own way.

STATEMENT OF MRS. LILA KEISER, COUNCILWOMAN MORRO BAY, CALIF.

Mrs. KEISER. Thank you, Senator Muskie. I had intended to come here and just talk off the cuff to you, but being a senior citizen myself, I thought that you would grant me the privilege of reading what I have written and it will take me about 6 or 8 minutes—because I said some things I think you will be interested in hearing.

Senator MUSKIE. By all means.

Mrs. KEISER. Senator Muskie and members of the committee.

I deem it an honor to have been asked to appear before this committee to discuss with you the needs and problems of the senior citizens.

As a bit of background, I would like to say that I am here speaking as an individual interested in the problems of my community rather than as an elected official.

By profession, I am a retired public health nurse and I have lived in Morro Bay for 14 years. The years 1957 to 1967 were spent as school nurse in the Morro Bay elementary schools. And this was an excellent opportunity to learn firsthand about the people—both adults and juvenile—and their problems.

Morro Bay is a delightful incorporated area by the sea, 220 miles north of Los Angeles on Highway 1. Morro Bay has a population of 7,100—and the nearest city is San Luis Obispo, 13 miles from Morro Bay. Now I hope you will pay attention to that 13 miles from, because herein lie some of our problems.

San Luis Obispo is the county seat. Medical facilities, county health department doctors and medical clinics, welfare office and Social Security offices are all located in San Luis Obispo, 13 miles from Morro Bay.

Approximately 1,600 people living in Morro Bay are age 65-or-over and many of them are living on small fixed incomes and inflation is taking its toll.

Health services are important to the retired senior citizen. Living in a small isolated community poses many problems for the senior citizens, especially for those who no longer drive an automobile.

Public transportation is nonexistent and is badly needed in our central coastal area. Unproductive discussion with the Economic Opportunity Commission has led to no constructive program for transportation. A private bus company was asked if they would provide transportation. The answer was that it wouldn't pay. I can understand that; however, I would like to point out the fact that if we cannot get transportation to and from medical centers, the time will come when the senior citizen with health problems may have to leave his home and seek placement in an extended care facility.[1] This could be far more costly than subsidizing a minimal transportation system.

I believe that it is in order to request a feasibility study and implement the findings to bring relief to a major health problem. Fares on any bus system must be reasonable so that the low-income persin can afford to pay.

Medical Care, Drugs, Eyeglasses, and Dentures

Medical care it most important to the senior citizen, Medicare does not provide for medicine; however, if the senior citizen has Medi-Cal, some drugs will be paid for. All drugs not listed in the Medi-Cal formulary and all drugs listed in Medi-Cal formulary preceded by an asterisk sign must have prior authorization [2] by the welfare agency before Medi-Cal will pay the bill. This means that in our area—San Luis Obispo County—health records must be sent to an authorization team which is in Santa Barbara, 100 miles away. When a person is ill and needs special medicine, time may be of the essence. There could be delay because of paperwork necessary before the authorization board would make a decision. I would hope that this practice would be investigated and corrected.

Medicare does not pay for medicine, dentures, or eyeglasses. Well-fitting dentures are important for the senior citizen. If he is unable to properly chew his food, he could develop a serious health problem which could be more costly than proper fitting dentures. Eyeglasses, too, are important, not only as a safety measure but as a recreation aid—reading, and so forth, for the enjoyment of walking, for example. For the total health of the aged person, complete dental and optical care are as important as medical care.

For total medical care, drug costs as well as eyeglasses and dentures, in my opinion, all should be included in the Medicare program.

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[1] See exhibit A, appendix 2, p. 49.
[2] See exhibit B, appendix 2, p. 49.

Nutrition Another Major Problem

Nutrition is another major problem of the senior citizen. Many retired people live alone and to purchase food that will given them a well-balanced meal becomes a tiresome task. To prepare a meal for one person and then sit down and eat alone is not a very happy experience.

A person who has to have a special diet finds it difficult to buy the necessary food. There is a need to develop some plan to bring daily, at least one hot, well-balanced meal to the senior citizens. Some communities are developing a Meal on Wheels program. A church group or perhaps a service club could sponsor such a program. A survey of the city must be made to determine the number of senior citizens who need this service. One well-balanced meal would be cooked and delivered daily to the senior citizen in his home. This would be the noon meal. This type of service could be carried on by volunteers within the community with the proper supervision. And then when I say proper supervision, I am thinking of a nutritionist who would be able to help with an adequate diet. Some equipment would have to be approved by the county health department. The equipment would be costly. Here a Federal grant would be in order. At least, it would suggest a feasibility study and the implementation of the findings. And I say implementations of the findings, because there are a lot of investigations that never get any place but investigations.

Home Health Service*

The senior citizen wishes to remain in his home as long as he can. Independence is his right. Home health services can play an integral part in helping these older citizens to remain in their own home by offering intermittent nursing care in the home—perhaps two or three times a week or daily for a few days, depending on the medical needs of the patient. Medicare at the present will pay only for skilled nursing care—that means a registered nurse or a doctor. If care to a chronically ill person is need, Medicare does not cover the cost. A chronically ill person can be taken care of by custodial help, under the supervision of an R.N. This in turn reduces the necessity of costly hospitalization and therefore reduces the total medical cost. Custodial help would consist of bathing the person, housekeeping chores, combing hair, et cetera. The chronically ill senior citizen should not be deprived of this type of health care. Custodial care should be considered along with the total medical care and should be included in the Medicare program. This service would be dispensed by the county health department.

Social Security

Many senior citizens in our area are on Social Security. Many of them have minimum Social Security and are also on Old Age Assistance, paid by the county and State. Each time Social Security is increased a few dollars, the amount of the increase is deducted from the Old Age Assistance; therefore, the senior citizen has gained nothing.

*See exhibit C, appendix 2, p. 50.

Now, here I would like to put in a point that I didn't have here, but I thought of this: Here we come along with the Medicare costs, now. We pay—either what we started—$3.50, I believe, and we are now paying $5.80 a month for Medicare. It costs also $60 now for your first illness in a hospital—the patient pays the first $60. Where is the older person that is on a low income going to get the difference—how are they going to pay for this? It's about $120 difference— or something in there.

The Social Security law needs, in my mind, amending. A senior citizen is allowed to earn only $1,620 a year. If he earns more, he is penalized and money is taken from the amount of his Social Security payment.

Senior citizens have a wealth of knowledge which took years to acquire and society is the loser when this knowledge is not used to the fullest. By limiting the earning ceiling, you deny the community the benefit which could accrue from their service.

Guard Against Overutilization?

Senator Muskie. Thank you very much, Mrs. Keiser.

I have one or two questions. There are more that occur to me but I want to be sure that we get on to our other witnesses.

My first question is this: A major argument that has been advanced for recent cutbacks in Medicaid and Medicare is to guard against potential overutilization.

How serious do you believe that problem is?

Mrs. Keiser. Well, Senator, let's take the case of a person who has, oh, Assistance to the Aged. All right, there is now a rule, I believe, that a patient can see the doctor just twice a month. Well, now, a chronically ill person might need to see the doctor more than once a month, and you mean to say that you have to wait for an authorization team to say that you may see a doctor more than twice a month? That doesn't make sense. This could develop into something quite serious. I don't know whether that answers your question or not.

But it seems to me that a person—I know that perhaps sometimes people have overused and have gone and gone and gone. But I think the average person—here you have an older person with a heart condition—oh, you have a hundred and one things that people can have that need to see the doctor. You are only going to make things worse and it's going to cost you more money if you're taking care of these when they should be taken care of.

Overutilization in Reverse

Senator Muskie. What you are really saying is that we have overutilization in the reverse. What is happening is that people who need health care are being undercared for.

Mrs. Keiser. That's right. They're not.

Senator Muskie. That's the accurate statement.

With respect to the San Luis Obispo problem, that you stated, how much is the taxi fare from Morro Bay to San Luis Obispo?

Mrs. Keiser. Now, you would ask me that. What do you mean, property tax?

Senator MUSKIE. No; the taxi fare.

Mrs. KEISER. Oh, the taxi fare.

Senator MUSKIE. What is the taxi fare?

Mrs. KEISER. This will floor you, Senator. It's $14.60 round trip. And how many low-income people are there that can pay that? It's 13 miles.

Senator MUSKIE. Have you yourself had some experience with high medical fees?

Mrs. KEISER. Well, I'm sorry; I'm an old gal but I am quite healthy. I cannot say too much about myself. So far I've had no cause to find fault with Medicare except to say it should include glasses, dentures, and drugs.

But I know in our own area that there have been people that have really been hard pressed, and especially on this transportation bit. They want to go in to a doctor and they can't get in there. I have a letter I think you will notice in the back of my transcript that I have given you stating that it took her a month before she should get someone to take her in. Now, some of you will say this is impossible. They'd certainly get in before a month. I don't know about that because there are a lot of senior citizens that are very reticent to ask someone for help. They are an independent lot and so that need—they need something to be fixed so that they can get in when they need to and don't have to ask. They don't want to be begging in.

Senator MUSKIE. Thank you very much, Mrs. Keiser. The exhibits which were attached to your statements will be included in the record.*

Our next witness will be Miss Doris Jackson.

STATEMENT OF DORIS JACKSON, LOS ANGELES, CALIF.

Miss JACKSON. I am Doris Jackson and I am filling in for Mr. Porter Hunter. He is 83 years old and he's ill today.

He owes doctor bills of $1,000. That's the sum of his bills that he owes from the cutback in Medi-Cal and Medicare. He has wanted to go to the doctor but many times he didn't, because he wasn't able to pay this bill. And I think that a person that is ill should be able to go to the doctor without the fear that he is not going to be able to pay his bill, especially, a man of his age.

He needs eyeglasses, which Medi-Cal nor Medicare will not pick up. He has arthritis, which he doesn't get the proper drugs to keep him healthy—where he cannot sleep—and have a restful night.

He is a member of the Senior Citizen's Club at Central City Community Mental Health Center.

So, I do know some of these things about him. In other words, we work very close with our clients. I work with low-income, no-income, and welfare recipients. And then another worker picks it up, who is Mrs. Louise Sadler, senior citizens coordinator. She could give more information. But I do know that they do have a very, very important need in our community for Medi-Cal and Medicare. The cutback has been a tremendous blow to him. Whereas he must cut back on his food

*See appendix 2, item 1, p. 49.

for the bills that have to be paid, such as his rent, he also has to pay car notes. Anyone that's in this predicament has to pay these bills first.

Cut Back on Food To Pay Bills

So where the cutback is, is in the thing that they need the most, which is food, which means they really don't have the proper diet. And if they need someone in the home to care for them while they're ill, they cannot get that either, and this is very needed.

Many times we have senior citizens that are ill who will come home from the hospital; they have to send a voucher in to the worker; they have to take it before the director; then they have to take it before another committee, and sometimes it is as much as 2 weeks before they can get a worker in the home to care for this person. And they're suffering a whole 2 weeks, sometimes without even eating properly—maybe someone will go in to give them a meal or something.

So, Medi-Cal and Medicare is very needed in our community, and I think all over. Senior citizens should get Medicare and Medi-Cal replaced so it wouldn't work a hardship on them.

Senator Muskie. Do I understand Mr. Hunter is 83 years old and he owes $1,000 in medical bills at the present time?

Miss Jackson. Yes; he does owe $1,000 in medical bills.

Senator Muskie. And also he has a mortgage and pays property taxes?

Miss Jackson. Yes; and he receives $150 a month from Social Security. His wife gets $50, and he has $80 from a rental, plus he has to pay the mortgage on the home.

Senator Muskie. His annual income is, as I understand it, about $3,300 a year?

Miss Jackson. Yes.

Senator Muskie. Does he get treatment now when he needs it?

Miss Jackson. No; he doesn't, because he's been going to his doctor and he owes this $1,000. He has to wait until he can save up enough money to pay some on this bill. Sometimes that takes quite a while. And the doctor's office is out on 1005 Venice Boulevard, and that's something like 15 or 20 miles. Sometimes he has to take the bus to that address, which costs extra money, because the carfare is over $1. It could be something like nearly $2.

Senator Muskie. Does he need drugs to avoid pain?

Miss Jackson. Yes; he does. He has arthritis. And many times he's without the medicine, and he doesn't get it because Medi-Cal or Medicare don't cover it. And that's the same reason he doesn't go to the doctor, because he owes this big bill and he's not able to pay it. He needs eyeglasses very bad, which Medi-Cal or Medicare don't cover.

Senator Muskie. Why couldn't he appear here this morning?

Miss Jackson. He was very ill this morning; he came down with a kidney infection. He's going to the doctor today. He has had appointments which he hasn't been keeping because he couldn't pay this money. So this could be the result of that—because he should have been going to the doctor regularly and he hasn't been.

Senator Muskie. Thank you very much, Miss Jackson.

Now, I would like to ask Mr. Juan Montaño, who I understand will speak through our interpreter this morning, to give his testimony.

STATEMENT OF JUAN MONTANO, CHAIRMAN, AREA COUNCIL 10, EYOA, LOS ANGELES, CALIF.

Mr. MONTAÑO (interpreted). Good morning, ladies and gentlemen. I am going to speak in Spanish to try and explain the problems of the Mexican-American aged. The problems as they have been described before that exist in the barrios—the barrios of the poor—and to describe the inadequate services that we are now receiving.

With the program of Medi-Cal and Medicare, they were very warmly received in our community because there is a big need for such a program. There are many problems that they should be able to help with.

In looking over the sheet that was handed out this morning, what has become very clear in my mind is that the money that is being put out in Medicare and Medi-Cal is really going for the administration of the program instead of to help the elderly with their problems that they face in their everyday life.

I have many people that I take to the doctor's office or to the hospital, where they have to wait many, many, many hours where they are supposed to be taken care of, yet they wait and they wait.

I know many people that after waiting so long become very frustrated, and they finally give up in despair after waiting. They go home very sad and oftentimes do not come back to get help for their medical problems. Sometimes I have known of people who have died because they didn't come back.

Oftentimes there are problems in a marriage where either the husband or the wife is not yet entitled to receive their Social Security. After you are 45, it is very difficult to obtain jobs in poverty areas because people are not trained in any particular jobs. Then you just have to suffer all those years waiting until you are able to get help with Social Security or Medi-Cal or any one of these programs. There is a long waiting period.

I live in a house in a housing project where there are over 100 elderly residents, and yet we have no medical doctor, either in the building or in the surroundings. We have had three emergencies where we have had to wait many, many hours, and there is no one to call. We should have a doctor either in this building—which is seven stories high—and which sometimes people fall down and hurt themselves: or else have a doctor in the community that can help us with our problems.

MUST BRING OWN INTERPRETER

The problem in our community—the various problems in our community are very similar to those of the problems of the elderly in any other community. But we also have the problem of bilingual personnel. For example, we'll go to the hospital and we'll have a health problem. After waiting many, many hours, we're told that they cannot understand us and we must bring our own interpreter. And oftentimes, in the interpretation, something very important is lost. Be-

cause if it is not a trained interpreter—a person that's acquainted with medical terms and perhaps does not even know the party that well—it should be the responsibility of that institution that is working in the community to have bilingual personnel to meet the needs of the community.

In our Mexican-American community, we also worry about the service for the children and other persons. We, too, are very concerned about housing, about poor education, and all the problems that they face. They should be entitled to a good environment to get education and everything else that this country is supposed to offer. But in our community, we do not have this; and we, too, the elderly of America, worry about this.

Transportation Grant Terminates End of Month

With the community of the elderly, there is always the problem of the shut-ins—the sick people that cannot get out the way that I can get out. These are people that we, in our community, often go and visit. At times we go and do their shopping for them. In our particular community, we have had a 3-year grant that has given us transportation for a very reasonable rate. The termination of that grant is the 31st of this month. After that, we will all be shut-ins because we will have no transportation. We will be unable to come to meetings such as this one. We will be unable to visit those people that are so sick that they cannot get out.

Thank you very much, Senator Muskie, and thank you, ladies and gentlemen.

Senator Muskie. Thank you very much, Mr. Montaño, for your excellent testimony. I think it came through very well.

It is apparent from what you have told us that this community is outside, for all practical purposes, the health care system at the present time.

I wonder if you could tell us what percentage of elderly Mexican Americans in your community receive regular care?

The Interpreter. Mr. Montaño says he does not know what the statistics are. However, the need is very great but the help is very small.

Mrs. Noriega (the Interpreter). For example, I work with the Department of Mental Health and I am very involved with senior citizens. We have one senior citizen at the project that is coming to our community—which is being funded by the county and the regional medical project. It's a small project that—it's a pilot program for 1 year—only $80,000. The difficulty we are having with that project right now is that the county of Los Angeles is being so rigid with the position of a social worker that although we have started this project since last November, here it is May and it still hasn't gotten off the ground. They insist on following the guidelines of the Social Work Manual, which is set up for an Anglo group, so in our community, we need somebody that's bilingual, somebody that has the experience of working with the aged, somebody that knows East Los Angeles and they have said, "No, not unless they have the necessary MSW." Because

the problems that we have had in our community, we don't have that many people that have degrees and the ones that are available, may not necessarily want to work for the elderly.

Up to now, we have not been able to get one bilingual social worker with an MSW degree.

Now, we have one—who is a former nun—who worked for 19 years at the head of a convent and who left the convent and is now receiving her MSW degree and had to borrow money for that education that she received, and now the county says, "Well, she cannot receive $14,000 that was alloted for that position because she doesn't have the experience." Yet this person has to have that full amount of money in order for her to pay back that debt.

So these are the kinds of problems that we have in our community.

Senator MUSKIE. Well, it's amazing how many unanticipated problems stand in the way.

Mrs. NORIEGA. It's the rigidity of many institutions that are serving, and irregardless of what the problems are with the elderly people, they say, "We must follow these guidelines," you know.

Senator MUSKIE. I think Mr. Montaño wanted to say something else.

Mr. MONTAÑO. We also need outreach programs where community people, elderly people themselves, will be hired to go out from whatever agency they are working in and to inform the elderly of the services that they are entitled to.

Senator MUSKIE. I know of Mr. Montaño's interest in this kind of service. I agree with him wholly.

Mr. MONTAÑO. I have been very fortunate to be elected the chairman of Area Council 10, Economic and Youth Opportunity Agency. Because of my involvement with the community, I know of many people that we could interview and hire for such a program if there were funds available.

Senator MUSKIE. May I say to him that if his community continues to enjoy the kind of leadership that he provides, maybe we can come to grips with these problems.

Mr. MONTAÑO. It is nothing. Thank you very much.

Senator MUSKIE. Thank you—all of you. Thank you very much.

Our next witness is Dr. John Anthony Smith, who is president of the Interns-Residents Association of Los Angeles County.

JOHN ANTHONY SMITH, M.D., PRESIDENT, INTERNS-RESIDENTS ASSOCIATION, LOS ANGELES COUNTY, LOS ANGELES, CALIF.

Senator MUSKIE. Dr. Smith, it's a pleasure to welcome you this morning.

Dr. SMITH. Thank you, Senator Muskie.

I guess you sort of told everyone who I am. I'll repeat to some extent. I am a third-year resident. I am in a program of training now as a specialist in internal medicine, now completing that program at Los Angeles County, University of Southern California, Medical Center. I am president of that medical center's interns-residents association. I have a very bad cold this morning. You will have to bear with me.

I have been asked to relate to this committee some of the problems that we have seen in our patients that are consequent to decreased funding——

Senator MUSKIE. That other microphone, I think, works better.

Dr. SMITH. Yes. Is this one working?

Senator MUSKIE. Yes; that's better.

Dr. SMITH. As I was saying, I have been asked to relate some anecdotes about what we have seen at Los Angeles County, University of Southern California, Medical Center as a consequence of the decreased State or Federal funding to the Medi-Cal program.

I hope to add something to your understanding, Senator, of the sense of isolation and frustration that the patients that we see—the ones that finally do get to some sort of medical care—experience. Our hospital, our medical center, comprises four hospitals, the women's hospital, the general hospital, the pediatric, and the psychiatric unit. We have a total bed capacity of, I should say, a total daily census of, about 1,800. We see about 3,500 outpatients a day. We are one of the largest medical centers in the United States.

"CAN'T TURN AWAY CASES"

As a medical community, our primary function is to provide medical care to individuals that, for whatever reason, can't obtain it in the private sector. We provide elasticity to that sector, because we "soak up" as it were, the excess in demand of care that the private sector, for whatever reason, doesn't deliver. We can't turn away cases because our hospital is full, because we are understaffed, because we are underequipped. In the past, this had led to poor—relatively poor—medical care.

Not unique to our community hospital, but characteristics of all community hospitals, this is accepted by the community because of a certain outlook surrounding the care of the aged.

As you have heard this morning, and as we are all aware, in the past few years, inflation generally, and the particularly reprehensible sort of inflation that's occurring now in medicine, has increased the number of people that are medically indigent. That can include a lot of people that by no standards are charity cases and includes the elderly people that now find that a catastrophic illness makes them a welfare case.

We have experienced these cutbacks that I and others have mentioned, and with increasingly complex and pointless and somewhat rigid interpretation of administrative procedures, there has been a decrease in the ability and the inclination of private physicians—the private sources of medical care—to provide that care for Medi-Cal recipients.

Professional associations in this State have advised their constituents—their members—that if they are unable for personnel reasons, or technical reasons, or if for personal reasons, they object to taking care of Medi-Cal patients, that these patients be referred to the county hospitals. All these practices have either acted to increase the numbers of patients that we see, or diminish our capacity to care for them.

It's too early to assess the ultimate effects of the Medi-Cal cutbacks at the county hospital in terms of admissions, and our census and outpatients visits, with any degree of accuracy anyway. Already some information is beginning to develop about what's happening. In January and February of this year, admissions—just numbers, now—were roughly 8,300 and 7,700 respectively. In the same month a year ago, admissions were 7.800 and 7,200. This is an increase of almost exactly 500 for both of those months. Whether that's due to the decrease in Medi-Cal or not may be in question. It may be only a casual relationship.

Tenfold Increase in Referrals

However, a major bit of information has just come to my attention. Of those patients, about a half are Medi-Cal recipients. And in the past, about 10 percent of those were referred by private physicians to us for care. In the last month, this Medi-Cal load amounted to 800 patients coming as admissions to our outpatient department. Of these 24 patients had been referred by the private physicians to the county hospital. In the month just ended, in April, there 1,164 Medi-Cal recipients seen in our hospitals, of whom 218 have been referred—almost a tenfold increase in the number of referrals from the community. This may indicate a decreased inclination or capacity of the private sector of medicine to provide the care to Medi-Cal recipients.

So we have had this increase in our patient population. As everyone knows, taxes have become burdensome. There has been a lot of public outcry over taxes here in California and as a consequence political efforts at all levels of government to reduce expenditures. This has been translated at the county level into various efforts on the part of the county administration to decrease expenditures. They have involved themselves in a way with management of the county department of hospitals by enforcing some specific cost-cutting actions. Specifically, the one that has proven most disastrous has been the freeze on new hiring. Medical personnel tend to have a relatively high turnover, that is, personnel—such as nurses—move around a lot. So we have had our normal amount of attrition and normally, the slack is taken up by the hiring of new people. This hasn't occurred the last few months because of the hiring freeze. This has led to decreased staffing in many areas, if not all areas, of the hospital and this decrease has had decidedly adverse effects and sometimes catastrophic effects on Medi-Cal recipients, on the medical care of everyone, including the aged.

Operations on First-Come, First-Serve Basis

As a specific brief example, the department of anesthesia and the anesthesiologists supervise the operating room nurses—that is to say, the department of anesthesia in our hospital operates the operating rooms. They are responsible for the surgical suites. This [the abovementioned attrition of personnel] has led to inadequate personnel to staff the operating rooms and the recovery rooms and has led to potentially tragic delays in surgery. We have so many surgical emergencies that—these are things that are truly considered emergencies at other

hospitals—they have to be taken to the operating room on a first-come, first-serve basis. If three people come in with a stab wound of the abdomen and they all require abdominal surgery, but there is only one operating room—the guy that got in first goes to surgery. This has led to inexorable and agonizing delays in surgery, and if it hasn't already, as I think it has, will eventually lead to the deaths of some of these individuals at the hospital. As the county administration knows, there is no legitimate defense to the accusation that this is indefensible inadequacy. There is neglect in this area.

I am going to cite some examples now of decreased care similar to the ones you have heard and some examples from the hospital. I am not trying to foster any sort of sensationalism here. I just want to call a few specific cases to everyone's attention.

Everyone has suffered in dealing with big, inflexible, rigid bureaucracies. So I think everybody can sympathize with what has happened to these people in our institution. We're not dealing with packages or forms, we are dealing with patients' lives. And the consequences of this bureaucratic bungling are only more heart rending because the stakes are higher and the suffering is a little more immediate, a little more real.

The first patient is an 85-year-old man who lives with his son. He suffers from diabetes, hardening of the arteries, cerebro-vascular disease, poor blood supply of the brain. All of this is sad. He's an old man. He's tired. He's becoming senile. But with the assistance of an attendant, he can live in his own home with his son—which he wants to do. His allowance for his attendant care has been reduced by the county to two-thirds of its previous level. We can no longer supply that gentleman with an assistant who can take care of him while his son works. So his son now is obliged to have to place this old man in a nursing home. And if I can speak as a physician here, those aged who are accustomed to live in a certain environment don't live as well in a nursing home, however good that nursing home is. I'm not trying to demean nursing homes, but a man is more comfortable in his own home. And in a way, he has been doing that. He has arthritis and is bedridden as a consequence. He requires an attendant every day to help prepare meals and clean him up and keep the house clean. Again, the attendant allotment has been cut almost in half.

Here's another where the allotment has been cut almost in half. And she's lost her attendant and has had to be moved to a nursing home now. She's not senile or anything. She's just bedridden with severe arthritis.

It's possible for any doctor to take some medical records and leaf through them—medical records of any patient who has died, and find some way to perhaps have extended that patient's life for a few hours. This is only dependent on how assiduous and intelligent the doctor is.

Cannot Deliver Ethical Medicine

These two cases I am going to cite now are of that character. They were brought to my attention by the doctors involved and the doctors involved are fully cognizant of the risk of litigation here. A canon of the American Medical Society states that it is unethical for a physi-

cian to place himself in a position where he has to practice medicine in a way that is not acceptable by the community standards. We have placed ourselves in a position in which we cannot deliver ethical medicine.

The first case is an 89-year-old gentleman who died in the hospital of uremia—malfunction of the kidneys—nonfunction of the kidneys. It was suspected by the physicians who were caring for him that this uremia was due to an obstruction of his urinary tract, which is a common problem of elderly men. However, it was impossible to obtain the X-rays necessary to document that in time to take this man to surgery. If it had been a surgically relievable obstruction, he might have survived. The reason the X-rays weren't obtained was because there was no one to transport him to the X-ray department to obtain those X-rays. Before they were scheduled, he died.

A 74-year-old woman died of peritonitis, which was associated with a gallstone obstructing the common bile duct. In younger people, that's not a particularly dangerous disease, but at her age, the gravity of her illness made her a poor operative risk. But she might have survived an operation had there been space in the operating room for her. Before she made it to the operating room she expired.

I could cite similar examples of bureaucratic bungling, deprivation of care of the aged, and loss of life ad nauseum. Anyone who has worked at the county hospital—or any hospital, I think, if they are perceptive, could. If anyone here feels that these are isolated and atypical examples of what is otherwise a smoothly functioning machine, I can present 10 times as many examples as I have here.

Reports Have Been Ignored

I expect skepticism from this report. For nearly 2 years now, frequently in this room, similar reports—similar statements have been made to county officials and to State officials, all of them ignored. I hope these anecdotes convey to you the frequent despair and desperation experienced by older patients and their families.

To simply pour more money into a system which already proven itself inadequate is certainly not the only answer. I share with most physicians a trepidation as these institutions become more involved in our health care system. But I feel an overhaul of our health care system is essential. It's vital and necessary that everyone involved—consumers; the people who are going to pay the bill, the taxpayers; and providers, the doctors and paramedical personnel involved—must actively involve themselves if any sort of intelligently conceived system is going to be evolved in place of the one we have now.

To sum up, the elderly patient frequently receives his outpatient care from a private source. When hospitalization is required, he is frequently referred to a county facility. Records seldom accompany the patient as he moves in either direction. This ping-pong move of the patient is deficient, it is demoralizing, and it frustrates everyone involved.

Improvement of communications among welfare agencies, and private, and public sources of health care would diminish the inadequate, episodic, crisis-directed nature of the health care of the aged.

Thank you, Senator, and thank you ladies and gentleman.

Senator MUSKIE. Thank you very much, Doctor. You indicated briefly that there was a growing reluctance on the part of doctors in the private sector to take Medi-Cal patients.

Dr. SMITH. I have friends in private practice now who have had difficulty dealing with the State. Apparently there are some rather—we use these forms at the county hospital—involved, quadruplicate forms that have to be filled out. There is a certain sort of language that is required in order to have them approved. These are forms to obtain funds for patient care or funds for hospitalization, or whatever service.

Many doctors—most doctors—find any sort of recordkeeping distasteful. And filling these forms out, they become sort of emotionally involved and they reject them.

Others have difficulty in being reimbursed for properly delivered care, and then they are reviewed again and they take a risk of not being reimbursed and losing money.

Yes, there has been a increase—I think I cited the date—an increase of almost 1,000 percent in the number of referrals from the private sector in the last month. This indicates that they are resisting.

Senator MUSKIE. It is obvious that this will throw the patient load increasingly on institutions like yours, a county hospital. Is that a less expensive or a more expensive form of health care?

Dr. SMITH. I feel that is is more expensive.

Senator MUSKIE. And poorer care.

Dr. SMITH. In the long run, it's poorer care. I think we must look at this in depth. For anyone that is taking care of a crisis, a catastrophe—a broken bone, you know, some emergency situation—the care at the county hospital isn't—if the patient can be seen in time—isn't much worse than it is anywhere else. But the patients, these people are sick full time. They're not sick, you know, once a month when they show up at the county hospital. So the care is so broken apart that it is ineffectual, inefficient.

Senator MUSKIE. You have given us some illustrations of what some of the consequences are of these cutbacks. Does the cutback in funds for hospital also lead to inefficient operation?

Dr. SMITH. I have submitted a report to the full committee.* Some of the examples of how inefficient the county operation becomes would be pathetically amusing, but they are tragic, awesomely tragic.

HIRING FREEZE CREATES BACKLOG

One of the best examples is this: Because they don't get enough State funds, the county has instituted a hiring freeze. The hiring freeze includes clerks. It includes specifically the clerks that are necessary to fill out the reqiured preauthorization form and "extensions of stay" forms for Medi-Cal patients. This led, in turn, to a backlog which is now approaching 3,000 requests which haven't been filled out because we don't have enough clerks. Each of these requests represents a loss to the county of State funds.

* See appendix 2, p. 51.

We operate a school of medical technology at the county hospital. It's a good school. They turn out a lot of graduates. In the past, we have taken the graduates from this school. We continue to operate a school. It's as expensive as any school in the system. But we can no longer hire the graduates of that school. This results in a decrease in our laboratory technologists.

Now, another thing the county does. Never in the past few years has our medical laboratory been able to do the tests that they would like to do. So there is a county program to buy laboratory tests from contract labs in the county. The hiring freeze has been a boon to them because we can no longer hire laboratory technologists, but we can still get the laboratory tests done. It's costing us now about $50,000 a month to have the laboratory tests done. We can hire six biochemists for $75,000 and save the county $500,000 a year. At $50,000 a month, it is costing $600,000 a year to send those tests out. And if we hire $75,000 worth of technologists, we can do that work ourselves.

Yes, I believe it's very inefficient.

Quicker To Repeat Expensive Study

Another example: An important function of an X-ray department includes filing of its X-rays so a doctor can find them. You take an X-ray and can't find it, it's the same as never having taken it. Well, we do a lot of very expensive studies at our hospital, but we don't have any file clerks because there is a hiring freeze. So, it's frequently quicker and in the patient's best interest to repeat a study that might cost $500 than to find the previous one that was done 3 days ago which is still in the filing system—in limbo. It's very inefficient.

Senator Muskie. Doctor, thank you very much for your excellent testimony, your report will be printed for the record.*

Dr. Smith. Thank you.

Senator Muskie. Dr. Hubert L. Hemsley, president-elect, Charles Drew Medical Society, Dr. Hemsley, we welcome you this morning.

STATEMENT OF HUBERT L. HEMSLEY, M.D., PRESIDENT-ELECT, CHARLES DREW MEDICAL SOCIETY, LOS ANGELES, CALIF.

Dr. Hemsley. Ladies and gentlemen, Senator Muskie. As president-elect of the Charles R. Drew Medical Society, I have been asked to give my impressions of the effects of the recent cutbacks in Medicare and Medi-Cal on the overall health of the community that we are so privileged to serve.

In order to respond intelligently and put these cutbacks in their proper perspective, you must be aware of the current atmosphere concerning the health care crisis in this country. While the entire medical and political community of this Nation is striving forward to deliver health care as a natural right for all Americans, this State's administration has taken a giant backward step.

In order to really clarify this further, we must understand that one in every 10 Americans has reached or has passed the 65th birthday.

* See appendix 2, item 2, p. 51.

Accounting for some 20 million Americans above the age of 65. There are approximately 12,000 above the age of 100, and it is estimated that by the year 2000, we will have 65 million people over the age of 65—clearly the problem is not going to go away.

Expressed in other terms, this indicates a net rate of approximately 900 people a day or 330,000 people a year, reaching the age of 65. Much of the same problem faces 18 million people between the ages of 54 and 65.

Look at it this way: Historically, in Cato's day, 149 years before the birth of Christ, the average length of life was 22 years. In the 16th century, it was 33 years. And at the turn of the century, in this country, it was 47.2 years.

It's quite evident then that the problems associated with old age were not overwhelming at any other time in our history. People just didn't live long enough for problems of any large scale to develop, especially if they were poor and black.

Medicare, which went into effect in 1965 with the promise of giving adequate medical care to those over 65, has achieved some good. Approximately 19 million people have automatically received coverage under Part A—Medicare hospitalization. However, 1.7 million declined to participate in Part B benefits—the supplemental health insurance—which originally cost $3 a month. This was to cover physician's services and now costs approximately $5.30. This increase of $36 a year to $66.60, along with the first $52 or first $60 of hospital costs as opposed to an initial $40, as well as the obligation to pay one-fifth of the remaining doctor bills is responsible for much of the plight that Mr. Porter found himself in this morning. No one on a fixed Social Security income of $75 to $80 a month can meet these expensive deductions. The costs now only cover approximately 43 percent of the health care needs of elderly people.

In light of this, when one looks at the cutbacks, one must think about what this will do to the health resources in our community; what does it mean in terms of physicians, clinics, nurses, et cetera.

Following the Watts revolt in 1965, the McKone committee indicated there were approximately 127 physicians per 100,000 people in the Greater Los Angeles area. In the Watts area, there are approximately 38 physicians for 100,000 people. The 10 percent cutback places an economic lid that will further restrict the expansion of immediate facilities in the ghetto area; will affect the quality of employees and rape the ghetto of its present medical resource! Those physicians whose practice consists of only 10 to 15 percent Medi-Cal and Medicare patients have already stopped seeing Medi-Cal patients rather than accept responsibility for their care and be forced by bureaucratic guidelines to render second-class medicine.

Only those physicians whose practice consists of 50 percent Medi-Cal–Medicare patients, or more, will be forced to further subsidize this program.

One-Third Physicians Refuse Medicare Patients

Throughout the United States, 36 percent of the physicians refuse to accept patients under Medicare—as reported in the Journal of

Geriatrics in 1967. The effect is also felt in nursing homes. And under the reeling impact of the new cutbacks, one of our neighbor nursing homes has already closed and many more are on the verge of bankruptcy and will close. forcing the old and the disabled back into antiquated county custodial facilities far removed from their communities to die in a subtle form of euthenasia.

The emergency rooms of both public and private hospitals have experienced and will experience a greater increase in caseload causing innumerable errors in therapy and eventually death to some unfortunate person.

The public hospitals, which have been recently indicted by their own interns and residents, because of their own inability to provide medical care in the face of the daily caseloads, are now even further inundated; and able to cope only with emergency life-and-death programs. All preventative, all rehabilitative, all theraputic programs will suffer. And we may well see a social crisis the equal of the Watts revolt if the elderly and the poor are unable to obtain needed medical services and die as a result.

The mortality rates of the elderly, the poor, and the nonwhite, when compared to middle class America, have increased! In 1930, two nonwhite mothers died in childbirth for every white mother that did. Now, four nonwhite mothers die in childbrith for every white death. Who can tell what these cutbacks will bring?

The South, the Southwest, the Southeast have a nonwhite population averaging 82.2 percent. They already have the highest fetal death rate, the highest maternal death rate, the highest infant death rate and the highest neonatal death rate of all the counties in Los Angeles.

Infectious Disease Will Increase

All infectious disease will increase. And those which are endemic such as VD, tuberculosis, polio, and so on, may become epidemic because of lack of proper treatment. Indeed, Watts, in 1960, although it accounted for only 17 percent of the Los Angeles population had 100 percent of all Los Angeles cases of polio and diphtheria as well as a disproportionate share of other diseases.

The incidence of all forms of mental disorder among the poor make the recent cutback more criminal and inhuman. Now, borderline psychotics roam our streets and ravage our people.

Paradoxically, while the administration was restricting all other phases of medical care, they seemed to be somewhat intent on sponsoring drug addiction in the minority community by the stipulation that doctors can only write for "yellow jackets" and "red devils" and empirin and codeine.

They completely wiped out any non-addictive preparations from the California area—aspirin, sodium salycilate—the chief treatment for arthritis in the elderly—were taken off the program. They also made it mandatory that doctors write for no less than 30 capsules at one time, even if in the doctor's opinion only eight or 10 would be needed. Is this some attempt to narcotize the poor? I wonder.

Other blatant deficiencies in the drug program include limitations on drug treatment of coronary insufficiency. And in pregnancy—no

vitamins, no folic acid derivatives, nothing for breast engorgement. And if our mothers do indeed survive to the age of 65, which ironically most blacks do not, nothing for hot flashes. In asthma, no liquid preparations for their children. Less effective measures are given, and injections are limited to one only.

Thus, the administration in its zeal for law and order has seen fit to make being old and being poor a crime; and has articulated the belief that the majority of our elderly and poor deserve their poverty and are on welfare because they like idle comfort.

In truth, of the 38 million casualties classified as poor by the Government, the majority are unemployable. When you add the 20 million over the age of 65, and 3.5 million who are too young, 2 million who are really too old and 900,000 mothers with no place to leave their children, 600,000 are totally disabled, others are emotionally or mentally handicapped. And ironically, contrary to what others may tell you, the majority of poor in this country are white, not black. This is a true profie of the poor. This, our administration has declared war against.

I firmly believe that one-fifth of the deaths among the elderly and poor, and one-half of the deaths among nonwhites are deaths that would not have resulted if economic differentials and racism did not prevail.

ADEQUATE SERVICES DO NOT EXIST

In summary, it is very apparent that adequate medical services do not exist at the present time. Public health facilities, are ill equipped and unable to handle present caseloads; and, if inundated with more patients as a result of wholesale cutbacks, only increased morbidity and mortality and possibly a revolution will result.

In view of this common knowledge and in face of the recent cutbacks in medical sources, the question must be asked: "Are high morbidity and mortality rates among the poor and elderly designed or accident?"

To the extent that men in public office have known, do not know, that inadequate medical care kills, that infection spreads and kills, that the social pressures deriving from poverty and racism kill, I have concluded that the medically indigent and the elderly of California, are the first victims of Reagan's war on welfare.

Senator MUSKIE. Thank you, Dr. Hemsley, for your excellent testimony.

As you may know—as you do know, I'm sure—it has been proposed that medical patients should be required to pay $1 for each visit to the doctor's office, and in addition, it has been suggested that Medi-Cal beneficiaries should be billed $1 for each prescription filled and $3 for each day in the hospital.

I think your answer to my question is evident from your testimony already, but focusing specifically on those proposed cuts, what kind of an impact would they have on the health care of aged Medi-Cal patients? Would this be the straw that breaks the camel's back?

Dr. HEMSLEY. I certainly think so—that there has been a lot of talk of overutilization. But it's common knowledge that the average person in America visits a physician 4.7 times. It's also common knowl-

edge that the elderly and the poor have a higher incidence of diseases. And because of the rigid, bureaucratic structures of most hospitals, and most physician's offices, they are turned away rather than encouraged to go and seek medical care, as Mr. Montaño graphically presented.

So the poor people and the black people get no special trip, no special thrill, from sitting up in the doctor's offices for hours and hours at a time. They indeed do not overutilize the program. We have just not done our job.

The $1 fee and copayment is really an idea of middle-class America to make the poor pay. The unfortunate thing is that these are the people that can afford to pay least of all. Reagan can deduct it from his income tax and pay nothing.

But it's very difficult for a welfare mother and some people living on fixed incomes to find the wherewithal to pay the first $50 to pay the copayments and as a consequence, they have a very difficult decision to make: They have to either buy food for themselves, or buy medicine. We see that they don't buy the medicine. They don't take digitalis, and go into congestive heart failure. It takes 3 days and 4 nights for some tired, overworked intern to try to bail them out—cursing all the time.

It is heart rendering to try to practice this type of medicine. It is heart rendering to try to render and bring the good care and dignity to our community. The dues that we pay and that we continue to pay are staggering. We refuse to give up on this society. We are not going to allow ourselves to be supplicant to anything.

An Insult to the Aged

The $1 copayment is really an insult to the aged of this country. It's an insult to the elderly who have worked all their lives and made this country as great as it is. I think men like yourself must have the character to challenge on this particular point. We're trying to get, I hope, a new system of health care for everyone in the United States.

Senator Muskie. With a spokesman like you, I think we can make it.

What do you believe, doctor, is needed most to bring medical personnel to the ghettos and areas where there are high concentrations of elderly persons?

Dr. Hemsley. Basically, I think we need some reassessment—a different philosophical approach to health care for Americans. I think we need a new health insurance system. I think we have to do away with coinsurance and deductibles and things which waste millions and millions of dollars in shuffling paper from one part of the country to another.

If we can do that, then there will be a challenge to our doctors to go into areas where they are needed. But right now, they're all disincentives to practice in Watts. You pay higher fire insurance—you know, because that happens to be the curfew area. You pay as much for your help and you pay as much for your penicillin and you are paid less for your care because of the "usual customary fees."

As a consequence, a doctor practicing in the ghetto has to see twice as many patients to get the same amount of fixed income as someone

in Beverly Hills. And some of the interns and residents, who I myself taught, charge as much as three times as much as I do for their particular procedures.

So despite the fact that we may want to go to practice in the ghettos, we must consider our wives and our children—we cannot sacrifice them. And many physicians, when forced to make that decision, move to Orange County—move to Beverly Hills. There are many, many problems which exist in the minority community that don't exist in more affluent communities. We have to be more than physicians; we have to be spokesmen for the underprivileged. We have to talk about community problems, we have to relate to people who have given up on the system and tell them that it can work. These are some of the crosses that we must bear.

Senator MUSKIE. Nationwide, doctor, an aged person's health care expenditures average about $800 per year. How does this compare with the averages in the areas where you practice?

Dr. HEMSLEY. I can only say New York and Los Angeles probably feel the greater impact of a migration of people from more primitive settings in the United States—I think at the rate of approximately 170,000 per year immigrate from the South. And they come to Watts, to Compton, to Harlem, to Bedford Stuyvesant. And they come with a combination of no skills, cultural biases, malnutrition, of parasitical diseases, et cetera. These are the things that we must fight—they come with their faith in witch doctors and in people who are soothsayers, and in herbs. All of this makes it much more difficult to get to them to provide the type of care that they want. You have to get them involved in a health educational process.

I don't know what the answer is, but I feel that a cooperative effort where all the people involved in health care, where health is truly a community concern, can really do some of the things that we want to do.

I am hopeful that resources development fund and moneys of that kind will do many of these particular things. And I have some very specific recommendations which I will forward to you in writing as to how we can do this.

Senator MUSKIE. Thank you very much, Doctor, and we will be in touch with you again and gain additional benefits from your experience and your insight. Your prepared statement will be inserted in the record. *

Senator MUSKIE. Our next witness is the Reverend John G. Simmons, who is the administrator at Pacoima Lutheran Hospital.

Reverend Simmons, it's a pleasure to welcome you here this morning. We look forward to your testimony.

STATEMENT OF REV. JOHN G. SIMMONS, ADMINISTRATOR, PACOIMA MEMORIAL LUTHERAN HOSPITAL, LOS ANGELES, CALIF.

Reverend SIMMONS. Thank you, Senator. I haven't seen you for a good long time. It's nice to see you.

Senator MUSKIE. Thank you.

* See appendix 2, item 3, p. 55.

Reverend SIMMONS. I have Senator, a longer statement than I am going to submit at this time.* I have a summary which I would like to offer and then perhaps respond to questions.

Senator MUSKIE. All right.

Reverend SIMMONS. I am speaking for myself; neither for the institution I represent nor for any other group.

I am the administrator of a hospital that "before earthquake" on February 9, Senator, was a 110-bed general hospital with a 26-bed mental health wing. And since the quake, we have been scrambling around trying to convert space, lease space, try to do things that are essential for our survival in the community we serve.

Now, the community we serve, in particular, is a community that is made up of about one-third of the population, black, one-third Mexican-American and the others white; surrounded on the edges of the general area we serve by an older group of senior citizens in an area of Tujunga.

I would like first of all, Senator, to say that to much of what we have heard this morning I can only say, as a preacher, "Amen." And if I can summarize it, the first thing is that all poor people are outside the "nonsystem." What we need is an ecological health system, if I can suggest the phrase. Ecology, as you know, is a totality of relations between organisms and their environment. And this is a "nonsystem" in which we are involved.

"NONSYSTEM" MUST BE RESTRUCTURED

More money will not give our senior citizens nor our medically indigent citizens adequate or acceptable health services. The present "nonsystem," fractured and fragmented, must be restructured into an ecological health services system.

The ecological health services system must be an integrated, comprehensive system embracing preventive and rehabilitative services, maintenance, and acute services, emergency, and continuity of services. The financing system must be related to a capitation system that encourages group practice and provides for the comprehensive services that I have indicated in the testimony, which you have, that will stress the preventive and rehabilitative aspects rather than merely the disease syndrome nonsystem.

Now, a word about rehabilitative services. There may be an adequate number of beds statistically, but the question of the services of these beds indicate maybe they are too poorly distributed to provide needed services to the aged. Let me cite one example: The most critical shortage in the Northeast Valley of Los Angeles—for that matter, in the entire State of California and possibly the entire Nation—is the rehabilitation facilities for that huge, hidden minority of those of our citizens over 65—and under 65—who are permanently disabled and yet who could be rehabilitated if we had the vision and the personnel and the facilities and were willing to expend the money. The lack of rehabilitation facilities is one of those statistical mirages which our so-called planners hide under their all-pervasive carpet of statis-

* See appendix 2, item 4, p. 58.

tical falsehood. There are no rehabilitative facilities in the north San Fernando Valley, and there isn't in Pomona, and yet, there is nothing in between. And yet, there are thousands, literally tens of thousands of persons who could be brought into the stream of society if there were qualified, competent rehabilitative services available to them.

There is nothing that dictates the chronological age line at age 65. Many women and men have served throughout history at age 70, 80, and 90. It is our obligation to extend the benefits of Medicare; make it possible for these people to serve society and to continue to live useful and productive lives.

I'm not going to say a great deal about the capitation system because perhaps some of those who follow me will have something to say about this financing system.

So let's take a look at health manpower. What is the cost of the restrictive licensing arrangement in the 50 States of this country? Why should a physician who is qualified in New York not be qualified in Florida or in Mississippi or in Montana?

Need National Certification

The disease he sees in any one of the 50 States and the treatment he prescribes will not and cannot differ materially. There was a time when the States used professional licensing as a restrictive mechanism to protect their own licenses against undue competition. Due to the manpower shortage in all the health fields, we can't afford the additional cost created by the maldistribution of the various licensing acts. Some kind of a national certification act which would certify the qualifications of physicians, nurses, and other health personnel will reduce the cost of medical care because it would more evenly spread the available manpower and personnel.

I could give you a number of illustrations of persons who have been qualified in other States who come to California to practice in a particular area. Then they must go through a licensing here. Suppose they are psychiatrists: They have got to pass a board of medical examiners including, that is, OB, GYN * with which they have not had any relationship for many, many years. So they have to take off a long time from their psychiatric practice in order to pass an examination in this State when they have once passed the whole thing in another State. So one more person is removed from the personnel of the health manpower needs of this country.

The same can be true of innumerable groups of health personnel. It has been a system which increases the cost and keeps the people from getting the services they ought to receive.

There is another area of health care services known as "group practice." There are over 20 States, Senator, which would prohibit or in some fashion restrict the group practice of medicine. In other words, two doctors can't get together to form a group in some States. Over 20 have some kind of regulations. This can be remedied by legislation because whatever economic factors created these restrictions, they are no longer in existence. To make medical manpower more efficient, group practice is one of the primary answers. And we can correct this by legislation at the national level.

*OB, Obstetrician—BYN, Gynecologist.

Let me just take a few other things that I want to say before I turn it over to you for questions.

System Makes No Sense

Part A and part B: The consumer of health services under part A and part B is totally confused, and ought to be, because the system makes no sense at all. You have a part A for $60 for the Medicare patient to pay, you have part B for the Medicare patient to pay the physician. This is a false distinction. So a person comes into the hospital, they have an EEG and they get a special bill for the reading of the EEG because that comes under part B and not part A. They don't understand that. I don't blame them because it's very difficult for any of us who have been in administration to understand it.

We heard very brilliant testimony from the doctor a moment ago concerning the problems that are faced by poor people. I thought you might be interested, in case you haven't seen it, of the description recently of the Medi-Cal cutbacks, and then I'll illustrate it—and especially the mental health, because that's my area.

The present Governor appears to view the mentally ill as malingerers needing only a solid slap by General Patton. These people live life as if it were a John Wayne movie and the guys who aren't leading really aren't sick—they just lack the guts to be healthy.

The present "nonsystem" is designed to discourage people, as it has been indicated, from seeking health services by all kinds of rules and regulations. It got to be for a while, after a doctor wanted to get an extension after 8 days, that they wouldn't let his nurse call, they had to talk to the Medi-Cal consultant personally. So the doctor—I have seen doctors in our community trying to serve poor people—where 60 percent of all of the people we are under Medi-Cal in the hospital I serve—sit on the telephone calling down to Santa Barbara Avenue trying to reach somebody for 45 minutes where the line would be answered, Senator, "Just a minute," and it took 45 minutes. Well, you can imagine how long doctors are going to put up with that kind of foolishness waiting 45 minutes to get an answer as to whether or not a patient, that's his patient that he has seen that he is treating, can stay in the hospital another day or two before they are released.

Now, the ridiculous system goes further, Senator. In this State, we have to have medical cards—Medi-Cal cards. Now, the Medi-Cal cards that they have to have, have to be in the hands of the patient. Let's assume a week ago last Saturday, which was the first of May, there was at our hospital—and a patient came in who said they were on Medi-Cal. They hadn't received their May card in the mail. Now, in many places they will not be accepted—as a matter of fact, a very large health institution in this community that has hundreds of beds accepts no elective surgery for Medi-Cal until after the fifth of the month to make sure that the cards have arrived on time.

Regulations Are Ambiguous

Now, let me give you the kind of paperwork: We are involved in a hospital where we are still trying to figure out what the regulations

mean. They are so ambiguous that it is impossible for an intelligent physician or his personnel to figure them out.

Now, there is a new bill in the State assembly called AB 949, Senator. There are a couple of sections that will be very interesting to you. The director, in the State of California, who, by the way, has never practiced medicine, would be given the power to specify which health care services will be included in the program. He is given the power to make unilateral decisions when and for what prior authorizations may be required. In addition to that, the number of visits are now to be limited and the number of days which a person can spend in the hospital can be limited; all of it direced toward only one thing—as far as my observation and experience in operating a hospital simply to cut out money. It has nothing to do with health care at all. As a matter of fact, it makes health care more impossible to be received because you have people who are handling problems that they don't know nothing about.

I want to return—we need some kind of a system—we don't have a system. We have a nonsystem, a fractured, fragmented, nonsystem. And it makes no sense until we begin to address ourselves to the problem of taking care of all of the needs of the people in terms of health care.

Thank you, Senator.

Senator MUSKIE. Thank you very much, Mr. Simmons. Your entire statement will be included in the record* The frustrating thing about all the witnesses here this morning is that you obviously have such a wealth of experience from which you could draw and we're not going to scratch the surface this morning.

But I would like to ask a few questions.

What happens when a clearance for treatment that has already been given to a patient is denied?

DOCTORS GET DISCOURAGED

Reverend SIMMONS. Then the hospital doesn't collect and so this is a part of the system which Dr. Hemsley was mentioning today, that sooner or later, you get the doctor totally discouraged. The hospital must absorb the expense of the service. That's what happens. The hospitals absorb hundreds of thousands of dollars of expense; this means that somebody else pays a higher amount for their service unless you are going to plan to go broke. There's no other way. You see, somebody else is going to pay more when the system does not provide adequate facilities or adequate compensation for the health services.

And by the way, you see, the Government agencies do audit afterwards and decide whether or not even what you receive was more than you should have received for the services rendered. And with the present bent of this administration, I can assure you that they are looking for every dollar that they can get back from you after you have rendered the service.

Senator MUSKIE. The President's Task Force on Aging recommended that a fixed percentage of the Medicare Trust Fund be used to estab-

*See appendix 2, item 4, p. 58.

lish a full range of geriatric health services including community health aides devoted exclusively to working with the elderly.

What is your reaction to this proposal?

Reverend SIMMONS. Excellent idea. There are so many people that can provide service with a minimum amount of training. You know, some health professionals make a lot of mystery out of things, Senator, that really aren't that mysterious. You know, there's nothing that replaces tender loving care. You can teach people some of the most elemental things that are essential in caring for the elderly. With adequate supervision, they provide an indispensable service.

I am working on another program which I hope in due time I can communicate to you which is a program in the paramedical field where we are taking careers similar to this and trying to provide some kind of training program.

That's an excellent idea.

Senator MUSKIE. There's another point I would like to get your reaction to.

The administration is also placing heavy emphasis on health maintenance organizations almost to the point, I think, of making it the central thrust of their proposal.

In your judgment, is Federal acquiescence to recent proposed State changes in Medicaid programs undermining the capability to provide health maintenance services?

Reverend SIMMONS. I have to begin by saying, again we have a nonsystem. If we could get an ecological health system from this approach I'd be for it. But the present administration at the State and Federal level doesn't seem interested in declaring such system. The health maintenance organization is more political than helpful.

The changes recently agreed to between the Reagan and Nixon administrations of Medicaid will continue to destroy the health services meagerly and independently being provided to the poor people. We need to develop a comprehensive ecological health system and we aren't doing much to work in that direction.

Senator MUSKIE. What we need to do is make the investment.

Reverend SIMMONS. Right.

Senator MUSKIE. Mr. Simmons, thank you very much for your testimony. We'll be back to you.

Reverend SIMMONS. Thank you.

Senator MUSKIE. I would like to say, before we get to our next witness.

I would like to thank Supervisor Ernest Debs of the Los Angeles Board of Supervisors as our host who has generously allowed us to use this hall today.

FORM LETTERS AVAILABLE

I would also like to say this to any of you in the audience who may be interested, there are forms like this [indicating] available in the back of the auditorium. And what they are designed to do is to stimulate any of you who would like to write to us, in any way that you would like, on this general problem. And it's a form of a letter. You

can say whatever you want to on it, and your letters will be printed [1] in the transcript of this hearing. And a copy of the printed hearing will be sent to all of those who contributed their views to the committee.

We had to schedule a limited number of witnesses here, but I am sure that there are many of you in the audience who would have something you could tell us of importance about this program, about its deficiencies, and about your own problems.

Our next witness is Dr. Robert Peck of the Medical Committee for Human Rights, and Mr. Thomas Moore, who is executive director of the California Council for Health Plan Alternatives.

We are delighted to welcome you both this morning.

STATEMENT OF ROBERT PECK, M.D., CHAIRMAN, MEDICAL COMMITTEE FOR HUMAN RIGHTS, LOS ANGELES CHAPTER

Dr. PECK. Senator, I feel that my role is made easier by so much of the material being covered, and at the same time, I feel that all I can do is add to a vision of sorrow and irrationality which is inevitably emerging from these series of excellent and authoritative speakers, starting with the people who are the victims—starting with the recipients and the people where it's all directed and the people who are the central question, the central issue before us.

I am the chairman of the Medical Committee for Human Rights, Los Angeles Chapter. There are 400 physicians and other health-care professionals. And I am a representative of the health care coalition of 17 organizations of medical recipients, health-care professionals, labor, and community groups.

Now, the Medi-Cal program, as you are aware, is the Medicaid program in California. It was achieved with the announced purpose of bringing poor people into the mainstream of medical care. Although it has never been achieved—mainstream medical care for all—it is an objective which must guide our efforts in the health field. Human need, not money, must be the decisive issue.

The cutbacks which went into effect December 15, and even more omniously, the new budget which has been projected and presented by the Governor for the year beginning July 1, 1971, fly in the opposite direction. And I will demonstrate, and of course, it has already been demonstrated very eloquently, that what has really happened is that most of the 3 million indigent people and medically indigent people in California are out of the mainstream of medical care, have been driven out or will shortly be driven out of it, so they won't be sitting in my office or the other private doctors' offices who are still seeing Medi-Cal patients, and they will be sitting in increasing numbers in the waiting room and the emergency room of the county hospital.

And beyond this, the fiscal imperative which allegedly necessitated these draconian cuts in the Medi-Cal care of the needy and of the aged were very obviously foreseeable and preventable. I refer you to an article [2]—which is included in my written testimony—in the Los An-

[1] See appendix 6, p. 130.
[2] See appendix 2, p. 64.

geles Times, which goes into this rather remarkable series of events that led to these emergency and drastic cutbacks.

Arbitrary Way Program Handled

The cutbacks themselves—and living with them as a doctor and seeing how patients live with them—comes down to things like this: First of all, there was an across-the-board 10-percent reduction in providers' fees. I'll talk about only one aspect of these cuts because it is my belief from knowing many doctors that it isn't the 10-percent cut that keeps them from seeing the patients, it's the onerous, restrictive, and arbitrary way that the program has been handled. The immense amount of exertion and frustration and overhead that goes into just filling out the forms and getting the prior authorizations and all those things is drying up the pool of doctors who will see the patients.

Now, in the case of the convalescent hospital, we have another situation. Here, the present rate allowed for convalescent care of the Medi-Cal patient is $12.60 a day. That is less than the charge in many moderate-priced hotels for a bed for the night. For that figure, the convalescent hospital has to provide around-the-clock skilled nursing care. They have to provide three meals a day. They have to have dietitians, and they have to have attendant care and numerous other services. The result is that many good convalescent hospitals are going out of business. Several have already shut their doors, adding hundreds of people to the pool of unemployed in this State in this day of rising unemployment.

It is my belief that the $62 billion a year health care industry in the United States is the resource of choice for employment and for training of the unemployed and those who are currently unemployable. Let's remember one thing about this industry and this profession: These are jobs which treat people. They are directed to human needs rather than the human destruction which has gotten the lion's share of our resources in the last number of years.

Handing Him a Loaded Gun

Going on with those items which are not cut arbitrarily in the Medi-Cal program like the 10-percent cut of fees, but now require prior authorization. What we have learned in living with this prior authorization is that this is the "catch 22" in the law. For example, medications have been referred to, and what more can I say but that we were denied all tranquilizers except one—which is a very effective and excellent tranquilizer—it's very potent, too, and for those that are sensitive to it, can be lethal. In terms of the sleeping medications, what does it mean to impose the restriction that we must prescribe no less than 30 sleeping capsules to a suicidal patient. It's handing him a loaded gun.

It should be mentioned, too, that on December 15, 1970, many of these drugs that were placed in the formulary on the basis of prior authorization only, have now been restored to the general category—so that we can, in fact, prescribe a number of them. What can we say about the intent or the responsibility, about the degree of care, on the

part of the administration—on the part of people that would cut away the formulary and take away the medications that the people need. Then when legal pressure from their old allies and dearest friends in the California Medical Association and related groups is brought to bear on them, and if political pressure becomes heavy enough, some of the cuts are then restored.

Medi-Cal has been cut to two physician visits a month without prior authorization. Perhaps this is not the worst thing that is happening. If somebody comes into our office and they have already had two visits that month, obviously we see them—but what about the limitation to two visits to your dentist every year? Dr. Max Schoen, who is a noted authority on dental health, has made an analysis of the present Medi-Cal program for dental care and a projection of the new bill which was introduced into the legislature, and if we don't do something about it, will go into effect as of July 1 of this year. What it does, in effect, is that it cuts from the present very bare-bones kind of dental budget of $50 million, it cuts $40 million, leaving $10 million for the care of all indigent and medically indigent people in this State for the next fiscal year.

Dr. Shoen has pointed out that over half of the people over 65 have no teeth, and that many of the people who have some teeth have very few. And the lack of an adequate number of well-functioning teeth limits the ability to eat, resulting in malnourishment and enfeeblement among elderly people who need all the nutritional help they can get.

Remains in Wheelchair—No Physical Therapy

Such items as physical therapy may sound to the director of this program—a young 28- or 29-year-old physician who, as has been pointed out, has not yet practiced medicine—they may sound to him as though they are of trivial importance. Now they can only be given on a prior authorization basis. But what does that mean to the elderly person who needs to be rehabilitated so he can get out of a wheelchair and get on his feet and take care of himself? Well, in one large local hospital, which has an excellent rehabilitation center, just such an individual had already had the physical therapy, the surgery, and the prosthesis so that he could wear an artificial leg. But he couldn't get the physical therapy to learn how to use the leg. So he remains in his wheelchair.

That particular hospital, is typical of the voluntary hospitals in this community. Reverend Simmons and the Pacoima Luthern Hospital are exceptional because of their devotion to the needs of the poor, but the clinic at this larger hospital I am referring to immediately put into effect a regulation: "No more Medi-Cal patients will be admitted to this clinic."

So the doctors in the private sector are dumping Medi-Cal patients on the private hospital. The private hospital has closed its clinics and they end up in droves and platoons and divisions at the county hospital with the disastrous effects that Dr. Smith has already described.

I think that you should take note of the problems that are Federal in nature and are not strictly of State origin, Senator Muskie.

For example, the Federal Medicare regulations require that physical therapy will only be available if it is rehabilitative—if it is likely to improve the patient very significantly. But what this means is that a patient who is now able to get around, let us say, with a crutch or a cane, will be reduced to a lower level of living, will become bedridden, and of course will require more acute hospitalizations.

Another aspect of the cutbacks of health programs demonstrates how there is a conjunction of all of these restrictive measures. There is a recent regulation by the Department of Health, Education, and Welfare which cuts back by 47 percent the grants for training of rehabilitation personnel. Again, we have so many able, tender, caring people who are unemployed and unemployable now who could be trained and are, or were, being trained to become physical therapy aides or to become rehabilitation aides, occupational therapy aides, and all the entire lexicon of people who are necessary to keep patients on their feet and out of these expensive and miserable places where they have to end up. They are expensive and they are terrible places to be. I'm speaking of acute hospitals, particularly county hospitals. They would be terrible if all best efforts were exerted, and we have seen that county hospitals are the victims of terrible neglect.

Need Rehabilitation Specialists

I feel that this program of Federal subsidy to train rehabilitation specialists certainly should be reinstituted. What has happened at the center that I spoke of is that they have, of course, cut out all these jobs, and so they have less ability to bring people back on their feet and make them functional citizens in this community.

Just a word ought to be said about the aged totally disabled. They are a particularly unfortunate group. Many of them are not yet 65, but are perhaps 60. So they don't even get the benefit of Medicare. They have only the Medi-Cal benefits and these have been cut back so drastically that many of them, many of them, have ended up in residential settings and county hospitals where they should be in convalescent hospitals, where they should be in doctor's offices, and where they should be moving ahead to self-sufficiency. Many of them are rehabilitatable.

New Medi-cal Legislation

I would like to point out just two of the frightening aspects of the proposed new Medi-Cal legislation, assembly bill 949, which Reverend Simmons has already mentioned. He described the copayment proposal. Let me mention what it means from a doctor's point of view. From my position, the idea of taking $1 from a poor person as part pay for his visit to your office is heartless and hopeless. And if, in fact, the doctors will attempt to collect this $1 per visit, they will find they will spend $5 in the collection procedure and will end up not collecting after all. On the other hand, if AB949 becomes law the patient would have a copayment charge for each prescription we write. No doubt many prescriptions, however important, would never be filled.

They talk about overutilization. What does this mean? What is being enforced is underutilization. A poor person remains out of the office longer than he does now and will come to us beyond the range

of easy help and will end up in a hospital; which is expensive and entails inordinate amount of suffering.

The other frightening prospect is that AB949 eliminates the provision which has made it impossible for the State to require prior authorization for acute care. This boggles the mind. If I am in my office and here is somebody who is either hemorrhaging or unable to breathe, and I have to call the man at the Medi-Cal Administration to find out whether I should call the ambulance and admit him to the acute hospital—you know, this is just madness.

In summary, I presented a brief history of the inception of the Medi-Cal program. I have mentioned the present great cutback, which is still extant. Two previous attempts were turned back as patently illegal by the courts, but this one has run for many months. I pointed out what it means to live with a drastically curtailed and frequently revised program.

The proposed bill for the beginning of July 1971 through June of 1972 offers a few small improvements, but really it shows by its curtailments of health care and even by its wording that there is no attempt to bring Medi-Cal recipients into the mainstream of medical care.

It is the hope of the Medical Committee for Human Rights and the Health Care Coalition that your hearings will help to restore the Medi-Cal program at least to the level of services available prior to the cutbacks of December 15. We all recognize that Medi-Cal was not a definitive answer to health needs of the poor and medically indigent of California, and it is urgent business to come up with a comprehensive system and not a "nonsystem." Reverend Simmons and Doctor Hemsley have made this point, too. But it makes no sense to destroy the existing Medi-Cal resources for our poor old people before a new system is there to take its place.

In conclusion, I feel that what we have heard this morning sounds like Alice in Wonderland rendered by Kafka, and now is the time to do something about it.

Senator MUSKIE. Doctor Peck, I thought we might take Doctor Moore's testimony at this time and then use whatever time we have left to ask questions that you might each respond to. Of course your full statement will be included in the record.*

So I might then invite Mr. Thomas Moore, who is executive director of the California Council for Health Plan Alternatives, member of the Committee of 100, and an advocate of national health insurance to testify this morning.

STATEMENT OF THOMAS G. MOORE, JR., EXECUTIVE DIRECTOR, CALIFORNIA COUNCIL FOR HEALTH PLAN ALTERNATIVES

Mr. MOORE. Thank you, Senator.

On behalf of the 2 million trade union members and our families and our retirees in California, I appreciate this chance to appear here and welcome you back to California.

You have had so much—I am a little in the situation that Bob Peck was in—you had so much good testimony that rather than be re-

*See appendix 2, item 5, p. 64.

dundant and ready my statement, I think, if it is satisfactory to you, I will simply summarize some points I made in my statement * which have not been covered this morning so we can get on.

MEDICARE/MEDICAID "PAYMENT SYSTEMS"

Much of what you have heard described here has its roots in the fact that Medicare and Medicaid neither in concept nor in organization in the statutes were designed to be health programs. They were put together to be "payment systems." As such, they obey one of the laws of insurance systems, and that is, whenever you have financial difficulties in the program, the first group you punish—or the first group to pay for the financial troubles, are the recipients themselves. Practically every administrative and legislative step that has been taken since these two programs began has taken its first toll on those who are the recipients of the services. And most of these steps have avoided any real impact on the institutional arrangements which are at the heart of the problem; that is, the unstructured setting in which medical care services are provided. When administrative agencies must resort to deductibles, to payment corridors, and to the kinds of inflation in part B premiums that Mrs. Brewster pointed out in her paper for the committee, when these kinds of things have to be resorted to, the only effect that they can have is either to further confuse or further fragment services for the recipient. They are not, in the long run, going to be money-saving because health problems can only be deferred and sooner or later must be seen and must be treated. They are responses to an actuarial situation and not responses to a health situation.

And there is one thing that from our standpoint we would plead with both the Federal and the State governments to do in examining these programs; turn them around from a framework of insurance management and make them aggressively involved in the provision of health care. Both the Federal and the State governments must begin to intervene directly in the operation, distribution, and provision of services in our society.

Another thing that characterizes the programs as they presently operate is that they have tended to fuel the inflationary problem by simply acting as money pumps. Now we have been guilty of this in the private sector as well. For many, many years, organized labor in this State has bargained insistently and repeatedly, and sometimes with considerable strength, for more and more money to purchase health services. We are now spending about a billion dollars a year in California through our collective bargaining agreements. That doesn't count the money that is coming out of our pockets; that is just what is coming through the contracts. That's an increase of $250 million over the past 3 years.

For that $250 million increase, we have not added either significant numbers of people or significant benefits. We have done this simply to stay even. And with the current Presidential mandate to hold bar-

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*See appendix 2, item 6, p. 74.

gaining levels at 6 percent, particularly in the building trades, including fringe benefits, and with a 7.4 percent unemployment rate, some of the trust funds which historically have been very secure and actuarily very sound, are finding themselves now in very, very deep trouble.

"NEEDED A HEALTH PROGRAM"

So that Federal and State experience with these programs is very similar to ours in the private sector and the problem lies in the fact that both approaches have been faulty and that both of them have used payment mechanisms where we needed a health program—both have relied on manipulation of benefits, which means the manipulation of the patient population, instead of moving on the basic structures of health services.

We think, particularly in view of the rising interest around the country in organized health delivery systems, that there is now going to be some move toward organized, structured health programs.

The Federal administration has proposed a program to use health maintenance organizations as the fundamental structure. But I don't think that the tentative efforts now being proposed will be effective unless they are combined with a leverage of large purchasing power—unless the moves toward organizing the delivery system carry with them the sanctions and the leverage of massive purchasing power which is Medicare and Medicaid.

I don't think that unless those things are combined that you will find a stimulation of new delivery systems and experiments in care to reach into the kinds of problems that were described here today or that exist in areas like Liningstone, Calif, or in Watts. We have tried to stimulate new delivery organizations in the private sector with our purchasing power. We cannot do it. It's going to require the use of private and public funds working toward common goals.

I think that the most serious step that could be taken to deal with the human problems that have been described here this morning would be first to make some profound overhaul of the general policy and general structure of the two major purchasing instruments that the Federal Government has in Medicare and Medicaid. And with that, I'll leave time for questions.

Senator MUSKIE. Well, thank you, Mr. Moore, for your excellent testimony. Of course, your full statement will be included in the record.*

I would like to call to your attention a statement made in the report of the President's Task Force on the Aging, issued in April of 1970. They were convinced that because out-of-hospital drugs are not covered by Medicare, some hospital stays are expanded solely so that patients can obtain needed medication. Also they said: "Because Medicare will pay for nursing care and home care on leave following a hospital admission, many elderly patients who could receive their diagnostic work on an outpatient basis are needlessly occupying hospital beds."

*See appendix 2, item 74.

Overuse Because of Inadequacy

Both of these suggest an overuse of hospital stays because of inadequacy in the program in other respects.

I wonder if you each might like to comment on that?

Dr. Peck. Yes; there is no question about this. I don't know personally of doctors having kept patients in the hospital in order to just get their medication; however, it may add up to the same thing because if they go out with inadequate medication, they'll soon get sick again and be back.

Let me cite you one—just one example—that comes to mind, and I think this is important too, because it involves the Federal program in this case rather than the State program. I am speaking of Medicare.

An elderly patient of mine has emphysema, who has chronic heart failure and who is able to make it nicely at home and go to the park and play pinochle every day, doesn't make it once he gets bronchitis. A cold settles on his lung and he can't breathe. And when I saw him at home one day, prostrate, unable to move, unable to drink, unable to do anything, we put him in the acute hospital. He remained there for 7 days and at that time he was able to go to a convalescent hospital. And this, I understand, reduces the bill to the Government by about one-third—from $117 a day average in Los Angeles, down to perhaps $30 a day.

He was there 7 days and then the ukase came from the deus ex machina: This man must be out of the convalescent hospital by tomorrow. And this is from Medicare. And this: "He must be out by tomorrow morning."

Now, I am not in a "group practice" with the State of California of enthansia or the United States Government. So I called the ambulance from the acute hospital and said, "Take him back."

So I had him 5 or 7 more days in the acute hospital and then he was ready to go home.

So there was the kind of savings that somebody at some bureaucratic role, or perhaps some even higher role, is bragging about in these regulations. It's a very empiric kind of savings if any kind. It might have killed him if he had been allowed to go home.

Mr. Moore. The segment from the Task Force report confirms our experience. Treatment tends to follow the benefit structure. If you pay for diagnostic services in a hospital, you will have an increased hospitalization rate. If you don't pay for them in a hospital, you don't get the services. It's insane, but true, that medical care tends to follow the pattern of specific benefit structures.

A physician concerned about the financial condition of his patient almost by instinct will pick up the health plan book or will look at what the Medicare program will pay for in order to determine what he can do to have the least disastrous financial impact on his patient. This is the direct result of the payment system which rewards for specific acts rather than dealing with overall health needs and an overall health program. And I think that there is considerable evidence in the Federal Employment Retirement System which shows the way in which health care delivery is determined by benefit structures.

PAYMENT SYSTEM BUILT NURSING HOMES

The President's Task Force—whatever the sources of that statement, there's plenty of evidence for it in both the private and the public sector. We saw this in California. We built a nursing home system because we pay for care in nursing homes. He overbuilt and we've got a huge surplus now of beds because the payment system was there. At the same time, there were not enough funds to care for people in nonnursing but protected settings, so a great many people who could have stayed out of a nursing setting had to go to nursing homes because the only way the funds would be available was for them to go into a situation that had nursing services.

Now, that's patient manipulation to satisfy the structure of a payment system rather than to meet their health needs. I think no matter what the size of the organization, it must be possible to serve the human needs first and let the machinery work for the patient rather than the other way around.

Senator MUSKIE. You've made that point very well.

Let me ask another question: The House Ways and Means Committee has tentatively approved a measure to repeal the requirement that the States have comprehensive Medicaid plans by 1977. What kind of an impact do you believe that would have on health care for the poor and the aged poor?

Mr. MOORE. If that provision passes, it will set back disastrously, I think, the efforts of many of us to move our Medicaid programs forward. There are a number of States which have not implemented title XIX. There are States which have implemented them only minimally. California began with what in many ways was regarded as a national model. At least, it was a good piece of legislation in concept. It is now being whittled back only because there is a collaborative relationship betwen the State and the Federal administration.

If Congress puts its blessing on reducing this commitment it will be practically impossible, I think, to hold the line at the State level in keeping programs or getting them adequate or holding them together, let alone improving them.

Senator MUSKIE. Thank you very much, gentlemen. I am sorry that our time has run out, but your testimony has been excellent and I will be back to both of you to get additional information.

In concluding this hearing this morning, I would like to say, we have seen some of the effects of the recent cutbacks in Medicare and Medi-Cal. And the conclusion seems to be very obvious: Many older people are getting no care; many older people are getting poor care; many doctors are forced to practice bad medicine; and many hospitals are forced to waste money on inefficient administration.

These conclusions are a shocking reflection on the present health care systems for the elderly. Our elderly deserve better, and I intend to do everything I can see that they get it.

The subcommittee is in recess, subject to the call of the Chair.

(Whereupon, at 12:25 p.m., the subcommittee was recessed, to reconvene at the call of the Chair.)

APPENDIXES

APPENDIX 1

MEDICARE, MEDICAID CUTBACKS IN CALIFORNIA

A working paper* prepared for the Subcommittee on Health of the Elderly of the Special Committee on Aging, U.S. Senate

INTRODUCTION

Early working papers of this committee have focused national attention on the retirement income crisis of the aged and the inroads that rising medical costs are making on their economic security. In July 1969 when "Health Aspects of the Economics of Aging" was issued, it clearly revealed that the threat of costly and catastrophic illness was all too real for millions of older Americans, even with Medicare. Valuable as it has been, Medicare covers less than 50 percent of the health care expenditures of the aged. Today many are forced to turn to the "welfare" medical program, Medicaid. Others, ineligible for Medicaid, see their life savings depleted or wiped out after years of independent self-reliance.

Nearly 2 years have passed since that working paper was issued. During the time medical costs have continued to rise sharply. With all levels of government experiencing financial difficulties, pressure has steadily mounted for "belt tightening." And health care for the aged has been in retreat, with cutbacks in Medicare and Medicaid. Caught in the middle of rising medical costs and limited incomes, the elderly—more often so than any other age group—have been particularly hard pressed by these "economy" moves. Their very existence is oftentimes threatened in one way or another by these budgetary decisions. And it is becoming increasingly apparent that these problems not only affect the low and moderate income aged, but also upper middle and higher income persons as well.

* Prepared for the Subcommittee on Health of the Elderly of the Special Committee on Aging, U.S. Senate, by Mrs. Agnes W. Brewster, Consultant on Medical Economics.

MEDICARE, MEDICAID CUTBACKS IN CALIFORNIA

A Working Paper prepared by Mrs. Agnes W. Brewster*

I. THE NATIONAL PICTURE

Before turning to the situation that led to the Senate Special Committee on Aging decision to hold hearings in California, a few facts should be before us, because health care for senior citizens is a complex subject, regardless of the locality.

Since 1965—the year that the Medicare law was enacted—older Americans have received four Social Security increases. During this time their monthly benefits have increased by 53 percent. Yet, in terms of health care, they have been on an economic treadmill. The stark reality is that most of the aged's expenses for participating in Medicare have advanced as fast or faster than Social Security benefits.

The premium for Part B is up 87 percent. (The table (table A) shows how the situation has changed since July 1966. An additional increase in Part B premiums by the beneficiaries is scheduled for July 1971, and has been shown on the table.)[1] The deductible on the hospital bill is up 50 percent.[2] Doctors' fees for office and hospital visits and surgery are up more than 25 percent, and so the coinsurance which Medicare calls for (20 percent of the reasonable and customary charge) takes more dollars. If the elderly patient goes into an extended care facility, the coinsurance he must pay—$5.00 in the initial legislation from the 21st to the 100th day—is up 50 percent to $7.50 per day. (Parenthetically, the $225 a month that coinsurance would cost is larger than the Social Security check received by most widows.)

The aged require twice as many doctor visits on the average and double the amount of hospital care and prescribed drugs as younger people, so they are in "double jeopardy" from inflation of all these costs.

In 1966, an aged person spending 21 days in the hospital and 60 days in an extended care facility following an operation that cost $400 in surgeon's fees would have spent out of pocket $396 including his Part B premiums. The same episode would cost him $563.60 in 1971 (when the surgeon's fee is assumed to have increased to $500), an increase of 42 percent for the combined expenses of this one episode.

In 1969 a total of $9.7 billion was spent in public programs providing personal health care on behalf of the aged and $3.8 billion was spent

*Mrs. Brewster, a health economist was the author of a working paper, "Health Aspects of the Economics of Aging," prepared for the Senate Special Committee on Aging in 1969. She is now engaged in consulting activities in California. In Washington as a Federal employee, she had served earlier in the Public Health Service and the Social Security Administration.

[1] The cost of the premium for Part B Supplementary Medical Insurance has increased from $3.00 per month in 1966 to $5.60 (effective July 1, 1971), for an 87-percent raise.

[2] The deductible for Part A Hospital Insurance has risen from $40 in 1966 to $60, for a 50-percent increase.

privately. These sums come to $692 for each aged person, $499 under public programs and $193 of private payments. The public portion includes the premiums that the aged pay for Part B, equal now to $63.60 per capita. If counted as private expenditures, out-of-pocket amounts would average nearly $257 per aged person per year. This amount can make a large hole in the average pension. An unavoidable reason for the aged spending so much themselves relates to drugs, which averaged over $70 of private costs to the aged, and would be more if all who need prescribed drugs could afford to purchase them.

The table which follows shows that the average aged person is still having to spend heavily for health care.

	Per Capita		
	Total	Public	Private
Fiscal 1966 (pre-Medicare)	$438	$136	$302
Fiscal 1967	486	286	[1] 200
Fiscal 1968	600	420	[2] 180
Fiscal 1969	692	499	[3] 193

[1] Excludes $36.00 of Part B premiums, counted as public.
[2] Excludes $38.00 of Part B premiums, counted as public.
[3] Excludes $48.00 of Part B premiums, counted as public.

TABLE A.—*Medicare Costs, 1966–71*

Effective Date	Part B Yearly Premium	Hospital Deductible	Hospital Patient Payment/ Day 61st–90th Day	ECF Patient Payment/ Day 21st–100th Day	Part B Deductible	20% of Reasonable Charge [1] Under Part B
July 1966	$36.00	$40.00	$10.00	$5.00	$50.00	$40.00
Apr. 1968	48.00	40.00	10.00	5.00	50.00	40.00
Jan. 1969	48.00	44.00	11.00	5.50	50.00	40.00
Jan. 1970	48.00	52.00	13.00	6.50	50.00	40.00
July 1970	63.60	52.00	13.00	6.50	50.00	40.00
Jan. 1971	63.60	60.00	15.00	7.50	50.00	43.20
July 1971	67.20	60.00	15.00	7.50	50.00	43.20

[1] Doctor bill of $200 in 1966 equaled $266 by January 1971; this assumes that the physician accepted assignment.

II. WHY CALIFORNIA HEARINGS?

In many respects, California has been a leader in the health care field. Its Medi-Cal program originally was a model of excellence for other States. But faced with a budgetary squeeze, large-scale cuts were instituted in December in an effort to halt rising costs. It is now becoming clear that if the problems found in California exist elsewhere, our national approach to public medical care needs to be reexamined.

Additionally, several other factors provided compelling reasons for launching the Committee's study in California.

The ratio of tax-supported medical care expenditures to all personal health expenditures is undoubtedly the highest in the Nation, because, in addition to Medicare and Medicaid, the dependents' medical care program of the uniformed services (CHAMPUS)[3] spends more in

[3] CHAMPUS—"Civilian Health and Medical Program of the Uniformed Services."

California—20 percent of its total—than elsewhere, and the number of Federal employees in California is high; they belong to a health benefits program which the Federal Government partially finances. The State has been a leader in tax-supported health programs, including State employees, mental hospitals, etc.

Concern about the impact of Medicare in California also stemmed from the sheer numbers of beneficiaries there. Only New York State has more senior citizens. The 1.8 million persons past age 65 in California[4] account for 9 percent of all beneficiaries in the entire country. As evidence of California's healthful climate and popularity as a place to live, the State ranks first in numbers of persons aged 85 and over. With two-thirds of the State's older citizens at least 70 years of age, the State easily exemplifies the problems of those who must look to Medicare and Medi-Cal as the answer to their increasing needs for medical services. By the same token, such an examination highlights provider problems and the problems of fiscal intermediaries, because of the impact of sheer numbers of patients and claims, and the mountains of forms and reports associated with these programs.

The State ranks:

Second in expenditures for medical assistance totally and per inhabitant ($34.85 per Californian in 1968 when such expenditures accounted for 17 percent of national medical assistance vendor payments in the United States.)

Fourth in recipients aged 65 and over per 1,000 recipients for which medical vendor payments were made.

Fourth in child recipients of medical vendor payments per 1,000 population under age 21 (this ranking excludes Virgin Islands and Puerto Rico).

Fifth in the proportion (68 percent) of OAA recipients who get both OAA and medical vendor payments.

In February 1969, a total of 833,000 persons in California had medical vendor payments made on their behalf; the numbers are even higher today. In that same month, California accounted for 19 percent of all the recipients aided in the whole country.

In California 151 out of each 1,000 aged persons receive welfare medical payments or have them made on their behalf, and 119 per 1,000 get money payments—two-thirds are recipients of both. When such large proportions need the supplementation of State welfare and Medicaid, it seems obvious that Social Security income maintenance and Medicare programs are not filling the requirements of the elderly.

A. Medicare: The Problems

California is about at the national average in Medicare admissions per 1,000 enrollees; the rates have been climbing ever since the program started. At last count there were three admissions for every 10 enrollees per year. Extended care facility admissions in California continue to be double the national average. As a percent of hospital admissions, the ECF admissions are well above the national figures; in fact, in California 18 percent of hospital admissions go from the

[4] HI Note No. 24, Feb. 19, 1971, O.R. & S.

hospital to an ECF. (Source: R. & S. Health Insurance Statistics Note No. 20; Oct. 15, 1970.)

For 1967 and 1968, beneficiaries of Medicare living in California received inpatient hospital services costing $643 million; 14 percent of the total Medicare bill for in-hospital care in that period. That care in California is more expensive than elsewhere in the country is indicated by the fact that, with 9 percent of the hospital admissions, and 18 percent of the ECF admissions in the country, California accounts for more than its share of all the expenditures of the program under Parts A and B combined. California's per diem hospital cost and medical insurance reimbursement per enrollee was the highest recorded in any State in 1969.

Few elderly persons in California would want Medicare abolished, for it has been of tremendous financial help even though getting that help is frustrating and reimbursement is often delayed. Recipients do not accept, without complaint, the fact that physicians are sending bills that are in their view, unconscionably high. For example, care rendered by a medical group to a woman with a broken hip resulted in doctor bills of $1,250—$750 for the surgeon, $150 for the anesthetist, and $350 for physician visits after the surgery. Medicare thought this excessive, too, and did not pay 80 percent of these amounts; the patient was out of pocket for the remainder since these physicians were not accepting assignment.[5]

There seems to be confusion in the health care field and in Social Security offices around the country as to the medical role of the extended care facility. The impression that results is that "tightening up the definition" has been done solely to tighten the purse strings, without any recognition of the useful role an ECF can play in providing for a continuum of care.

In a case the Special Committee on Aging has learned about, a 97-year-old woman who had to have "sitters" around the clock because of inadequate staffing in a suburban hospital, was denied any Medicare benefits for her stay in the hospital from the 21st day to the 49th day after she broke her hip, on the grounds she could be in an ECF. The hospital had already had current Medicare payments withheld on some cases to cover "overpayments" on care rendered other patients, reviewed months after the fact and payment retroactively denied. The administration was taking no more chances; regardless of the advanced age and physical condition of the patient, she received no reimbursement for a period when she was still helpless. One can only sympathize with a hospital whose cash position is jeopardized by the uncertainties resulting in the failure to honor the cost of care already provided in good faith. The hospital is then forced to attempt to collect from the aged person or his estate, neither course an easy or humane position for the institution.

Furthermore, the fiscal intermediaries do not relish having to confront hospitals with the changes in regulations that emanate from the Federal Government such as the proposed new regulations about reviewing length of stay earlier and the possibility of a charge to the patient starting on the 13th day. The books containing regulations,

[5] For further discussion of "assignments," see "Developments in Aging—1969," a report of the Special Committee on Aging, U.S. Senate, p. 27.

amendments to regulations, cancellations of previous rules, are thick volumes after 4 years of the program.

B. Medi-Cal—The Problems

Californians are well aware of the welfare medical program of the State, for it is constantly in the headlines, "Drastic Cut in Medi-Cal Service—Economy Move," "CMA Bitter Over Medi-Cal Cutbacks," "How Medi-Cal Cuts Affect People," to mention a few. To be continually in a state of agitation seems to be par for the welfare course in this State. Lawsuits are commonplace and injunctions and court opinions are sprinkled through the history of the program under the present State administration.

Confronted with a deficit said to be as much as $140 million, California State officials proposed several measures in December 1970 to reduce costs and services in the Medi-Cal program. To help trim back this announced deficit, a 10-percent cut in fees for providers was ordered. Additionally, the availability of certain elective services was postponed. Among the major cutbacks:

—Dentistry, eyeglasses, and hearing aids were virtually eliminated, except in certain emergency situations.
—Maximum per patient payments by the State to nursing homes were trimmed back by 10 percent, from $14 to $12.60.
—Prior authorization [6] was required for prescription drugs not listed on the new Medi-Cal formulary.
—For more than two visits per month to his physician, a sick elderly patient would require prior authorization.
—And certain ancillary services were reduced. Prior authorization is now required to visit a psychiatrist, podiatrist, optometrist, or chiropodist for more than once every 6 months.

This action precipitated vehement protests from many concerned groups, including physicians, druggists, nursing home operators, and the elderly themselves.

Among the major complaints:

—One of the important elements of good quality care is that there should be continuity in that care. Yet the arbitrary rules that are being injected into the California programs that treat with aged, ill persons are affecting quality adversely and probably increasing costs in the long run, even though they appear to be cutting costs. We heard of a public hospital—the County Hospital in Auburn—located in one of California's rural counties, where the staff doctors have a genuine regard for the patients they have brought along the road to recovery. The Medicaid rules say patients must be transferred to the proprietary nursing home on a given day. The county physician is no longer able to observe his patient since he is not permitted in the nursing home. But as soon as the patient has lost ground because of inadequate attention, she is quickly sent back to the county facility.

[6] There are constant complaints asserting that rules for prior authorization interfere with physicians' judgment on medical matters.

—And the cuts in payments by the State to nursing homes, from $14.00 to $12.60 (described by its critics as an arbitrary 10-percent cut) has meant cuts in service, food quality, and the amenities in many homes. Some homes have gone out of business rather than skimp on care.

—Trimming the Medicaid program to provide certain services only in emergencies automatically excludes many preventive services and precludes early attention. It is said that in California, one must be nearly blind to have eyeglasses authorized.

—The uncertainties that have been introduced into Medi-Cal by rulings, reversal of rulings, changes of the ground rules, etc., in the State's administration have a subtle deleterious effect which further penalizes the poor. Providers of services, particularly physicians, no matter how highly motivated they may be, are reluctant to go to or stay in low income ghetto areas with the economic uncertainties that have been injected into treating the poor.

—The comprehensive group practice plans that are providing broad coverage to a segment of the low-income population are also deterred from offering services by what they term the "accordion effect" of the method of administering the program. When the fiscal approach conflicts directly with the philosophy of prepayment for all of a family's medical care needs, the sufferers are the welfare clientele.[7]

Initially, it was feared that Medi-Cal consumers would overutilize the program; but there has been no substantive evidence to support this contention. Instead, a recent report on the Medi-Cal program—made at the request of the Governor—described numerous instances of (*a*) abuse of the program by providers; (*b*) failure of the State to develop an administrative mechanism that would make effective even the minimum potential of the program; and (*c*) failure by the State to take any action against program abuses, whether occasioned by providers or ineptness at the bureaucratic level.

III. WHAT IS HAPPENING IN ONE CALIFORNIA COMMUNITY

Halfway between Los Angeles and San Francisco there is a delightful smog-free town on the water. Morro Bay is becoming a retirement place for more and more people who leave Los Angeles in search of a less expensive, less crime-studded environment. They are buying little summer cottages or living in the older motels that no longer attract tourists. Some have a little money left from the sale of their urban real estate after purchasing a modest place to live in this community, so they have small investments to augment their pensions. Even so, numbers of people in this area are on welfare.

Unfortunately the town is not financially able to provide the kinds of services it should have for an ever-expanding aged population. And

[7] California officials have proposed additional cutbacks in the Medi-Cal program. For example, the May 1, 1971, issue of the Washington Post reported that officials from the California Department of Health Care Services have proposed to the U.S. Department of Health, Education, and Welfare that Medi-Cal patients should be charged $1 for each visit to a doctor's office; $1 for each prescription filled at the drugstore; and $3 per day for hospital or nursing home care. Existing Medicaid law precludes making these charges to the poor.

the voters, many of them living close to the poverty line, are unwilling to vote higher town taxes for even such essentials as municipal garbage collection or a transportation system.

Inquiries revealed that getting medical care in this town was a very real problem for the retirees. A total lack of organization in the delivery of health services was evident. The seven doctors in Morro Bay are already so busy that they refuse to take new patients and won't make house calls. Locating a local doctor for a heart attack victim proved impossible recently; the patient died en route to the nearest hospital where the fire department had to take him after wasting vital minutes trying to find a local physician to minister to him.

Medicare is considered a boon in this community, once the aged person gets into the hospital. A very real problem in trying to see a doctor for checkups or for "pains and problems" is the lack of transportation to the larger town where there is both a hospital clinic and a group of doctors practicing together so a physician is always available. The word has gotten around in Morro Bay that three of the seven doctors overcharge patients and will not take assignment from Medicare, nor will they see Medi-Cal (welfare) patients.

There is no public transportation to San Luis Obispo; a round trip taxi ride costs $14, a big bite out of a pension or welfare check. Old people hate to "be beholden" so they stay away from the doctor rather than ask friends or neighbors to drive them.

The town leaders recently conducted a survey and the returns didn't indicate that a private bus company could operate profitably. So they turned to the economic opportunity program. To quote one citizen, "This program has been fooling around for more than a year and there is nothing to show for it." Without subsidy for transportation, this situation will only worsen. The sentiment was expressed that "Uncle Sam should stop the war and put the money where it is needed."

Other health services are nonexistent or poor in this community. The Family Service Agency has folded for lack of financial support; the cuts in the mental health program made by the State could not be made up by the county and the town so the program collapsed.

The town has a rest home that a public health nurse living there feels should not have been approved by welfare as it is a fire trap, with poor food; no effort is made to provide recreation or rehabilitation. "The old folks just sit and rock."

All in all, a new health care delivery system, attuned to the very evident needs of the people seems to be the answer in this town. For example, a prepaid group practice plan or HMO located right in town, linked to the county hospital and having its own patient pickup and delivery system, would provide ambulatory services before serious illness meant an expensive hospitalization or unnecessary death.

The town just described is far from unique—the situation can be duplicated over and over. Increasingly, as the departure of older people from the inner city becomes more pronounced, small towns are going to find themselves confronted with older people desperately in need of services the community feels it cannot afford on its slim tax base. The dilemma of the small towns is as real as that of the inner cities.

CONCLUSIONS: MEDICARE AND MEDI-CAL

With the enactment of Medicare and Medicaid nearly 6 years ago, a two-prong approach was adopted to make high quality medical care available for older Americans and others, regardless of age, who are unable to afford such services. But today these goals are being compromised. Recent action at the Federal and State levels has led to sharp cutbacks in coverage, forcing aged persons to pay increased expenses from their limited budgets. Coverage under Medicare is in retreat, and seems to be disappearing. The Medicaid program is also endangered. And many older persons must do without the care they urgently need.

Commenting on the seriousness of the situation, the President's Task Force on Aging pointed out last year:

> Health care expenditures in the United States are second only to those for national defense. Every sign points to further increase. Despite this there is evidence that the American people, especially the elderly, are not receiving the health care they need and for which they are paying.

Moreover, the Task Force added, "Medicare and Medicaid leave serious gaps in coverage and also force unnecessary use of scarce and costly hospital facilities."

In order to assure greater security in retirement, it is essential that we, as a nation, must resolve the medical cost problems which pose an imminent threat for those living on fixed incomes and forestall every alternative for genuine economic security for 20 million older Americans.

APPENDIX 2

MATERIAL SUBMITTED BY WITNESSES

ITEM 1. EXHIBITS SUBMITTED BY LILA H. KEISER, COUNCILWOMAN, MORRO BAY, CALIF.*

EXHIBIT A—LETTER PERTAINING TO TRANSPORTATION FROM MORRO BAY TO SAN LUIS OBISPO.

MORRO BAY, CALIF., *April 29, 1971.*

TO THE EDITOR: Upon reading about the findings of Mrs. Brewster regarding our problems, the oldsters of course, I simply must comment. My husband (aged 85) and myself (age 74) have been without transportation for five years. This problem becomes acute very often—for instance it took a month to find somebody to take me to Sierra Vista for some very necessary barium X-rays. I had a colon X-ray which has left me absolutely helpless. I wanted to stay at the hospital over night for another X-ray—but no beds. So I have to wait to recuperate before I go for another one.

We live in a trailer park. Plenty of people and lots of cars but not one offers to take us to the Market. They act like we do not exist. Trailer people are not what they were ten years ago. And—yesterday when the Bulletin was delivered—every trailer received one but us—we had to go to an empty trailer to get one. Looks like every body is out to do us in.

One other thing, I have been trying for a year to get a woman to clean house for me. Not a chance. I can't do it myself so I feel we are living in filth. A woman advertised for housework in your paper. I called her but what she wanted was an office job.

Everything is such a mess. I don't see how Mrs. Brewster can do any good—all talk and nothing else!

It's about time people loosened up and tried to do something about the problems of the old people. We are absolutely helpless, you know. I just wonder how much longer an 85-year-old man can walk and carry groceries.

If this is not coherent—I'm sorry—I'm just too sick.

Sincerely,

EXHIBIT B—NONEMERGENCY SERVICES REQUIRING PRIOR AUTHORIZATION

Type of provided service and pertinent regulation	*Prior authorization required for*
Physicians' services 51305	(a) Cosmetic surgery; (b) Eye refraction; (c) More than two outpatient (all types) visits per calendar month (per beneficiary); (d) More than one outpatient psychiatric visit within a 6-month period (per beneficiary).
Dentists' services 51307	More than one visit within a 6-month period (per beneficiary).
Services of chiropractors 51309 (a).	More than one visit within a 6-month period (per beneficiary).

*See statement p. 5.

Services of podiatrists 51309 (b)	More than one visit within a 6-month period (per beneficiary).
Services of optometrists and opticians 51309 (c).	More than one visit within a 6-month period (per beneficiary).
Physical, occupational, speech therapy, and audiology services 51309 (e).	More than one outpatient or one nursing home inpatient visit within a 6-month period (per beneficiary).
Psychology services 51309 (f)	More than one visit within a 6-month period (per beneficiary).
Home health care services 51337	More than one visit within a 6-month period (per beneficiary).
Prescribed drugs 51313/59999	(a) All drugs not listed in the Medi-Cal formulary; (b) All drugs listed in Medi-Cal formulary preceded by # sign (except drugs for hospital inpatients).
Nursing home services 51335	Admission and extension of stay.
Inpatient hospital services [3] 51327.	All services (emergency admissions must be so certified by the attending physician).
Hearing aids 51319	(a) All hearing aids; (b) any repair service costing more than $10.
Eye appliances, prosthetic eyes 51317.	Any appliance or repair costing more than $6.
Prosthetic and orthotic appliances 51315.	Any appliance or repair costing more than $50.
Assistive devices (durable medical equipment) 51321.	Purchase price, cost of maintenance, repairs or cumulative rental exceeding $50, ($10 if for nursing home inpatient).
Medical transportation 51323	All nonemergency medical transportation (except for admission to or discharge from hospitals or nursing homes up to 25 miles).
Hospital outpatient services and other outpatient services (use appropriate regulations).	See appropriate requirements for pertinent service listed above.

[1] Emergency amendment effective January 11, 1971.
[2] Covered only as an institutional service.
[3] Refer to length of stay guidelines.

Exhibit C—Home Health Service Agency

The Home Health Service Agency of San Luis Obispo county is a non-profit, self-supporting organization which works as a subdivision of the County Health Department and provides home health services to patients under medical supervision regardless of age, race, creed, or national origin. Because it also provides services under Medicare, it has to comply with regulations set forth by the Department of Health, Education, and Welfare.

According to the Social Security Act, the term "home health agency" means a public or private organization which:

(1) Is primarily engaged in providing skilled nursing services and other therapeutic services.

(2) Has policies established by a group of professional personnel which govern the services provided

(3) Maintains clinical records on all patients

(4) Is licensed according to law

(5) And meets other conditions of participation as the Secretary of Health, Education, and Welfare may find necessary in the interest of the health and safety of indiyiduals receiving services through such organizations.

PRIMARY FUNCTION

The primary function of the Home Health Service Agency is to provide skilled nursing services on a visiting basis in a place of residence used as an individual's home.

In addition to skilled nursing services, provided by or under supervision of Registered Nurses, the Agency provides physical therapy services and home health aide services to homebound patients on a part-time or intermittent basis.

Most patients who qualify require service a few hours a day, several times a week. Some may require longer service on one day than on other days, or daily services for a limited time.

Decisions on the desirability and practicality of accepting patients for care are based on medical, nursing, and social information provided by the physician responsible for the patient's care, by institutional personnel, and by staff of the home health agency. Anyone within the county who is under medical supervision is eligible for care.

Fees for private patients are based on ability to pay according to a sliding fee scale. Medicare and Medi-Cal patients pay according to regulations. The patient furnishes his own medications. The agency has equipment and supplies available at no extra cost to the patient. Durable items such as hospital beds, wheelchairs, commodes, Bennett Pressure machines, Incubators, etc., are available on a loan basis. Expendable items, such as dressings, catheters, syringes, etc., are supplied to the patient.

All services and items provided to patients are specified under a plan of treatment established and regularly reviewed by the physician who is responsible for the care of the patient. All Medicare patients need to be certified and re-certified as to the need for services.

The original plan of treatment is signed by the physician responsible for the care of the patient and incorporated in the records maintained by the agency for the patient.

The total plan is reviewed by the attending physician, in consultation with agency professional personnel at such intervals as the severity of the patient's illness requires, but in any instance at least every two months. The professional registered nurse or the physical therapist are expected to bring to the attention of the physician changes in the patient's condition which indicate the need for altering the treatment plan or for terminating services.

Objectives of home health agency:

(1) To assure continuity of care for patients leaving the hospital.

(2) To meet the needs of the individual. It avoids separation and keeps the patient in a familiar environment.

(3) To free precious hospital beds for those who require hospitalization.

(4) To minimize cost to the individual or to the community if the family is medically indigent.

(5) To provide the opportunity for family health education and for medical guidance.

(6) To allow people to assume more family responsibility when acute illness strikes or when long term illness prevails.

(7) To provide the opportunity to discover other health problems in a family for referral for medical or rehabilitative service.

(8) To provide assistance to the physician and families in accomplishing discharge from the hospital at the optimum time.

In conclusion.—Visiting Nurse Service is Professional nursing care at home including bedside care, specific nursing procedures, physiotherapy, health supervision, nutrition guidance, the teaching of a nursing skill, appraisal of a family or attendant's ability to cope with a home situation, evaluation of the family's attitude toward medical care, and other specific medical care prescribed by a physician. The nurse is strictly under orders of the attending physician and all records are confidential. Reporting back to the doctor on the patient's condition is her responsibility. Our aim is to assist, in cooperation with other agencies of the community, the promotion of health and the prevention of disease.

ITEM 2. REPORT FROM DR. JOHN A. SMITH *

I have been asked to relate to the committee the impact of reductions in expenditures of State and Federal funds on medically indigent patients of Los Angeles County. This report is based on the observations of myself and my colleagues at Los Angeles County-USC Medical Center. I hope to convey something of the sense of isolation and frustration of the patients who obtain primary care at our hospitals.

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* See statement p. 12.

Los Angeles County-USC Medical Center comprises a large general hospital, women's hospital, pediatric pavilion, and psychiatric unit with a combined average daily census of approximately 1,800. About 3,500 people attend our outpatient facilities daily. As in other communities, our primary function is to provide medical care for those persons unable to obtain it in the private sector. The individuals fall into basically four classes:

(1) Those individuals not receiving governmental financial assistance and unable to afford private sector medical care.

(2) Those individuals receiving or eligible for financial assistance but unable to obtain private sector medical care.

(3) Those individuals in need of specialized care unavailable in the community.

(4) Those individuals requiring emergency care unavailable in the community.

The adverse effects of decreased funding affect all groups in a general way but are particularly devastating to those receiving assistance and unable to obtain private sector care. I cannot accurately characterize for you the demographic features of these groups, but those most affected by budget cuts are the very young, the very old, and the disabled. Individuals and families receiving old age assistance, aid to families of dependent children, aid to the totally disabled, etc. are disproportionately represented in our patient population. Diminished funding affects not only their medical care but, since many require outpatient services such as home health aides, attendances, VNA visits, etc., their pattern of life may be disrupted.

The county hospital system provides "elasticity" to the community health care delivery complex by accepting all of those unable for whatever reason to obtain private sector care. We cannot turn away patients because we have filled our beds or because we are understaffed. In the past, less than adequate care at the county hospital was accepted because of the Poor-Law mentality surrounding medical care of the indigent. However, rising costs and increasing numbers of elderly have increased the numbers of the medically indigent to include many individuals not easily classified as "charity cases." Further, recent cutbacks in medical funding coupled with increasingly complex and seemingly pointless administrative procedures have contributed to a decrease in the ability and inclination of private sources of health care to provide care to MediCal recipients. Professional associations have advised their membership to refer any MediCal recipient to the county hospital if the practitioner cannot or will not handle the requisite paperwork.

The current financial recession in Southern California has also increased the potential patient population of the county hospital. These factors probably explain the recent upturn in admissions at our hospital, this is the face of several years of decrease. It is too early to assess the ultimate effects of these budget cuts on our admissions, census, and outpatient visits with any degree of accuracy. However, in January and February of this year our admissions were 8,353 and 7,729 respectively. For the same months in 1970 the numbers were 7,861 and 7,208. Those data can be summarized as an increase in monthly admissions of approximately 500 patients. I might point out here that nearly one-half our admissions are MediCal recipients and that 10% of these are referred to us from private physicians.

Several phenomena have conspired to diminish the capacity of the county hospital to respond to demands for health care and these same factors have increased the population seeking care there. Inflation of costs of medical care are too often implicated as the sole cause of increasing medical expenses. But, as medicine advances, more numerous, sophisticated, and expensive examinations and therapies evolve, continually adding new costs. Further, as the level of education improves so does the demand for medical care. Onto this pattern of increasing costs and increasing demand, there has been recently added public desire to reduce taxes. Political pressure has led to efforts at all levels of government to reduce expenditures. I hope others have clarified for you the fiscal complexities of Medicare, MediCal, and categorical assistance programs in this county. They are not clear to me. It is apparent that funding under the option method of the MediCal program has been insufficient here for several years.

Since early in this fiscal year, efforts have been made within the Department of Hospitals to reduce this year's predicted deficit. Among these efforts has been an almost total freeze on new hiring. It is worthwhile examining the hiring

freeze for it demonstrates how the inflexibility of beauracracy can be self defeating. The county administration, rather than simply restricting spending in its various departments, involved itself indirectly in management by ordering the institution of specific economy measures. Among these was a hiring freeze. Medical personnel staffing is characterized by high turnover and as people left they have not been replaced. This has led to decreased staffing in many critical areas with decidedly adverse and occasionally catastrophic effects on medical care. This has led to reduction in service by:

(1) The Department of Radiology;
(2) The Pulmonary Function Laboratory;
(3) The Clinical Laboratories;
(4) The Department of Anesthesiology; and
(5) All nursing services.

The self defeating aspects of these cutbacks are, at best, pathetically humorous. Because of insufficient state funds, the county instituted a hiring freeze. The freeze included the clerks necessary to process the required preauthorization forms and extension of stay forms for MediCal patients. This, in turn, has led to a backlog now approaching 3,000 such requests Each unfiled request represents a loss of revenue to the county.

The county operates a large and excellent school for clinical laboratory technologists and recruits heavily from its graduates for its own laboratories (80% of the graduates stay on). With the hiring freeze the expense and time involved in training these personnel has not changed, but the hospital cannot hire its own graduates.

The clinical Biochemistry Laboratory has never, recently, been capable of performing all the requested tests and the county has sent the excess to a commercial contract laboratory at a cost of about $50,000 per month. Each clinical biochemistry technologist produces for the county about $100,000 worth of tests per year. Employment of six such technologists at an approximate cost of $75.000 per year would result in a saving to the county of over $500,000 per year. But by executive fiat expensive contract work in preferred over doing our own.

A critically important but unrecognized function of the Department of Radiology is maintenance of file of a file of its films so they are rapidly accessible. Because radiology file clerks cannot be hired, access to films is so delayed it is frequently quicker to repeat an expensive study than to find a prior one.

Another inadequacy of the Radiology Department which is unequivocally due to understaffing is the insufficient capacity for emergency studies. Despite adequate equipment and professional staffing, the lack of trained X-ray technologists frequently delays important studies until the reason for obtaining them has passed.

The Department of Anesthesia has been dangerously compromised by the inability to replace damaged equipment and to recruit necessary personnel. Anesthesiologist, surgical technicians, and operating room nurses are all too few. Despite appeals by the Hospital Administration for emergency authorization for hiring, no new personnel have been permitted. This means inadequate personnel to staff the operating rooms and recovery rooms, and leads to potentially tragic delays in operations. So many surgical emergencies are admitted that they must be taken for their "emergency" procedure on a simple first come first serve basis. The inexorable and agonizing delays which result must eventually, if they have not already, lead to an avoidable death. All physicians involved know that, in the words of the Hospital Administration, there is "no legimate defense to the accusation of neglect in this area."

The Recovery Room (Post Anesthesia Room) is plagued by vacancies in its roster of Registered Nurses. This had led to closure of this life sustaining facility for as many as five nights a week. The jeopardy in which this places the patient who is sent directly from the operating room to a general surgical ward is obvious to all.

Innumerable less obvious, but no less significant, examples of diminished capacity to deliver care could be cited, all to county budgetary cutbacks in response to reduced MediCal funding. The inadequacies lead to less efficient utilization of facilities and hospital stays are prolonged. This aggravates the problems of understaffing, demoralizes the patient, and increases the Country's costs.

These examples are cited to show how decreased funding is translated into decreased services. The decrease in service capacity leads to frustration of the involved health professional and the inability of the Administration to deal

with his grievances leads to a sense of isolation. With frustration in work and insensitivity of the administrative bureaucracy is it surprising that resignations are tendered?

Although it is an unavoidable risk, the following specific individual examples of suffering are not presented in an effort to foster macabre sensationalism. Anyone who has dealt with a large, inflexible, and insensitive bureaucracy will be sympathetic. These examples are only more heartrending because the stakes are higher and the suffering more immediate.

E. C., an 85 year old man, lives with his son. The patient suffers from diabetes, arteriosclerotic heart disease, and cerebrovascular disease. These words indicate only that this is a tired old man, growing senile, but with the care of a daily attendant, able to live with his son during his last days. His allowance for attendant care has been reduced by nearly two-thirds and he no longer can stay with his son, who must work, but must be placed in a nursing home.

N.W., a 62 year old lady, lives alone with the assistance of a full time attendant. The patient is completely disabled by rheumatoid arthritis and is bedridden. Her attendant care allotment has been reduced by over one-half and she can no longer stay in her home but must be moved to a nursing home.

E.M., is a 76 year old lady with arteriosclerotic heart disease; aortic aneurysm, and high blood pressure. She is very weak, walks with a cane, but lives, with the aid of an attendant, in her own home. Her allowance has been cut to one-third and she will have to go to a nursing home.

Z.L., another 76 year old lady, is totally bedridden, is incontinent, and needs complete personal care. Her daughter had been caring for her and has received payment as an attendant. However, the daughter's only income is a small pension she received on the death, from cancer, last year, of her husband. The patient's allowance has been reduced to the point that the daughter can no longer pay her expenses and she must place her mother in a nursing home.

A.W., a 79 year old woman, lives with her disabled daughter and did receive $171 a month. This was reduced to $100 a month because the daughter was expected to contribute to her mother's care from her disability payments of $78. a month.

It is possible for a competent physician who is particularly assiduous in his investigation to find in retrospect some way to have, at least temporarily, extended the life of any patient who has died. The following are not such cases. They were brought to my attention by the physicians involved, fully cognizant of their own risk of litigation, for the canons of the American Medical Association consider it unethical to place oneself in a situation in which a physician cannot practice medicine of a standard acceptable in the community. There are times when we find ourselves in such a situation. Some of the following tragedies do not involve aged patients, they are, perhaps, even more tragic.

Patient A, an 89 year old male, died of uremia. Although it was suspected that this was due to obstruction of the lower urinary tract which might have been relieved surgically, the radiological studies necessary to prove this were cancelled becaues there was no one available to transport the patient to x-ray for the studies.

Patient B, a 74 year old woman died of peritonitis secondary to obstruction of the common bile duct. Although her age and the gravity of her illness made her a poor surgical risk, she might have survived an operation. However, no operating room was available because of understaffing, and she expired before an attempt to operate could be made.

Citation of similar examples of beauracratic bungling, thoughtless deprivation of the aged, and tragic loss of life could be pursued "ad nauseum". If anyone feels these are isolated and typical examples of an otherwise smoothly operating system, I can present them with ten times as many specific problems as I have here. I expect, at best, skepticism for those who peruse this report. For nearly two years now similar statements addressed to county and state agencies have been essentially ignored.

The elderly patient frequently receives outpatient care from a private source but, when hospitalization is required, is referred to a county facility. Vitally important records seldom accompany the patient as he moves in either direction. This ping-pong movement of patients is obviously inefficient and, worse, is demoralizing and frustrating to all involved. Unification of welfare programs and improvement of communication among social service agencies, private physicians, and the county medical complex would greatly diminish the current fragmentation and inadequacy of care.

To recapitulate, reduction of Federal and State supplementations of county welfare funds has led to deterioration of the medical care of the elderly of this county. This reduction in service is manifest in two objective areas, that is decreased capacity of many aged to sustain their pattern of living and diminished medical funding. The administrative complexities and limited benefits of available medical aid programs to other fragmented and episodic health care with little attention given to health maintenance.

I hope these anecdotes convey to you the frequent despair and desperation experienced by our older patients and families. To simply pour more money into a system which has proven itself inadequate, is certainly not the only answer. I share with most other physicians trepidation as governmental agencies become more involved in our health care system. This trepidation is enhanced by my experience with governmental beauracracy here in Southern California. An overhaul of the health care system is essential, and it is vitally necessary that all health care consumers and providers are involved in planning if an intelligently conceived system is to evolve.

ITEM 3. PREPARED STATEMENT OF DR. HUBERT L. HEMSLEY,* M.D.

As President-Elect of the Charles R. Drew Medical Society, I want to thank you for extending to me the invitation to appear before you to give voice to my concerns about the health care problems of the elderly and poor. In order to respond intelligently and put the recent Medical, Medicare cutbacks in their proper perspective, one must be aware of the current atmosphere concerning the health care crisis in this country, especially as it pertains to the elderly, the poor and minority groups. The complexities of aging and poverty, when combined with race, have created an environment where we merely postpone death rather than enhance life. If this society were to be evaluated and judged on the way in which we care for our elderly, poor and our minority people, I am deeply afraid that we would fare only a little bit better than more primitive societies who utilized death and abandonment to solve the problems of the nonproductive members of their society. While the entire medical and political community of our country, i.e., AFL–CIO, the Kennedy Committee for National Health Insurance, American Hospital Association, large insurance companies, even the AMA and the president are striving *forward* to make quality health care available to all Americans, the Reagan administration is taking a giant step *backward* against the aged and the medical indigent of California! The consequences of such actions are both immediate and delayed. The immediate effects of the cutbacks are:

A. HEALTH RESOURCES

The McKone Commission indicated that there existed a ratio of physicians to population of 127 physicians to 100,000 people in the greater Los Angeles area while in the Watts area, there were 38 physicians to every 100,000 people. The ten percent cutback places an economic lid that will further restrict existing medical providers and prevent establishment of new facilities. In effect, it will rape the ghetto of its present medical resources! Those physicians whose practices consist of only ten percent of the elderly and medical indigent have already stopped seeing these patients rather than accept the responsibility for their health and be forced by bureaucratic guidelines to render second class care. Those doctors whose practices consist of fifty percent or more of the elderly, the poor, minority groups will be forced to further subsidize this program.

B. NURSING HOMES

Under the impact of the new cutbacks one of our nursing homes is already closed and many more will close forcing the old and disabled back into antiquated county custodial facilities far removed from their communities to die.

C. EMERGENCY HOSPITALIZATION

The emergency rooms of both public and private hospitals have experienced a drastic increase in case loads causing delay in therapy and eventually death to some unfortunate person.

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*See statement p. 18.

D. OVERLOAD OF PUBLIC HOSPITALS

The public hospitals which have recently been indicted by the interns and residents because of their inability to provide quality medical care in face of the increasing daily case load will be further inundated and able to effectively cope with only emergency life and death procedures adequately. All preventive and rehabilitative programs will suffer! We may well see another social crisis equal to the Watts Revolt if the aged and poor are unable to obtain needed medical services and die as a result.

E. MORBIDITY AND MORTALITY

The mortality and morbidity rates of the poor—when compared to middle class America have increased. A survey concluded in June of 1967 found that over 96 million people in the United States suffer from chronic ill health. This represents almost 50% of the population of the entire nation. More than 72% of the population between 45 and 64 years of age and 86% of persons 65 years and older have chronic health conditions. The life expectancy of the nonwhite population in 1965 was ten percent less than that of the white population, 64.5 years compared to 71 years. IRONICALLY, THE AVERAGE BLACK WILL NOT LIVE TO RETIRE AND UTILIZE HIS OLD AGE PENSION!!

All data indicates that the consequences of chronic health ailments in the aged and in the nonwhite population is more severe than in the white population! The consequences of illness appear catastrophic for low income groups. There is a greater incidence of stroke, heart disease, mental illness, and hypertensive conditions in nonwhite populations as compared to the white. Could this be attributed to the social pressures stemming from racism? In July of 1963 through June of 1964, the white population reported an average of 4.7 visits to physicians per person compared with an average of 3.3 visits per person among the nonwhite group. Dental visits in the white population average 1.7 per person per year and in nonwhite population 0.9 visits per person per year. Look at it in another way. About 67% of the white population, and 56% of the nonwhite population saw a doctor once a year prior to the 1963–64 survey. Of an estimated 183 milion persons in the civilian non institutionalized population in the period of July 1962 to June 1963 approximately 23 million persons or 12% were living in families with incomes of *less than $2,000.* About *18%* of the population had family incomes of $2,000 to $3,999, 39% were in the $4,000 to $6,999 bracket and 31% had incomes of $7,000 or more. The 23 million persons living in families with less than $2,000 annual income were rather evenly distributed amongst the age groups. Roughly ¼ in each of the age groups under fifteen, 15 to 44, 45 to 64, 65 years and older. Probably the most marked difference in population by family income are those by *race.* As income level increased the proportion of nonwhite persons decreased. 96% of people living in families with income of $7,000 or more were white and 4% nonwhite.

During its first year Medicare had made substantial improvements in the care and treatment of the aged. There have been over 5 million admissions representing about 4 million persons for inpatient hospital services representing a 15 or 20% increase in utilization of services by older people. There are some difficulties, however. Primarily those in administrative and budgetary restrictions, difficulties in obtaining prompt payments of claims problems resulting in the fact that 36% of the nation's doctors do not accept any assignments under Medicare as reported in the Journal of the American Geriatrics Society in 1967. Historically the government has played a role in health care for 170 years. President John Adams authorized care for merchant seamen in 1798 by establishing the Public Health Service which was recognition that the government had responsibilities for the health of its citizens. This recognition has been carried on in recent legislation. The Medicare and Medical legislation mark the entry of the government into the financing of health care and while it is not a perfect measure it is a step toward insuring proper health care for all. The future of federal provisions for health care remains to be seen. But if the goal of optimum service for all is to be reached, a truly comprehensive program must be devised. Individuals must achieve ecological balance with their environment if we are to have total health. This means housing, employment are a major part of any health provisions.

You might ask yourself how did we get into this position? We must recognize now that one in every ten Americans has reached or has passed the 65th birth-

day. Accounting for some 20 million Americans above the age of 65 with approximately 12,000 above the age of 100, it is estimated that by the year 2,000 (some 30 years hence) that we will have 65 million people over 65. Expressed in other terms this indicates a net rate of approximately 900 a day or 330,000 a year. Much of the same problems face 18 million people between the ages of 55 to 64. Historically, in the Rome of Catos' day the average length of life was 22 years. In Montagnes day in France it was 33 years, and at the turn of the century, the average length of life in the United States was 47.2 years. It is quite evident then that the problems associated with old age were not overwhelming at any other time in our history. People *just didn't live long enough* for problems on any large scale to develop especially if they happened to be black and poor.

We must always remind those who are preoccupied by the wonders of our affluence and technology that beneath it all there is a large segment of poverty. The poor of America are suffering no temporary aberration, but are subjected to a persistent and constant degrading suppression of their independence and individuality throughout their lives, relinquishing whatever chance for humanity they ever possessed. Under the driving and crushing impact of the Triple Revolution we have placed many Americans under the Triple Jeopardy of age, poverty and racism. The casualties of technology, automation, and cybernation are not accidents! They are produced by many factors which are known by our industrialists and politicians. Perhaps half of the aged poor are *newly poor* and if the fears of the Triple Revolution analysts are realized then cybernation will lead to another group of poor, formerly well-off workers displaced into long term unemployment by new productive servo-mechanisms resulting in an enormous shift of the employed work force out of manufacturing and into services usually under governmental programs. This hardly means that a displaced auto worker becomes a government clerk because he neither trained nor has the inclination for that sort of work. We are now discovering as with space workers that the new job, after months of search, is apt to be a poor one in relationship to the previous job or he may very well remain unemployed. Meanwhile most of the new entrants into work force at the rate of 1.5 million a year find no jobs or go to work part time at low pay generally in the service area.

Consequently the economy has a frozen unusable industrial reserve which is increasing with no probable relationship to the affluent functioning segments of society. Advanced mechanization and automation are substituting machines for men with increasing frequency. Control over machine itself is exercised by machine. An industrial measure is done electronically. The outcome is a movement out of the skilled occupations into the semiskilled accompanied by unemployment and these shifts strike most directly at the aged, to the poor and the nonwhite. By this analysis the aged and the poor and the nonwhite in this technological society have become *obsolete!* They can no longer compete with machines! And have become a conglomerate collection of economically and socially useless persons exploited by demagogues and played upon by politically motivated people SUCH AS WE HAVE IN SACRAMENTO! Just what is poverty and who are the poor? Poverty seemingly is harder to find and even harder to measure. I would agree with Webster that "poverty is the quality or state of being poor or indigent". But, like all definitions that are not controversial, it is also *not* very meaningful. It is only when Webster attempts to elucidate his meaning and equate poverty with need, destitution and inadequacy that the true nature of poverty comes in focus. Garbreigh, for example, considers people as poverty stricken when their income, even if adequate for survival, falls markedly behind that of the community.

Several years later Leon Keyserling placed the poverty line at $4,000 for a family of two or more persons, and at $2,000 for unrelated individuals. On this basis he estimated that about ⅕ of the nation, 38 million Americans, lived in poverty in 1960. Building on Keyserling's estimate, Gunnar Myrdal concluded that more than 12½ million Americans or nearly 7% of the population lived in utter destitution which he defined as less than $2,000 per year for families of two or more persons and $1,000 a year for unrelated individuals. Attention must be called to the *great diversity* that exists amongst the poor. Poverty is not just a black problem, a California problem, a southern problem, an unemployment problem, a problem of the aged, it is all of these and then more. You must note that 31% of the poor are aged and 17% represent broken families. Their poverty has little to do with unemployment, yet together these groups account for nearly half

of the poor. Negroes account for only approximately ⅕ of the poor. Medical science then seems to be adding years to life while politics are adding misery and poverty to those years. There is a myth about the aged and nonwhite that they do not need as much money as the younger and middle class people. This is presumably because older people typically spend less on clothing, housing goods than younger families (but more on medical care), and blacks don't need as much money as whites because they require only enough food to buy low-cost food items such as chitlings and fat backs and turnip greens and seemingly are happy with hand-me-down clothes, two dresses and one pair of shoes.

I don't think that we can truly point with pride to our system of old age insurance as having accomplished the original purpose of insuring adequate income to the aged. OASI (Old Age Security Insurance payments) amounts to no more than 2% of our gross national product. If we add all other types of federal programs, the expenditures to the elderly might amount to 4% for population segment is about 9% to 10% of the total population. The greatest obstacle is the failure at all levels to appreciate the unique nature of the problems that must be faced head on in this truly, truly great social problem. If affluence and poverty continue to confront each other, a class warfare will develop and the shock of the encounter may indeed shatter our nation. The paradox of poverty in the midst of plenty cannot continue! Those of us who are over 30 say that "we know what it's like to be poor" which was the way we lived during the great depression. That is somehow taken as an automatic qualification. Right wing action, particularly that as represented by the Reagan forces, is clear and quite predictable when the legitimacy of our system is questioned in any context. They argue that the fault lies with the poor for being lazy or stupid and not taking advantage of opportunities. If you are John Wayne it is because you are a white supremist and superman in cowboy clothes or Senator Goldwater who tells our poor "you earn your keep or you get out and stay out."

Thus, conservatives make no effort to conceal their reliance on maintaining the status quo. They quite frankly do not want to change the present distribution of wealth or to see that the nation as a whole benefits from the Triple Revolution. They seem to think they're successful because they first deserve to be successful while others are poor because they are inately incapable of doing any better. Thus, we see that the Reagan administration in its zeal for law and order, and its attack on the welfare system, has seen fit to make POVERTY A CRIME and state in no uncertain terms that the poor, elderly, indeed deserve their poverty and they are on welfare because they like idle comfort. I firmly believe that ⅕ of the deaths among poor whites and ½ of the deaths among nonwhites are deaths that would *not* have resulted if economic differentials did not prevail. It is very clear that adequate medical services do *not* exist at the present time for the aged, poor and minority people. Public as well as private health facilities are inadequate to handle the present case loads and when inundated with more patients as a result of cutbacks, only increased morbidity, mortality and possibly revolution will result.

In view of this knowledge which is *common* and in light of the recent cutbacks of medical service the questions must be asked: Are higher morbidity/mortality rates amongst the poor DESIGN OR ACCIDENT to the extent that the men in Sacramento HAVE KNOWN and DO NOW KNOW that inadequate medical care for the aged and poor and the nonwhite segments of our communities KILLS, that infection spreads and KILLS, that social pressures arising from repression, poverty and racism KILL! We *must conclude* that the *aged* and the *medical poor of California* are the *first victims* of *Reagan the Hawk's war* on welfare as he *prepares for his try at the White House.*

ITEM 4. PREPARED STATEMENT OF REVEREND JOHN G. SIMMONS*

I am John G. Simmons, the Administrator of Pacoima Memorial Lutheran Hospital and an ordained Lutheran Minister. These two professional endeavors have, indeed, the same basic purpose. That is, to help others.

History will record the judgment of our society, not by our technological achievements, not by our great affluence, not by a man walking on the moon, but by the treatment we accord our aged, our infirm, the lame and the halt. A society is judged by what it does or fails to do for those least able to help themselves.

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*See statement p. 23.

The scripture says "Cast me not aside in my old age" and "I have given you the choice between life and death; choose life."

Have we, as a society, performed well and nobly? We enacted in 1966 Medicare Legislation and we looked to this legislation to provide a protecting umbrella over the effects of illness to those of our society who are 65 and older. But the umbrella is weak, it has many holes and oft times its shelter is too small and too inadequate.

What have been the effects of Medicare on the cost of health care, on the quality of health care and how has it performed the functions which the legislature had intended?

Not well. Not well at all. Since 1966, the cost of medical care has risen precipitously. The physicians of this country, in spite of their opposition to Medicare, have greatly profited from the bounty of Medicare. Last year the U.S.A. spent over seventy billion dollars on medical care, seven per cent of our gross national product, and yet, with all these tremendous sums of money, the quality of care, the availability and accessibility of care has left the aged hardly better off than they were before. I submit to you that Medicare is a valiant attempt to solve the problem of illness among the aged, but it looked toward a solution which was purely financial, which did not concern itself with the delivery of care, the quality of care and the accessibility of care. All that Medicare provides are dollars. Dollars, as we have see nover the past five years, are simply not enough.

Let me explore with you for a moment the "availability of Medical Care." There exists a tremendous mal-distribution of physician and paramedical personnel in the United States. Why should not this society insist that every doctor go, for at least two or three years, where he is truly needed? Let us remember, that we, the taxpayers, subsidize the education of every physician by at least $50,000.00 in direct tax subsidy. When was the word service erased from the shield of Aesculapius?

To what avail is the protection of Medicare to those who cannot reach the facilities, the physicians and the hospital? To what avail is the financial protection of Medicare to those who, after they reach a physician or facility, must wait interminable hours to receive the professional services.

The effect of the maldistribution of medical manpower ranges from poor to the disastrous and it will not be solved by legislating more money. It will be solved by paying more to fewer people. It will find its solution only when we face, with courage and with dedication, the issue that physicians, nurses and all health personnel who are subsidized in their education by an ever beneficial government, must repay this beneficince in "service." In my own area, the Northeastern part of the San Fernando Valley of California, even though it is accessible to the huge metropolitan area of Los Angeles, we find shortages of physicians, nurses and other personnel, as well as shortages of hospital beds and health facilities. . . . Shortages which have serious effects on large numbers of the economically depressed population. Let me interject here that statistics alone do not tell the story. There may be an adequate number of beds, statistically, but the question of the services that these beds indicate may be too poorly distributed to provide needed facilities to the aged. And let me here cite just one example: The most critical shortage in the Northeast Valley of Los Angeles, for that matter, in the entire State of California and, possibly, the entire nation, are rehabilitation facilities for that huge "hidden minority" of those of our citizens, over 65 and under 65, who are permanently disabled and yet who could be rehabilitated if we had the vision, the personnel, the facilities and if we were willing to expend the money. The lack of rehabilitation facilities is one of those statistical mirages which our so-called planners hide under their all pervasive carpet of statistical falsehood. There are no rehabilitation facilities in the Northeast San Fernando Valley. The nearest is either in Pomona or in Downey and there is nothing in between and yet there are thousands, literally tens of thousands, of disabled persons who could be brought back into the stream of society if there were qualified, competent rehabilitation services available to them. Nothing dictates the chronological line at age 65. How many men and women have served throughout the history age 70, 80 and 90?

It is our obligation to extend the benefits of Medicare, make it possible for these people to serve society, to lead useful and productive lives.

Now, let me address myself to the "quality of care," directly related to our failure to deliver to our people, Medical services and healing care at a price which is reasonable. Belatedly, now, and however late it is, all of us have begun to recognize and accept the fact that Medical Care is a "Right," an inherent right of every citizen of this land, and not a Privilege. But to have an "inherent right" must be defined as CARE, available, accessible and of high quality. And look at the question of "Quality of Care." The American Medical Association has said that it, and it alone, will protect the public as it relates to the quality of care. And it will brook no interference from anyone. And yet, they have admitted that among their membership there are incompetent physicians. But I ask you to investigate how many physicians in the United States in 1970 have lost their license because of "incompetence."

In the hospital setting, we have committees and we diligently and valiantly try to maintain and improve the standards, but no one watches the physician in his private office. No one sets standards, no one decides upon the quality of care. And so I submit to you that Medicare has not fulfilled our hopes—it has not created the security for our citizens over 65 which they deserve of us and it has not done so because we have failed to recognize that we cannot solve the problem by more and more dollars. That solution to the problem lies in a new, completely revised assessment of the delivery of health care services. And we cannot achieve it by "compromise." We cannot achieve it unless we are willing to recognize that the judgment of history will record our failures and our actions. The greatest and most serious failure is our lack of courage. It will take a tremendous courage to say to the all-powerful American Medical Association, we will insist, we have the right to insist, that your members provide service where service is needed, that the service be of high quality, that it be made available to all and that it be made accessible to every citizen, wherever he may be in this great land of ours.

I believe that I have worn my hat as a Minister enough for this statement. Let me now put before you a number of facts and recommendations which may well, on an interim basis, provide some signposts. Medicare, this financing scheme which has not worked, was based upon the concept of an insurance program with deductibles and copayments as a retarding and preventing mechanism against over-utilization, and on the theory that the copayment would dissuade the patient from seeking medical care. Maybe it has dissuaded the patient from seeking medical care, but how de we know that by his failure to obtain early care, the disease or the symptom has not grown to unmanageable and, possibly, even fatal proportions. How do we know? The whole concept of the deductible and the copayment does violence to the word "care." The concept of the deductible presumes he ability of the patient to pay the deductible. And this is a presumption which we cannot make in the face of the statistical evidence of the number of poor, near poor, "medically poor" (what a term, medically poor).

The cost of drugs, gentlemen, is staggering. In Great Britain the cost of prescriptions is 10% of the total cost of the Health Service Program. Ten percent. If this were to hold true in the United States, the sum of money not covered by medical care will take on staggering proportions and so I submit to you that a whole new look is required, as it pertains to the deductible, the copayment and our failure to provide reasonable prescription drugs to the aged. Surely, the question of generic drugs has been thoroughly investigated and need not be discussed here.

The Administration has proposed a series of cutbacks in Medicare benefits. It has taken the axe, attempting to chop off what is inadequate already, instead of addressing itself with courage to the required "change in the system." A system which creaks along in spite of the great amount of money, a system which has put the United States not at the top, but somewhere 14th or 15th in life expectancy, mortality and morbidity statistics.

Now I want to address myself to that segment of our population over 65 who are covered not only by Medicare, but who are so poor that for the deductible they must be covered by Title XIX (Medicaid). Let me submit to you here that the cutbacks in Medi-Cal in the State of California, as forced upon us by a governor, who will be recorded by history to our everlasting shame and sorrow. Here in the sun kissed and sun blessed state, one man has turned back the clock and conjured up inhumanities—insensitivities which are akin to the treatment which was afforded in ancient times by the most barbaric societies who took the aged and the infirm to the mountain top to die. History will remember this governor in-

this way, and make no mistake, history will record nothing else of the governor of California.

And now let me summarize: It appears to me now, both as a Minister and as an Administrator of a Hospital, that the solution of our Health Care crisis lies both in ethical and financial area. We have recognized in the reordering of our priorities that medical care is a "right" and not a "privilege," certainly an ethical change. We must seek solutions which will fit into our changed socio-economic climate. It must have become obvious to all that we can no longer create a patch-work quilt of financial solutions in which we allocate more and more money into a never satisfied "pool of providers". "We must reorder our priorities."

First, let us analyze the questions and slogans and labels under which we operate. There is nothing sacrosanct about the so-called "fee-for-service" system. It is one of the acceptable methods of paying for medical services, but it is not the only acceptable method.

Nor is it the only proven acceptable method. We must also put to rest this question of "freedom of choice" in which the patient's right to choose his physician becomes the paramount issue. And the extension of this so-called "freedom of choice" becomes involved with the whole complex array of medical ethics—"this is my patient"—as though the physician "possesses the patient." The only so-called proper referral is that "his" patient can see another physician who is then beholden economically and ethically to the first physician. This whole complex of ethics works to the disadvantage of the patient—rarely to the disadvantage of the physician. And so I want to label the "freedom of choice" myth as the "freedom of insecurity" for the patient.

There is an even more fundamental problem. We must look to ourselves for having failed to grasp the quinti-essential necessity of maintaining our health, rather than waiting until a crisis, an episode, a pain or a disease hits us. We have had a disease syndrome orientation in our approach to health. The system is structured to support the disease syndrome, not health. We, as a people or a society, have done very little to maintain our health and to prevent the disease. Overwhelming statistics exist in this land of plenty and, surrounded by incredible affluence, the physical fitness of our population is a sad fact. One need only look at the physical rejection rate in the Armed Forces to recognize the validity of these statistics. Health Maintenance is not a medical problem per se. Health Maintenance is a social, an economic and, certainly, an educational problem. The frightening increase in the rise of veneral diseases, drug abuse, etc., is further proof of our failure as a society to act in this area of Health Maintenance.

In reordering our priorities, therefore, we must recognize that this is one of the crises of our society. We must reorder our educational processes to put emphasis on good health, on cleanliness, cleanliness of body and cleanliness of mind. We must reorder our priorities. The maintenance of good health and the prevention of illness involves the abolition of poverty and adequate income, meaningful work and the abolition of hunger. Health is not merely the absence of disease or the availability of medical care, but concerns a whole way of life. Man can no longer befoul his environment externally, nor can he persist in befouling his internal environment.

No amonut of additional money, be it 70 billion or 100 billion or 150 billion, will create this new way of life. Only a change in our priorities will provide us with health. Allocating more money to Medicare or Medicaid will only increase the cost of health care services and increase the cost of an appendectomy by an additional $100.00 or $200.00, yet the additional $100.00 or $200.00 will not improve the health of the patient. It will not improve the performance of the surgeon nor enable the patient to walk out of the hospital a single day earlier.

However, we cannot take the opposite approach—that cutbacks, reducing the money available for medical services, will produce any realistic savings. We will only delay paying the bill. The patient who has an infected tooth today, which in accordance with California Medi-Cal regulations cannot be treated, will probably develop an infectious arthritis of the knee which may incapacitate the patient for weeks and months and may cost thousands of dollars in medical services. The treatment of the tooth may have accomplished this for from $10.00 to $20.00. This type of medieval thought processes, as represented by the current California Medi-Cal cutbacks, cannot be described as either prudent or rational. What then are the immediate solutions?

Throughout the land various forms of prepayment plans have prospered—HIP in New York, Kaiser on the West Coast, Group Health in Washington, Group Health in Washington, D.C. and many, many others. Though they have yet to make a significant impact on large numbers of people, they have proven that good medical care can be provided, combined with preventative services, because it is in the interest of the prepayment plan to keep its members healthy at a predictable cost without penalizing the physicians or providers of service, by relegating them to penury. The physicians income and other benefits of Kaiser and the other Group Health Plans certainly are on a par with physicians in private practice. Yet they have succeeded because they have been able to see that the "solo" practice of medicine is, as the only method of rendering health services, anachronism which we, as a society, can no longer afford. We can no longer afford permitting the physician or the hospital or the technical allied health personnel to practice or locate wherever they desire while leaving areas of our land without health services.

In reordering our priorities therefore, it must be a national policy to further prepayment, encourage Medical Societies, if they wish, or other groups, to set up prepayment plans in and around hospitals, the natural and logical Health Care Center of the Community. Simultaneously, we can provide physicians and other health workers productive incomes and support health facilities.

There is a time for every idea. And the time for a new Health Care Program in the United States has come. It is belatedly here and it must do the following:

1. It must clearly set the tone of preventative health maintenance and health care services in this order.
2. They system will be a whole, unified (not uniform) system and not an additional patch on the nonsystem.
3. The method of financing health care by adding more and more dollars must be supplanted because it has not worked and does not work and there is no reason to believe that it will work tomorrow.
4. The political power of the consumer of health services must be recognized and used to ensure changes and support for the changes at the polling booth.
5. The power of the insurance industry must be chanelled into productive avenues of prepayment programs with preventative and maintenance health services adequately ensured.

If, indeed, Health Care is a "right" in the United States, then it must be right in California, Illinois and Mississippi. It must be an even-handed and equal right. We must set forth adequate, reasonable standards for the entire United States. We must immediately work toward the creation of prepayment programs on a National basis using as an example the successful plans which are already in existence. And yet, I am cognizant and I recognize that one cannot, with the stroke of a pen, change the entire delivery system in the United States from "fee-for-service" to prepayment by "Capitation".

And so, recognizing the reality, I am recommending to your Committee that we use a transitional approach. This approach has worked remarkably well in the San Joaquin Valley in California, under the able direction of Dr. Donald Herrington. A plan which has been described by our own consultant, Dr. George Shecter, as "Capitation-in" and "Controlled fee-for-service-out" leading by evolution to "Capitation-in" and "Capitation-out". This plan recognizes that we must utilize the available medical manpower, that we cannot make a 24-hour switch and that we will find most "providers-of-services" willing at least to move in this direction. And I would recommend that we use the power of Government only if the power of persuasion fails with the providers and consumers of health care services.

I have stated that we must approach this matter of Health Care for the Nation with foresight and courage. It will take a tremendous amount of courage to go counter to the economic interests which now control our Health Care Services. The hospital, the physician, the insurance industry and the patient each have specific economic interests which each considers more important than the patient's welfare. And make no mistake, the question of the National's Health cannot be left alone in the hands of the Medical Profession, the Insurance Companies and the Hospitals. We have had the foresight not to leave the defense of our nation in the hands of the generals; certainly, we would be ill advised to leave the health of the nation in the hands of the dectors and the hospitals.

To assess potential savings in dollars, let me clarify my own position; the important issue is not just saving dollars, the important issue is the quality of

medical care, the availability of medical care for all the people in this country at a reasonable and predictable cost.

The following factors consistently and persistently add to the cost of medical services. For example, what is the cost of the restrictive licensing arrangements in the 50 states? Why should a physician, who is qualified in New York, not be qualified in Florida? Or in Mississippi? Or in Montana? The disease he sees in any of the 50 states and the treatment he prescribes will not and cannot differ materially. There was a time when the states used professional licensing as a restrictive mechanism to protect their own licensees against undue competition. Due to the manpower shortage in all the health fields we can't afford the additional cost created by the maldistribution of various licensing acts. A National Certification Act, which would certify the qualification of physicians, nurses and other health personnel, will reduce the cost of medical care because it would more evenly spread the available manpower personnel.

The time has come where we must, in effect, require physicians, nurses and other health personnel to go where they are needed. A novel concept? Possibly. A restriction on individual freedom? Possibly. But we have subsidized each and every one of these people, paying, in part, for their education and we have a right to expect service in return.

There are still more than 20 states which prohibit, or in some fashion restrict, the Group Practice of medicine. And this again can be remedied by legislation, because whatever economic factors created these restrictions are no longer in existence. To make medical manpower more efficient, group practice is one of the primary answers and we can correct this by legislation.

One other factor which increases the cost of medical care is the cost of malpractice insurance.

All these add to the cost which ultimately the patient or the taxpayer must pay. Recognize that the most important thing is no the infusion of more dollars, but a courageous look at our present non-system. We must devise a system which fits into our pluralistic society and yet provides all of our people with medical care of high quality, accessible and at reasonable cost. For too long we have placed the primary emphasis on in-hospital services. This has been encouraged because third party payors discriminate between in-hospital and out of hospital services. There is no reason why a chest x-ray performed in a hospital should be a reimbursable or insured item while a chest x-ray outside of the hospital is not insured and/or reimbursable. This is true for a whole gamut of diagnostic and therapeutic procedures. The present method encourages in-hospital care by providing reimbursement for all costs, and at the same time, discourages out-patient care by requiring the patient to share in the payment of this cost, or, by not paying for it at all, thereby, literally coercing physician and patients to use hospital facilities which may not be needed.

Finally, these insurance policies directly discourage outpatient services by not paying for physicians services in his office, while they are willing to pay for the same services when the patient is hospitalized. It has been proposed that we simply reverse the present emphasis on paying 100% for inpatient services and a reduced portion for outpatient services by paying for all the services on an outpatient basis and requiring a deductible for each hospital admission. I do not know whether this is a desirable method, but I would be willing to try it as an approach to rectify the present imbalance.

The shifting of emphasis from inpatient to outpatient care has been one of the main positive features of group prepayment practices. Let me just cite you one statistic—the number of inhospital days for a population segment covered by a capitated prepayment plan is half the number of hospital beds required for an identical population which is insured with a fee for service insurance program. (For reference see the Steel Worker's Report by Dr. Fein.)

Dr. Edward Pinckney, in his testimony before Senator Hart's Committee stated, that the Royal College of Physicians and Surgeons in Canada, had released a report showing that one out of every four surgical admissions could be treated as an outpatient procedure as safely and more economically than in the hospital. It is then if we recognize all the factors, not a matter of infusing more dollars into the economy, which will pay doctors more for their services, fill more hospital beds, it is, rather, that we need a reordering of all of our priorities.

The now, so often discussed, trend toward Health Manpower Maintenance Organization, or the American Hospital Association's Ameriplan, all these are just words which designate a new approach. A new approach away from the

crisis and episodic form of medical care, from the fee-for-service method, to a form of prepayment which encourages the maintenance of good health, including physical, mental, environmental, ecologic and socio-logical factors. Our whole society had better find a reordering of its priorities and do so now. When we do this, we will find that we will provide better medical care to more people, that we will not remain 13th or 14th on the statistical quality list as compared to countries such as Sweden and Denmark.

The issue, then, must move from the economic theatre, from the dollar area into the sociological and, of course, the political arena. You must pass the laws which will change the direction. A direction which the President has said "Is a crisis moving toward a disaster." You will not stop it by adding a few more billion dollars. You will only stop it if you recognize that we must change from a non-system to a system, and while I do not know if the entire answer lies in prepayment, I am willing to try it. A group of physicians practicing at our hospital have declared their willingness to form a Group Practice and to contract on a capitation basis with the Health Maintenance Organization. But we will need help. We will need guidance from the Government. We will need help so that the typical competitive forces which insist upon the status quo, and I am referring specifically to the proposal introduced by the American Medical Association which goes under the name of Medi-Credit, not be allowed to restrain others from trying a new approach.

I have already referred to the 22 states which have restrictive or prohibitive measures against Group Practice. Surely, we will need your encouragement to try a new approach.

Finally, let me remind you that the demonstrations, the frustrations, the air of violence and revolution are not limited to the war in Vietnam. They are the end result of many frustrations, among which the lack and unavailability of good health care is certainly a primary issue. I would hope that this issue will rise above partisan politics and that it will find, in our country, a response, a universal response of open minds, of open hearts and a willingness to tread now pathways.

ITEM 5. PREPARED STATEMENT OF ROBERT M. PECK, M.D.*

Medicare and Medic-Aid began under titles 18 and 19 of the Social Security Act Amendments of 1965.

This legislation was a nodal point in a 20 year struggle to establish in fact quality medical care as a basic human right for every American.

Medic-Aid (title 19) called Medi-Cal in California was achieved with the announced purpose of bringing poor people into the mainstream of medical care in America.

Mainstream medicine for all, never fully achieved under the Medi-Cal, is an objective which must guide our efforts in the health care field. Human need, not money, must be the decisive issue.

The emergency Medi-Cal cuts instituted December 15, 1970, to last until July 1, 1971, fly in the opposite direction. The Governor's proposed Medi-Cal program for the fiscal year starting July 1, 1971, would institutionalize most of these meat-ax type cuts in the Medi-Cal program and add some additional reductions in services. The result, in my opinion, would keep most of the 3,000,000 indigent and medically indigent Californians out of mainstream medicine in their private doctor's offices and force them into the emergency rooms and waiting rooms at the County Hospital.

The fiscal imperative which allegedly necessitated this drastic reduction in the health care of the poor may have been forseeable and preventable, as noted by the following article from the Los Angeles Times of 27 April.

[From the L.A. Times, April 27, 1971]

WILLFUL UNDER-FUNDING OF MEDI-CAL CHARGED

(By Robert Fairbanks)

SACRAMENTO—A Democratic lawmaker charged Friday that the Reagan Administration deliberately under-funded the Medi-Cal program this year, knowing the action would generate drastic cuts in health care services for the poor.

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*See statement, p. 29.

The charge has been made before and denied. However Assemblyman Leo T. McCarthy of San Francisco offered newsmen an Administration document to support his allegation.

The document was a memo prepared by Dr. Earl W. Brian, director of the Department of Health Care Services, the agency that administers Medi-Cal.

Dated May 22, 1970, the memo said Medi-Cal was under-budgeted $202 million for the coming fiscal year—1970–71—which was to begin July 1, 1970.

However, McCarthy said, the Administration sought and received only $60 million additional from the Legislature before the Medi-Cal budget was finally voted in June.

McCarthy charged the Administration withheld reports of the remaining $142 under-budgeting because it wanted to hold down budget levels in an election year. Reagan was running for a second term at the time.

On Dec. 2, 1970, Reagan announced that Medi-Cal faced a $140 million deficit for 1970–71 and blamed it on excesses in the program. He also ordered major reductions in services for the programs 2.4 million recipients and a 10% fee reduction for doctors and other health care providers.

In the May memo, Brian listed several alternatives to correct the under-budgeting, including a request to the Legislature for more money.

However, under the heading conclusion the memo said:

"The Medi-Cal program should continue as currently constructed, with all the administrative cost-saving actions proposed implemented as soon as possible—with full realization that rather drastic program curtailments will have to be made in the spring of 1971."

When asked about McCarthy's statements, Brian said the memo was based largely on his "conjecture" and that it was "absolutely, purely coincidental" that the memo turned out to be almost precisely correct.

The memo was directed to Reagan, but Paul Beck, the governor's press secretary, said later the governor never saw it.

Brian said he submitted the document to Lucian B. Vandegrift, then secretary of the Human Relations Agency. Brian said Vandegrift challenged several cost estimates in the document and did not pass it to the governor.

Vandegrift, 44, left the Administration in December, 1970, after Reagan appointed him a Superior Court judge in Butte County.

Late in 1970 when the Governor and his aides decided that a $140,000,000 deficit in the Medi-Cal budget impended, they chose a technique for cutting the program which was arbitrary and potentially disastrous.

Competent agencies of state government were apparently not consulted—for example, the Department of Mental Hygiene.

The Citizen's Advisory Council on Mental Health concludes its report on the effect of the cuts:

"Worst of all, the proposed regulations seem contrary to the philosophy of Lanterman-Petris-Short and Short-Doyle legislation. After many years of work, research, and pain, California, through the excellent effort of the Legislature, has one of the best, most humane, and most efficient mental health systems in the nation. It is bottomed on the premise of care in the community, and outpatient assistance at minimal cost with the greatest use of available facilities. The new regulations are inconsistent with this philosophy. And they throw the carefully devised planning process into a temporary shambles."

In answer to a question from the Committee (Assembly Special Committee on Medi-Cal), the Department of Health Care Services replied:

"The Department of Mental Hygiene was not consulted prior to these changes, although they had an opportunity to participate in the meeting of the Health Review and Program Council on December 2, 1970, when the proposed changes were discussed. Since these changes were implemented, we have had continuing discussions with the Department of Mental Hygiene, and a number of revisions have been proposed to alleviate the difficulties encountered."

Apparently the Department still does not understand the interrelationships with the total mental health system. On February 1, the Department stated:

"As for the effect of the cuts on state hospitals, we predict no significant effect, since treatment will continue to be authorized for serious, or potentially serious, mental illness that would require hospitalization if not treated."

The Advisory Council concludes otherwise:

"In summary, it appears that in the near term, the new Medi-Cal regulations will create a chain of events which will result in the referral of patients out of

the private sector, into the county Short-Doyle system, and ultimately into the state hospital system. At every juncture, such a result would run counter to the avowed purpose of legislation in mental health and for the medically indigent. The regulations undermine the clear legislative intent to provide equal care for all citizens regardless of economic ability, to allow the medically indigent a free choice of arrangement, and to emphasize the role of preventive care and minimize the displacement from normal milieu."

The unconscionable restrictions placed on physician and patients in the drug formulary of December 15, 1970, were established in spite of competent contrary advice.

"It is amazing, that the Department of Health Care Services assembled an advisory committee of considerable skill and then drew up the current formulary without benefit of their expertise. Although they apparently consulted the committee *after* the formulary was created, it is not apparent that it was approved by the advisory committee although it is evident that they did criticize it."

That such words could issue from so staunch an ally of the Governor's regime as the California Medical Association is a measure of the enormity of the Medi-Cal cuts. The report concludes:

"(1) The arbitrary limitations placed on therapeutic agents, ignoring the patient's and physician's individual needs and problems, such as adverse drug reactions and interactions, individual sensitivities, and allergies."

"(2) The arbitrary intervention of a distant consultant and the physician-patient relationship, adding a great time-consuming burden to the physician's practice as well as impeding his ability to treat his patients in an effective and timely manner. Historically, consultants have enhanced the attending physician's capabilities, and now they 'act, primarily, to impose restrictions on the provision of quality medical care'."

"The Medi-Cal Formulary, with its thousands of items, is paradoxically established so as to eliminate or impede a physician's access to the majority of established, modern and effective therapeutic agents."

Other aspects of bad planning for these cuts were:

No implementation of a 1968 law requiring in effect a standby plan for elimination of elective services if budgetary deficit made cuts necessary.

Disregard of the effects of cuts on other state programs as Crippled Children's services and the Short-Doyle (community mental health program) and foster care program for children, all of which depended heavily on Medi-Cal for funding.

THE NATURE AND EFFECT OF THESE CUTS IN THE MEDI-CAL PROGRAM

The cuts reduced payments for services by all providers by 10% across the board, except for in-patient acute hospital care.

In addition, prior authorization by the State Department of Health Care Services for a wide range of service and goods including:

Many medications
Hospitalization*
More than two physician visits per month*
More than two visits to the dentist per year*
More than two psychiatric visits per year*
Physical therapy
Eye glasses
Nursing home care

Hearings before Assembly Special Committee on Medi-Cal held in Los Angeles January 15, 1971, produced the following testimony:

"The State Department of Health Care Services alleged that prior authorization was being handled expeditiously by telephone—everywhere but in Los Angeles County where (42% of state population resides) 26,000 requests for prior authorization had accumulated in one month in Los Angeles alone."

Over 30 witnesses—recipients and providers of health care services under Medi-Cal in Los Angeles—followed. They described from various aspects what the meaning of those Medi-Cal services now delayed or denied was in human terms.

*Except in emergency cases.

One witness at those hearings has survived 4½ years on renal dialysis. He is a productive person—a photographer and artist— despite his having no kidney function and requiring renal dialysis three times per week. His survival depends in a considerable measure on his psychiatrist. He must maintain emotional adjustment to abide by the strict diet and other vigorous requirements for life without kidneys.

The Medi-Cal cuts reduced psychiatric visits to one every 6 months. Prior authorization for additional visits requires that the psychiatrist convince a Medi-Cal consultant that the patient is suicidal or homicidal.

Other examples of disregard for human needs include the crisis in rehabilitation services. The situation in the rehabilitation center at a large local non-profit hospital is typical. A representative of this center testified before the Assembly Special Committee on Medi-Cal on January 15, 1971, that amputees who required physical therapy to prepare their limbs for prosthesis were, in some instances, delayed from receiving these treatments thus putting off their ability to wear the prosthesis and become self-sufficient. Pyhsical therapy treatments to enable an amputee to use an artificial leg, for example, were also postponed. Since that time, the situation has deteriorated. Rehabilitation patients have to be treated free if they are to be treated at all because Medi-Cal denies treatment in many instances. At the same time, doctors are "dumping" Medi-Cal patients on the clinic of this hospital and other clinics. The load is so great that the clinic has closed down its intake. The Medi-Cal Formulary does not allow over-the-counter drugs such as aspirin, which are necessary in large amounts for people with arthritis to become active. The clinic used to give aspirin and other medications to the patients but, because their expenses have risen so much and their income from Medi-Cal has been cut drastically, they no longer provide these medications without charge.

Those Medi-Cal recipients who have been treated in the belief that the clinic would be reimbursed by Medi-Cal have been turned down for payment in many instances and the denial was retroactive to last year.

The picture is further complicated by cut-backs in Medi-Care payments. Benefits for patients over 65 who are eligible for the Medi-Cal program for the needy and medically indigent come in part from the Medi-Cal funds and in part from the federal Medi-Care program. Sometimes the Medi-Care representative will deny payments also. Their criteria are that the physical therapy and other modalities of rehabilitation must be restorative. Thus, chronic illnesses such as arthritis or multiple sclerosis which cannot be expected to improve are denied treatment. The treatment, however, is necessary simply to maintain the patient at a given level of function, for example, walking with the use of a cane or crutch rather than deterioration to bed invalidism.

The cuts in authorization for physical therapy treatments have been heavy but the cuts in speech and occupational therapy have been far more drastic and these, in effect, are being denied to patients who must rely on the Medi-Cal program for their medical care.

Another factor of decisive importance in deterioration of the Medi-Cal program is the refusal of most private physicians to care for Medi-Cal recipients because of the increasingly onerous restrictions. Many of these patients have sought care at the private hospital clinic. As a result, the administration of the hospital I am referring to sent out a memo that no new Medi-Cal patients could be accepted because:

(*a*) The Medi-Cal program does not authorize treatment

(*b*) The denial of claims and the reduction in payments for patient services have made the program financially unacceptable to the hospital.

Thus, this hospital, like many others, has refused to take any new Medi-Cal patients since the Medi-Cal cuts went into effect December 15, 1970, except perhaps in exceptional circumstances.

The tragic result is underutilization of this excellent rehabilitation center at the very time when the growth in numbers of our aging population and vastly improved rehabilitation modalities makes the need increasingly great.

Another related development is a cut in the federal Department of Health, Education and Welfare budget for training rehabilitation personnel. This budget was recently cut by 47 percent. This includes areas of great need such as rehabilitation including occupational and physical therapy, specialists in training

patients to use prosthetic devices, and specialists to work with mentally retarded patients.

It should be pointed out that in a period of rising unemployment the whole field of rehabilitation offers one of the most immediate, necessary, and rewarding areas for training and employment of the unemployed, and presently unemployable.

Thus, we see a developing pattern in which an alleged six-month saving of $140,000,000 to be accomplished by gutting the medical care of the poor turns out in a large measure to be only postponement of costs or transfer from the state and federal to the county budget when the patient denied care by his private doctor or voluntary hospital comes to the county facility instead. The human cost of these alleged dollar savings cannot be calculated.

How cynical of the State of California to proclaim savings by denying vitally needed medical services. Los Angeles county officials are especially irate over advice from the Governor that they should not treat Medi-Cal recipients for conditions turned down for care by the state. This, despite the statutory and moral obligation of county hospitals as the medical facility of last resort to provide care for the needy.*

The 20 percent rise in utilization of Los Angeles County-U.S.C. Medical Center, the largest county hospital in the country, is one example of the cynical deception inherent in these alleged fiscal savings. This in the face of a freeze on hiring and reduction of critically short staff by attrition at the Medical Center.

The laudable moto on the banner flying over the Governor's mansion is "No More Taxes!", subheading "Lighten the Property Taxer's Burden!"

But the new Los Angeles county cut-down streamlined, bare-bones budget features an 18 percent rise in property taxes, 75¢ per $100 evaluation this year—the second largest in history. The reasons—unemployment with swelling welfare rolls, an increased county hospital expenses brought about by increasing utilization by Medi-Cal recipients and decreased Medi-Cal support for medical services. Let us examine other effects of the Medi-Cal cuts.

Dental care:

Dr. Max Schoen, a leading authority on dental health, has prepared the following analysis of the effects of the Medi-Cal cuts already instituted and those proposed in the 1971–72 state budget on dental care:

POSITION PAPER WITH REGARD TO DENTAL SERVICES UNDER MEDI-CAL

The proposed budget for Medi-Cal for the fiscal year starting July 1, 1971, has cut the dental care portion from over 50 million dollars to about 10 million dollars. This amount will be less than one percent of the budget.

It appears that the authors of such a proposal consider dental care services to be hardly worthy of being considered health care services. Aside from the major considerations of importance to health, dental care costs have inflated at a slower rate than most other categories of service in this field. In Medi-Cal, dental services are provided on a fixed-fee basis, so any unit cost increase is related entirely to the fees set by the Department of Health Care Services in its Table of Maximum Allowances.

If decay is not treated it will inevitably progress to a point where the tooth cannot be saved and must be extracted. Such destruction is accompanied by either acute or chronic infection of the jaws and often considerable pain.

The most prevalent disease in children is dental caries. Without fluoridation or fluoridization it affects over 90 percent of them. The budget as presented (about $4 per eligible person per year) will hardly be sufficient to handle painful emergency situations to say nothing of providing any other type of dental care service. If the teeth of these children are not cared for the following problems will definitely occur:

1. Considerable pain will result.
2. Infections which may have general health ramifications will result.
3. Discomfort, reducing the child's ability to eat properly, will result. An inadequate diet will lead to malnutrition with all of its sequelae.
4. Tooth loss will result. Such tooth loss will cause both disfigurement due to unsightly gaps in the dentition and to preventable malocclusion from loss of space and shifting.

*Section 17000 of the Welfare and Institutions Code.

5. The pain, discomfort and disfigurement will result in psychological damage to a number of the individuals concerned.

6. The combination of the foregoing problems will result in individuals who will be less apt to be producing members of society and who will have more problems as they grow older. The eventual costs to society will be far greater then the expenditures for dental care could possibly be.

The most prevalent disease in adults is periodontal disease or pyorrhea. While adults suffer from tooth decay, too, more teeth are lost from periodontal disease after age 35 than from decay. The major preventive measure related to this disease is the maintenance of a "clean" mouth. Both dental care in the form of thorough prophylaxis and home care are necessary. The problems associated with tooth destruction and loss in adults are similar to those for children. Pain, infection, discomfort, inability to eat properly and poor appearance inevitably result from the progressive nature of dental disease. The end results of such processes, aside from the unmeasurable amount of suffering, are clearly an increased expense to society.

While life occasionally is at risk from the effects of dental caries and periodontal disease, it is always at risk from cancer. Cancer of the mouth and tongue is curable if detected early. It is usually readily detected during a thorough dental examination. It is more prevalent in certain categories of middle aged and older people, particularly those who have badly diseased mouths from a dental standpoint. Even if cured, after relatively late discovery, the individual is disfigured to a major degree and rehabilitation is difficult and costly if not impossible. Since an early malignant or pre-malignant lesion is not painful the only way to discover it is through appropriate preventive examination.

Prior to the present "emergency cut-backs" it was possible to provide care for the candidates just enumerated. Not only treatment but prevention was included. The new budget, which reduces the expenditures for dental care by over 80 percent, will clearly result in higher expenditures at a later date.

Of much greater importance is the fact that a well established and recognized health care service will have been almost totally destroyed as far as the medically and other indigent population are concerned. Even though mortality is usually not at stake the quality of life is certainly involved. It is well known that a great proportion of all medical care is not involved with mortality but with ability to live and function comfortably. In this respect dentistry is similar to the other health care components. An individual suffering from the effects of a diseased and destroyed mouth may be just as badly off as one who has arthritis, bad eyesight, ulcers or any number of other diseases.

If the state were seriously interested in developing and improving the existing service many innovative ideas are possible. They might not cut costs at first but people's health would be improved with consequent changes in their relationship to society.

In sum, the cuts are inhuman and represent a return to a health care concept approximating that of middle ages. They place the richest state in the wealthiest country in the world on a par with the so-called "underdeveloped" nations. The dentists involved will be able to survive rather easily, since they are in short supply in many communities, but the people will suffer irreparable damage.

CASE HISTORIES

No. 1

A patient, age 45, has severe pyorrhea. He has been on the Medi-Cal program for about one year because of a back injury sustained in an automobile accident with resulting disability. He can be rehabilitated and become self sufficient again, in my opinion. His dentist says that two of his remaining teeth must be removed. He should have the teeth cleaned and should have gum treatment so that the rest of his own teeth can be preserved. The dentist estimates a minimum time for preservation of his own teeth to be 10 or 12 years if this treatment program is accomplished now. The treatment would then consist of partial dentures, leaving a majority of teeth his own. He was sent to the dental consultant of the State Department of Health Care Services. This doctor would authorize only extraction of all of his upper teeth and some of the lower teeth followed by a full upper denture and partial lower dentures.

The basic precept of dental care is preservation of natural teeth. The proposed sacrifice of many good teeth in this case was described as inhuman by the patient's own dentist.

No. 2

An elderly patient was confined to a mental hospital for 18 months during which time he did not wear his dentures. He has been released from the mental hospital as able to adjust to life in his home and the community. However, his dentures do not fit at all and he cannot wear them because of the long period when they were not worn. He is unable to understand why the doctor cannot refit or replace the dentures but Medi-Cal regulations prevent this.

No. 3

A diabetic patient in his sixties was referred to the dentist by his physician so that the patient could be given dentures. This would allow better control of his diabetes because he could eat a fuller diet. The authorization to make the dentures was turned down and a great deal of time had to be spent by the dentist in reapplying and making telephone calls before dentures were authorized.

The dental cripples who we see among the elderly began to lose teeth years ago. A 15-year-old girl with rheumatic fever and rheumatic heart disease needs extraction of front teeth because of extensive decay and infection. The infection is life-threatening in a patient with rheumatic heart disease; however, the dental care consultation of the State Department of Health Care Services will not authorize the replacement of the front teeth if they are removed because she will not be fully edentulous. This youngster and her family have the practical alternative of going through life without front teeth until such time as all her teeth must be removed or living with the constant threat of infection which may spread to the valves of her heart with disastrous consequences.

In summary, as pointed out by Dr. Max Schoen, 10 percent of the population of the United States is edentulous. One-half of people over 65 have no teeth and most of the rest have only a few. The lack of an adequate number of well-functioning teeth limits the ability to eat resulting in malnourishment and enfeeblement among elderly people who ned all the nutritional help they can get.

AID TO THE TOTALLY DISABLED

Even those who are most vociferous in their attack on "welfare bums" pay lip service to the right of our totally disabled citizens to necessary medical care. What has happened in the life of those unfortunate individuals who are totally disabled and poor? Let me sight a few examples:

A patient of mine is 57 years of age. He is totally disabled by severe dorsal kyphosis (his head and shoulders and upper back are hunched forward by rigidity of the upper spine). As a result, he has minimum expansion of the chest cage and severely impaired ability to breathe. When he lived in a rooming house, he frequently contracted colds which progressed to bronchitis and sometimes pneumonia. These respiratory infections caused reduction in oxygen exchange and led to cerebral anoxia (inadequate oxygen supply to the brain). He would then experience grand mal epileptic seizures (convulsions). This combination of events required numerous hospitalizations at the USC–Los Angeles County Medical Center. The cost to taxpayers amounted to more than $100.00 per day of hospitalization. The cost in suffering to the patient cannot be counted.

After one of his frequent hospitalizations, he was accepted for care in an excellent local convalescent hospital. However, the enumeration and description of his disabilities and need for convalescent hospital care did not convince the state Medi-Cal consultant.

On November 11, 1970, I sent a detailed and long letter to the Medi-Cal consultant appealing his decision. On November 27th I received a reply again rejecting the patient for convalescent hospital care and stating that placement in a residential care facility was appropriate. On December 8th, I sent another letter to the Medi-Cal consultant again requesting reconsideration. The nursing home administrator also made requests. Finally, the state relented and the patient remains in the convalescent care facility. As a result, he is no longer bed confined. He is able to walk about and take care of his immediate personal needs and he has had no need for county hospitalization in the past six months except for a brief stay because of an unrelated eye ailment.

Another patient under care my by my associates and me is a woman of 45 years of age. She suffers from pulmonary tuberculosis which is inactive requiring daily anti-tuberculous medication. She has disabling rheumatoid arthritis and recurrent bronchial asthma. This unfortunate woman has recently experi-

enced several hemorrhages from a peptic ulcer. In spite of her handicaps and total disability, she is the mother and homemaker for a teenage son and an older son who is now self supporting. This is a most challenging and difficult medical problem in which the appropriate treatment for one condition may have disastrous effect on another. Our medical care has been made more difficult by Medi-Cal's refusal to pay for occasional injections which were necessary to relieve acute attacks of bronchial asthma. In addition, we must make out requests for prior authorization when she has to be seen in the office more than twice a month. Our policy since the Medi-Cal cuts went into effect is to see Medi-Cal patients under our care as often as necessary whether the state pays or not. We follow similar policy regarding injections. Where prior authorization for medication is denied by the state, we pay for the medication. In this case, the patient needed a pain medication containing no aspirin. None is authorized under the Medi-Cal formulary.

Doctors do not have to put up with this sort of thing. We are in very short supply. The inevitable result is more and more doctors refusing to see Medi-Cal patients. It is my contention that responsible state officials who instituted these cuts in program are well aware of this fact and are intentionally pushing these people back into the county hospitals.

Other case histories provided me by Mrs. Mollie Piontkowski, Executive Secretary of the Committee for Rights of the Disabled are the following:

Case No. 1:

Age 64. *Condition:* Diabetes mellitus. Cardiac failure. Ulcers on the plantar surface of feet for 2½ years, at present healed but left foot is swelling. Doctor claims infection has spread through the system.

In February of 1971, the patient was taken to Daniel Freeman Hospital, on an emergency basis, in a coma. Under the law, only allowed 1 week of hospitalization. Patient is in need of further hospital care, but would have to go to County General Hospital for this further care. While in the hospital, the patient went into another coma ; couldn't be revived.

The doctor had to get special authorization for the patient to remain in the hospital. The patient was lucky—the doctor took the time to get this special authorization.

The patient is continually having severe headaches. The patient must pay for his medications as the medications are not listed on the Corollary.

Case No. 2:

Age 62. Patient was granted ATD in 1962. Spouse worked for American Can Company until 1961 when he had to quit his job to take care of his disabled wife. Married for 30 years. Patient totally disabled. She has to be carried to and from her bed. Was in County General Hospital recently.

Patient needs full-time attendant care. Must get medication four times per month but under the present law the patient can only get her shots two times per month.

Patient's condition is deteriorating. Arthritis.

Case No. 3

Age 52. On ATD since October 1967. Totally disabled. Disability diagnosed as severe parkinsonism and severe discogenic disease of lumbar and cervical spine. Cervical fusion done May 14, 1970.

The effect of these various problems is that the patient is severely disabled. The patient needs full-time attendant care. The patient has to pay $8 per month for some of her medications (has vaginal infection, bladder infection, loss of speech). Goes to doctor 2, 3 and 4 times a month. Must pay for any visit over two. Was in Rancho Los Amigos Hospital for 5 days; to return in 60 days. Rancho cannot care for patient because of the cost.

Patient going for therapy.

Case No. 4:

Age 56. Patient has been on ATD since 1967. She is 56 years old.

Diagnoses: Hypertension. Cardiovascular disease. Obesity of undetermined origin. Chronic pain in muscles and joints. Unable to ambulate.

The patient is extremely obese, in wheelchair or bed-bound. Limited in movements due to rheumatoid arthritis. Because of the arthritis in her arms, shoulders and hands, she is no longer ablt to transfer to wheelchair unassisted.

The patient only gets attendant care 3 times per week for ½ day each. Husband is out of work, needs help himself, is blind in one eye. The husband helps but it is difficult for him to do. Patient has to pay for some of her medications, such as for Indocin $10.70 per month.

The doctor comes to the home twice a month. Many times the doctor has to be called in between these visits for flare up of pain.

Case No. 5:

Age 62. On ATD since 1964. Patient suffers from progressive neurologic disease, believed to be Huntington's chorea. Advances inactive tuberculosis.

Patient was taken to Centinella Hospital on an emergency basis for impacted bowels. Was transferred to L.A. County Medical Center. Patient's doctor tried to get the patient admitted to Good Samaritan Hospital and then St. Vincent's Hospital but these hospitals would not admit the patient because he was on ATD. The hospitals claim that they do not get paid on ATD cases.

The patient's doctor was not able to see him while he was at L.A. County Medical Center.

The patient went home home after three days. He couldn't urinate. He was taken to Mid-Wilshire Convalescent Hospital. His doctor is allowed to visit him two times per month under the present law. The patient has lost quite a bit of weight because the attendants at the hospital don't help feed him. The patient's wife would stay to help feed him. The patient was there for three weeks. He is home now.

His doctor has written for special authorization for medications. The patient needs constant care.

The situation in convalescent hospitals (extended care facilities) has been thrown into chaos by the Medi-Cal cuts of December 15, 1970. The maximum payment for this type of nursing home care is now $12.60 per day. This is substantially less than rates for decent hotel accommodations in Los Angeles. For this figure, the nursing home must provide three meals, professional nursing, including a registered nurse, dietitians and attendant care plus many incidentals. The result has been that some of the best convalescent hospitals have closed their doors. This aggravates unemployment at a time when the $62 billion per year health industry should be the major resource for training and employment of the unemployed. One very conscientious convalescent home administrator has had to discharge the part-time social service worker previously retained to arrange follow-up care in adequate residential facilities when patients were rehabilitated sufficiently to leave the convalescent hospital. She has also had to discharge their physical therapist because of disallowance of physical therapy by the Medi-Cal administration. As a result of the cuts in Medi-Cal, the upgrading of nursing home care achieved in the last twelve years years is being lost. The patients, of course, suffer and are reduced to less adequate care, less opportunity for rehabilitation to self sufficiency and require more acute hospital care.

CUTS IN THE MEDI-CAL FORMULARY

The contention of the state administration is that no necessary medical care has been denied at any time. "The Catch–22" is prior authorization. A particularly flagrant abuse of medical care was the drastic revision of the Medi-Cal Formulary on December 15, 1970. Many drugs which were vital for prevention of death or serious impairment were placed on a list requiring prior authorization. Such prior authorization took weeks to obtain even though the need might be acute. In addition, the new regulations required the doctor to prescribe enough of certain medications to last one month. This was one of the restrictions most frequently cited at the Assembly Special Committee on Medi-Cal hearings and was one of the bases of a law suit by the California Medical Association against the State of California. Seeking a restoration of the full Medi-Cal program as it existed before December 15, 1970. As described by one physician, the placing of a month's supply of sleeping medication or powerful tranquilizers in the hands of a suicidal patient is like giving him a loaded gun. In addition, all tranquilizers except Chlorpromazine, an extremely potent agent with life threatening side effects in sensitive patients, were eliminated from the list of drugs freely prescribable without prior authorization. In February of 1971 and again in April of 1971, the drug formulary was revised with heavy expansion of medications allowed without prior authorization. The question must be raised as to

the motive of the state administration in making such drastic cuts in the Medi-Cal drug formulary in the first place and then in the face of heavy legal and political pressure rescinding many of the cuts in the formulary.

It should be noted that on two previous occasions, the present state administration has made comparable drastic cuts in the Medi-Cal program. Each time, the cuts have been found to be patently illegal in the courts and the program was restored. Legal suits by the California Medical Association and other groups are now pending. Should the program be restored again by legal order what irreparable harm will have resulted during the intervening five months?

The proposed Medi-Cal program for the fiscal year 1971–72 is before the legislature.* We must now look to the state government for the shape of health care of the poor for the next fiscal year. The program proposed by the Governor and his supporters in the state legislature make a few valuable improvements. Chief among these is inclusion of some people who are not currently receiving Medi-Cal benefits but are so poor as to be on general county relief.

The question may seriously be raised, however, would the reform plan bring county indigents up to the level of Medi-Cal recipients or would it, in fact, lower Medi-Cal recipients to the level of county indigents? Important restrictive aspects of the proposed plan include the following:

Prior authorization could be required even in an emergency requiring immediate treatment. The possibility here is that even the emergency room, everywhere but at county hospital, would be closed to the Medi-Cal recipient because of need for prior authorization even though his condition be acute or life threatening.

The new plan eliminates the requirement that recipients be afforded at least one arrangement under which they will have a free choice of physicians and pharmacists. It eliminates the provision requiring that the reasonable charge for a physician's service will take into account customary charges for similar services. It requires co-payment in named amounts for those considered able to pay. That is, $1.00 for each provider visit or drug prescription and $3.00 per day to be paid by the indigent patient for hospital or nursing home care.

These proposals have been presented as reforms. The stated purpose is to see that Medi-Cal recipients not be entitled to more care than the average Californian (who pays for his own care with or without the assistance of various medical insurances). Even if this objective were achieved under the proposed new program, Medi-Cal recipients would hardly have attained equal care with the average Californian. These people have a disproportionate number of multiple and disabling conditions. Many of those we are talking about are uninsurable by private insurance companies. Being poor insures that, as a group, they are more sick than the rest of the population. In short, they are the end product of a system of health care characterized by wide spread neglect. The concept of co-payment, like so much of the present state approach to the care of its poor, is directed toward prevention of abuse, that is, over-utilization. In fact, it is an indiscriminate obstacle which will more likely discourage necessary and timely visits to the doctor and obtaining needed medications than it will prevent over-utilization.

The cost of the added paper work is nowhere spelled out. From the point of view of the doctor already inundated by forms to fill out on his Medi-Cal patients, the co-payment would best be written off. If this is done, of course, the alleged over-utilization will not be prevented and the doctor will simply be subsidizing the program further by an additional reduction in his fee for uncommonly difficult and often complex care of these unfortunate patients. The pool of doctors still available to the Medi-Cal recipients will shrink further. For many of them, private medical care is already unobtainable because the state has made such care intolerable for a vast number of doctors. It should be clear that the cases we have cited are those of patients who are under the care of private physicians, dentists and hospitals devoted to their health enough to put up with the various impediments to quality health care. What about the plight of those who have been effectively forced out of the mainstream of medical care? Their story can only be told by the doctors and other health workers in emergency rooms and in the county hospitals and by the patients and their families. I hope they will tell it very loudly to this Committee and to the country rather than suffer in silence as the poor have historically done.

In summary, I've presented a brief history of the inception of the Medi-Cal program, of its three great reductions, the first two outlawed by the courts, the

*AB 949.

third still extant. I have pointed out what it means to live with this drastically curtailed and frequently revised program. The proposed Medi-Cal bill for the year beginning July 1, 1971, offers some improvements but overall further reduction in health services. Various changes in the wording of the new bill make it clear that no attempt will be made to bring the Medi-Cal recipient into the mainstream of medical care. It is the hope of the Medical Committee for Human Rights and the Health Care Coalition that your hearings will help to restore the Medi-Cal program, at least to the level of services available prior to the cut backs of December 15, 1970. We all recognize that it was not a definitive answer to the health needs of the poor and medically indigent of California. We are also studying alternative health care plans. Meanwhile, it makes no sense to destroy the existing medical resources for our poor old people before a new system is there to take its place.

ITEM 6.—PREPARED STATEMENT OF THOMAS G. MOORE, JR.*

My name is Thomas G. Moore, Jr. I am executive director of the California Council for Health Plan Alternatives (CCHPA), CCHPA is a voluntary federation of California's labor unions including the AFL–CIO, Teamsters, International Longshoremen's and Warehousemen's Union and the United Auto Workers. We are exclusively devoted to finding ways to improve the quality and availability of health services to all Californians, and to stabilizing the inflation now rampant in the health industry.

On behalf of the two million union members, retirees, and their families in California, I thank the Chairman for the opportunity to be heard today and for your continued and enlightened interest in the nation's health problems.

For too long, difficulties in government health programs have been attacked by manipulating the beneficiaries and bookkeeping of the programs.

When hospital costs threaten the Medicare budget, the answer is to reduce benefits.

When physician charges increase the solution is to raise the premiums for Part B.

And when our state administration first conceals and then denies knowledge of Medical funding shortages the people who must pay for the resulting mess are the people who by their financial and medical characteristics are most in need of health.

If there is one principle that seems to guide federal and state policy toward Medicare and Medicaid it is that when something goes wrong, you first take it out of the hides of the program supposed to serve. This is program management through manipulation of the poor and the elderly, the most politically vulnerable members of our society.

Much of the fault lies with the basic structure of Medicare, beginning with the first section of Title XVIII which declares, in effect, that nothing can be done by the federal government anytime about anything wrong with the way health care is delivered or medical practices in this country.

Although there are federal efforts such as Regional Medical Programs and Crippled Childrens' Services (to name only two) that are designed to intervene in and improve the quality and organization of health services, neither Medicare nor Mediciad is designed or functions for those purposes.

They are funding mechanisms. Neither one assures that their beneficiaries will receive the care they need or that the care will be of high quality.

This is what comes of legislating an insurance program instead of a health program. Medicare and Medicaid are basically payment systems, not health systems, and they do very little to stimulate change in the health system we now have.

In other words, Medicare is a money pump, based on the assumption that all we need for more and better health care is more and better money.

But the health industry has an insatiable demand for money and the nation has a limited supply of it. So when shortages occur in the program, the first move is to cut back the benefits to the recipients and the next move is to raise the cost to those who are now using the program.

By now it should be clear that a payment system is not enough. The payment system must be combined with other economic and statutory leverage directly intervening in the ways health care is organized and provided in our society.

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*See statement, p. 34.

Government programs aren't the only lessons pointing toward the need for change.

California's unions now spend approximately $1 billion annually in negotiated health benefits. That amount is generated by collective bargaining agreements and does not include the various substantial amounts our members pay out of pocket for health.

Three years ago we spent about $750 million, yet while our costs have increased by one-third, our benefits have increased very little. And the number of people covered has not risen significantly.

And now with the President pressuring us to limit collective bargaining increases to six percent including fringe benefits, and our current 7.4 percent unemployment rate, some of our strongest trust funds are facing serious troubles in the months ahead.

One would think that with two million members and one billion dollars purchasing power we would have some leverage in California that could be used to improve the way health care is delivered and smooth out the inflation in health costs. At least we thought so.

But the painful truth is that our purchasing methods—which consist mainly of turning our money over to insurance companies—have been even less constructive than those of government. We have bargained for more and more money to satisfy an even more rapid demand from the health industry for more income.

When we became aware of the extent to which we were aiding and abetting inflation, we attempted to pursuade the health industry that we stood ready with money and membership to support new kinds of delivery systems provided those delivery systems offered cost and quality measurements and controls not now available from any source.

But the providers of health care are in a sellor's market. As long as government pays them in a way that perpetuates their current piece work organization they don't need to respond to us. And as long as we in labor continue to supply the providers more and more money for doing the same things, they can resist government pressure to reorganize.

Remember that we are in no position to apply traditional consumer pressures against the health industry. We can't use boycotts. When we are sick we must see a doctor. When we need hospitalization we go to the hospital. We can't shop around between health plans except in a very limited way.

So we must look to legislation that can apply economic leverage on the health industry and stimulate new forms of health delivery.

It is clear to us that most of our problems and those of Medicare and Medicaid would be solved by the passage of S. 3, the Health Security Act, and we are pleased by your early and strong support of that legislation.

But since things are frequently clear to the voters and the public than to the Congress and the President we expect the debate over national health insurance to continue for some time.

Meanwhile there are some steps that could be taken now that would considerably improve the performance of Medicare and Medicaid and relieve many of the abusive affects that they now have on the elderly and the poor.

Specific changes in both programs should be guided by these principles:

1. Benefits should be complete.

Medicare should be a complete health program, including drugs and ambulatory services, rehabilitative services, and the other health needs of the elderly. The need for complete benefits has been documented time and time again before Congress. Failure to make benefits is usually attributed to program costs. But that means that the patient goes without needed care or makes sacrifices to obtain it. Neither situation is consistent with good health program organization or with humane social policy.

2. The payment system should be designed to purchase complete health care and not to reimburse fragmented providers for the costs of health services.

The current cost reimbursement system is an administrative nightmare, expensive to administer, and confusing to both providers and patients.

The federal government should contract with agencies—whether public or private—for services to the patient population for a fixed period of time.

This would compel the providers to establish a budget and stick to it. One important and unpleasant side effect of present reimbursement methods is that when a hospital is retroactively denied payments for a Medicare patient, the hospital must find some way of recovering the money because it has already been spent. I have been told by numerous hospital administrators in California that

disallowed MediCal claims are usually laid off in some way onto private patients. Or else, the patient himself is forced to pay.

The patient's costs should be predicable. He should not learn that he owes money weeks or months after an auditor has decided that the services rendered were unnecessary or unauthorized. The patient has no choice in the matter when his physician or the hospital staff say something is to be done, the patient can only hope that they are right. He cannot summon an auditor to his bedside and demand to know what Medicare or MediCal will pay for.

Under the present system private patients including our members are paying a hidden subsidy for the disorder in the Medicare payment system. We are the relief valve economic pressure applied by federal audit policy.

This leads to the third rule which is

3. The government should contract with organizations willing and demonstrably able to provide complete benefits at fixed costs per person.

This is an old idea now dressed up in new nomenclature as Health Maintenance Organizations.

The point is that whatever they are called, we must have structured relationships between various kinds of facilities and providers so that we evolve health delivery systems at the community level. If Medicare and Medicaid would pay for care only provided by organized delivery arrangements, then we in labor could add our purchasing power to those systems. The result, I believe, would be some significant experiments and innovations in health delivery organization.

These organizations should share in the cost risks of the program so that after they have contracted to provide care for a fixed amount they must absorb some percentage of any cost overruns they experience.

For example, if costs exceeded contract payments by seven percent the providers should absorb at least the first five percent with arrangements for federal payment of the remaining two percent if it is found valid.

They would greatly increase provider incentives to discipline themselves and it would reduce present tendencies to make the patient day for provider extravagances.

Further, this kind of arrangement would reduce the distortions that cost reimbursement methods bring into the practice of medicine.

So long as we pay separately for nursing home care, or physical therapy, or physicians' services, or for each of the other elements necessary to complete health care we must constantly adjust and juggle the payment program to meet problems created by the payment program itself.

Moreover, when dollars are scarce we create competition between the providers for the funds the patient generates. Instead of stimulating a cohesive effort between all providers we stimulate them to lobby the public funds for their special interests.

Under these circumstances the patient's needs get lost in the debate. He may not get the care he needs; instead he may get the care the program will pay for. This is particularly true when program payments are manipulated to have private capital investments such as in hospitals and nursing homes.

But if all providers were merged in a common economic interest I believe they would rapidly begin finding ways of monitoring each others behavior.

You can create that common economic interest by saying to them that there is only so much money available per patient and that patient is entitled to these benefits: find ways of making that money meet the patients needs or be prepared to account for your failures.

There are some dangers in this approach. One of them is that organized providers can and do make money from capitation payment systems by denying needed costly services to patients.

But I believe it would be far more useful and certainly no more difficult to monitor organized providers to see that they do not deny needed services than it is now to go back after the fact and try to learn if they provided too many or inappropriate services.

4. The final principle that ought to guide legislative change in these programs is that the federal government has a responsibility for stimulating new methods of delivering health care. should assume an aggressive role in improving existing delivery organizations. and should become a public monitor of the quality and cost effectiveness of organized delivery mechanisms.

This means, among other things. that federal policy should deliberately shift toward development of standards for delivery system performance, the provision

of technical assistance to those providers who need help improving their services, the development of disciplinary machinery in the form of sanctions against providers who fail to meet standards and funds to help develop new delivery systems of demonstrably high quality and cost effectiveness.

Specifically, the federal government should develop a system of accrediting organized delivery systems and contract only with those that receive accreditation.

There should be a scrupulous monitoring and surveillance system to determine that an accredited program continues to meet standards.

There should be a cost effective monitoring system that makes possible comparisons between accredited organizations. Among other things, public accreditation and fixed contract costs would enable other organized purchasers such as unions to bargain with the same providers.

The tentative moves being made to develop organized delivery systems by the current administration need the reinforcement of the federal government's purchasing power, as I have said, purchasing power alone is not enough, but without purchasing power organizing efforts are likely to result in a spotty, unplanned, unmeasured drift toward new modes of health delivery.

While we in labor strongly favor delivery systems with a high organization of providers we are also anxious for a great variety of experiments to test whether other structured relationships can work as well. I don't think that experimentation is likely to occur unless federal policy first sets the stage through economic pressures such as I have outlined, and then provides the assistance to that vast majority of health professionals who would like to serve the public's needs more effectively.

APPENDIX 3

MATERIAL SUBMITTED BY INDIVIDUALS AND ORGANIZATIONS

ITEM 1. PUBLIC SOCIAL SERVICES COMMISSION

COUNTY OF LOS ANGELES,
Commerce, Calif., May 17, 1971.

DEAR SENATOR MUSKIE: I attended the hearing on "Cutbacks in Medicare and Medi-Cal Coverage" held on May 10, 1971, in Los Angeles and, although I did not testify, I would like to enter the attached material into the hearing record.

Our Commission held public hearings in January, 1971, and one of the hearing topics was "Medi-Cal Cutbacks". The attached material includes edited testimony taken at the hearing on this topic as well as written statements submitted for the record.

The Public Social Services Commission has opposed cutbacks in medical care in the past and will oppose any cutbacks in the future. We believe the lack of adequate health care services for poor people can only result in suffering and the accumulation of medical needs which will eventually have to be met at far greater expense.

Sincerely,

BENJAMIN M. BENDAT,
Chairman, Public Social Services Commission.

Enclosures.

EXHIBIT A.—MEDI-CAL CUTBACKS AND AID FOR UNWED MINOR MOTHERS, JANUARY 28, 1971

Mr. Chairman and members of the commission, this commission is gathered here to hold hearings on the rising costs to county government of welfare and welfare related costs. Perhaps no greater single factor adding to these rising costs in the remaining fiscal year and the year to come will be the impact on counties, and Los Angeles County in particular, of the Governor's recently announced Medi-Cal cutback. Due to what we now learn was in part a "clerical error" the administration lost over 20,000 medical recipients in its fiscal projection for the present year, thus failing to request the needed funds from the legislature. Following this negligent administration of the Medi-Cal program, the Governor now refuses to seek the needed funds from the legislature and instead seeks to place the entire burden of his mistake on thousands of needy Medi-Cal recipients.

We need only pause for a moment to recount a few examples of how deeply the Governor and his director of health care services have cut into the Medi-Cal program. For example, we learned that the new drug formulary promulgated on December 15, has reduced in absolute number the number of drugs available for use by Medi-Cal recipients. More significantly, nearly 60% of the drugs may now be dispensed only with a time consuming process called "prior authorization" whereby a physician's medical judgment is second guessed by a pharmacist as to the need for the drug in a particular case. A few specific examples of the deficiencies in the new formulary will be useful. For example, the new formulary completely omits the drug Flagyl, the only drug for treatment of a disease process called Trichomonos Vaginalis; cardiac drugs are limited to the nitrates only, without prior authorization; all but Thorazine have

been eliminated from the class of psychiatric drugs; and narcotic analgesics only are now available without prior authorization, even for use in children.

More significantly from the point of quality health care is the limitation to two visits per month per recipient to a doctor. If a patient needs to see his doctors after his two visits per month, he must now wait for his condition to become a genuine medical emergency before seeking the proper medical care, or have his request for additional care processed through the time consuming bureaucratic system of prior authorization, which is designed not merely to discourage the seeking of such care but to totally eliminate certain kinds of care.

This new system of prior authorization has already resulted in long delays to patients. For example, in recent hearings before the State Assembly Subcommittee, held here in Los Angeles, state officials admitted that over 26,000 requests for such prior authorization were sitting in their offices in Los Angeles County alone. Further they admitted that requests sometimes require two, three or even more weeks to process. It is known that drug requests have waited even longer. But the state in its adoption of the present system of prior authorization has not appeared to take into account the fact that disease processes do not wait upon bureaucratic processes. The average course of an infectious disease is two weeks. Yet the state guidelines allow ten full working days, or two weeks to decide whether to help the doctor intervene on behalf of the patient to fight this infectious disease process. Such delays have prompted many private physicians to abandon the Medi-Cal program, concluding that they cannot in good medical conscience treat patients under these conditions. What then does this mean to the county and to the rising costs of county government?

First county hospitals are ultimately the health resource of last resort to Medi-Cal recipients. The county is obligated by law to provide what the state is cutting back. This results in excess burden on the county hospitals and forces the recipient back into a dual system of care, which Congress, in enacting, Title XIX, sought to prevent. Any administrative system which forces beneficiaries back into this dual system, thus violates the spirit of federal legislation, which provides and I quote "that achievement of medical goals requires the fullest possible application of medical knowledge and the use of *all* health resources." But the administration action does not merely violate the spirit of the federal medicaid program. It also arguably violates the letter of federal statutes, which require that medical care to medicaid and California Medi-Cal recipients be rendered *promptly*. Any administrative system, producing the types of administrative delays which are currently being experienced in the California Medi-Cal program under prior authorization, would clearly appear to violate the federal promptness requirement. Federal statutes also require federal approval prior to reduction in the scope and quality of sevices rendered in a state's medicaid program. The change in the state's Medi-Cal program virtually eliminates meaningful psychiatric care, by limiting the numbers of visits to psychiatrists to one every six months.

Is this not a reduction in the scope of services? Is not the limitation in physician visits, to two visits per month, a similar reduction in scope of services? Yet we learn that at no time did the state seek prior approval for the reduction in the scope of services from the federal government. Finally federal statutes require that services be such that they be sufficient in amount, duration and scope to reasonably achieve their purpose. Yet, under the cutbacks a physician is permited to see his patient twice a month, but not to see them a third time to follow up the care initiated in the first two visits with routine diagnostic procedures.

But we need not look merely to federal law to find a questionable basis on which the state is seeking to deny payment for medical care to the Medi-Cal eligibles. The state guaranteed a maximum ceiling on county expenditures on medical care for the needy. Prior reference has been made in this hearing to the state's subsequent adoption of a ceiling on these reimbursements to the counties participating in the so-called county option plan. It has been assumed by many that the refusal by the state to *provide* this care through the Medi-Cal program, places ultimate responsibilily to pay for the care back to the counties. While it is true that the counties are obligated to *provide* the care to these patients, it is at least arguable under the terms of the state statute, that where a Medi-Cal eligible patient is no longer a recipient of Medi-Cal services, but instead receives those services from the county that the state is still obligated to option counties for

all expenses incurred in the treatment of such patients about base year level costs. Thus the state by forcing Medi-Cal recipients onto the county and continuing to refuse to pay for the cost of their care, will be violating its own guarantee.

We are now joined in legal combat with the Governor over these actions, but resorts to the courts cannot hope to obtain the full and broadest measure of attention which this problem deserves. As has already been urged upon this commission in earlier testimony, attention must be directed to the unmet health needs of the poor, the disabled and the blind. Cutbacks in medical services of the present type, which by the state's own guidelines are designed to eliminate medical care, of the type which would assist one in engaging in employment, can only add to the welfare roles, further increasing costs to state and county government. Refusal to pay for such medical care is the quintessence of penny wise and pound foolish fiscal policy. We therefore urge this commission to advise our supervisors to exercise every conceivable device to provide health care for the Medi-Cal recipients and to ask the state to live up to its obligations to reimburse the county for that care. Secondly, we urge this commission to urge the supervisors to add their voice to those being heard in Sacramento, to urge the Governor to reconsider this cutback and for the legislature to appropriate the necessary funds to restore the full program.

Before closing I should briefly like to turn the commission's attention to yet another example of the state's penny wise and pound foolish policies with the Medi-Cal program. Under a recently announced new Medi-Cal policy, the state is refusing to authorize payment for medically indicated therapetuic abortions to unwed pregnant minors where it appears that the parents of the girl, or the father appear financially capable of paying for the needed medical care.

This policy has been adopted despite existing state law already entitling the state to seek reimbursement for such care from the parents or father financially capable of doing so—and amount to nothing more than throwing additional bureaucratic red-tape in front of the unwed pregnant minor who qualifies for a therapeutic abortion and is Medi-Cal eligible. The effect of this red-tape is to further deter or in some cases prevent such girls from obtaining the indicated abortion—and from a fiscal point of view this is utterly illogical—since having the child will add far more to the state's costs than the cost of approving the abortion. This latest policy of the state, setting obstacles in the path of the unwed pregnant minor seeking a therapeutic abortion, seems to have originated from the same punitive oriented mind, which construed a recently passed state statute permitting minor girls to obtain medical assistance without first obtaining parental consent as not permitting them to seek therapeutic abortion without parental consent, despite what would appear to be clear statutory language to the contrary. The blindness with which those in authority have persisted in viewing this medical consent statute has forced resort to the courts. The case is now pending before our courts. If the state persists in this most recently announced policy, similar time consuming expensive resorts to the courts will be necessary. In the meantime another class of Medi-Cal recipients will be denied care which they rightfully should have.

CRAIG CULLEN,
Attorney, National Legal Program on Health Problems of the Poor.

EXHIBIT B.—STATEMENT BY THEODORE R. ISENSTADT, EXECUTIVE DIRECTOR OF THE JEWISH FAMILY SERVICE OF LOS ANGELES, ON BEHALF OF THE JEWISH FEDERATION COUNCIL OF GREATER LOS ANGELES, OPPOSING CUTBACKS IN THE MEDI-CAL PROGRAM

(Special legislative hearing, January 15, 1971, Los Angeles)

I am presenting this statement on behalf of the Jewish Federation Council of Los Angeles, a voluntary organization representing the Los Angeles Jewish community. The Jewish Federation Council, through its network of programs offered by a number of agencies, concerns itself with the health, welfare and special needs of the rapidly burgeoning Jewish population in our expanding community.

Some of the agencies serving the Jewish population are also beneficiaries of the United Way. Others are completely funded through the annual United Jewish

Welfare Fund campaign. The Council through its Social Welfare Legislation Committee has always been concerned with the maintenance of strong and sound public medical care and social welfare programs for all citizens of the community and has supported legislative measures to attain these goals. It has decried the recent evidences of attempts to decrease the scope and effectiveness of these programs for people who are genuinely in need and who have no other available resources.

We are alarmed that the introduction of drastic revisions in procedures for authorization of Medi-Cal payments will restrict and reduce the quality of medical care available to people who are unable to purchase this care independently. The economic recession in which this community finds itself at the present time heightens the need for an even stronger more inclusive program. Instead the cutbacks already under way restrict even more the availability of much needed medical services to growing numbers of people.

In the Jewish Family Service of Los Angeles, to which many people bring their problems at a time of crisis, we are already beginning to see a steady growth in requests for help from people to secure medical care, medication and appliances. They include both recipients of the various forms of public assistance, as well as individuals and families with marginal incomes.

The requirement of prior authorization for specified services delays their immediate delivery to people who need them at a point of a physical or emotional health crisis. The limitations on the extent of service allowed are a further restriction. The voluntary agency cannot replace what has come to be recognized as an appropriate government function—providing payment for adequate health care for persons who cannot meet these mounting costs with their own limited resources.

I should like to cite for the attention of the Committee several illustrations from among recent applications to us by persons adversely affected by the present Medi-Cal cutbacks:

A middle aged woman with a known diagnosis of epilepsy receiving an anticonvulsive medication has had the prescription discontinued until "prior authorization" can be received. There has already been a three weeks delay and still no authorization.

A 30 year old man, emotionally ill, with a history of several institutional commitments, now receiving public assistance under the Aid to the Totally Disabled program, has been seeing a psychiatrist and receiving tranquilizing medication. With the combination of psychiatric interviews and mood altering drugs, he had been able to function marginally in the community. His psychiatrist has notified him he can no longer see him until he receives "prior authorization". The medication is not one listed on the formulary. Our worker believes that the young man's emotional condition has deteriorated and has recommended his referral for institutional care which in the long run will prove a more expensive charge upon the community and will impede this young man's recovery.

A 20 year old emotionally unstable man has for the past 18 months, been seeing a psychiatrist with a degree of regularity, which has given him the capacity to function independently in the community. Treatment has now been discontinued pending "prior approval".

The Jewish agencies in the community have contact with a large number of older, enfeebled, and ill persons. Most of them are recipients of Old Age Security allowances and receive their necessary medications through Medi-Cal payments. The recently instituted requirement for prior authorization for many of these medications has stirred up considerable anxiety and heightened the insecurity of this already insecure sector of the population. Taking a prescribed medication regularly is an important prop to an older physically or emotionally ill person. Altering the pattern of delivering this medication can seriously affect personal adjustment and ability to continue to live independently in the community.

Out of our growing experience with the impact already evident from the recently instituted Medi-Cal cuts and the conviction we hold for a soundly administered system of payment for medical care and related services for those unable to purchase them independently, the Jewish Federation Council urges that the recently revised regulations be withdrawn.

EXHIBIT C.—CALIFORNIA COUNCIL OF THE BLIND, INC.

JANUARY 27, 1971

The following is a supplement to the oral report given by Carolyn Helmer in behalf of the California Council of the Blind.

Subject: "Effects on blind recipients of Medi-Cal cuts and poor administrative procedure."

As a representative of the California Council of the Blind, an officer in Active Blind, Inc., and the director of a blind center, I find the effects of the Medi-Cal cutback are catastrophic. I come in contact with it every day, and the workings of the Social Services Division every day. As a spokesman for the blind, the experiences I have had with the department are but a microcosm of the entire department, as the Blind Division is the smallest and represents only approximately 4,500 people. Therefore, I feel that if the very smallest division can be so inept with a few people to handle the bureaucratic ailments, then the entire division must be a veritable clossus of errors. At the State interim committee meeting last week on the cuts in Medi-Cal, we were able to cite a number of cases:

Although Sacramento is over 26,000 authorizations in arrears and there is a necessity for the county to take up the slack in medical treatment, there is an unrealistic viewpoint that an edict or a governmental cutback will make the intolerable situations disappear. But it has not disappeared in the blind categories on aid.

Many of our recipients are being forced to buy drugs that have been taken off the Formulary. As a consequence, people living on a budget of $200 a month or less, have drug bills amounting to $20–25. Attached is such a bill for drugs that have been removed from the Formulary.

In spite of the television propaganda that recipients of aid go to podiatrists solely to have their toenails trimmed, in the Blind Division we have many diabetics with foot injuries that can lead to amputation. These people must have podiatric treatment for circulatory purposes and the removal of "proud" flesh. Also, I have an experience of one of our participants who, due to nervous instability coupled with growing blindness, needs weekly psychiatric care. No authorization has been forthcoming, but in the meantime, the recipient made an aggressive attack on another resident at board and care home.

Now let us get down to some of the monumental decisions made in the Department in the name of economy. The interrelation between the Medi-Cal costs and social welfare program is pointed up by a postoperative lung cancer case, the case of Bennie Jones. The Social Welfare Department maintains a closed-end policy in attendant care. Hence, attendant care is being cut back. As a consequence, more money is paid by both State and county because such a patient is advised by the MRT (medical review team) to be put in a hospital or nursing home. The doctor's recommendation for home care is completely ignored. The human element is forever ignored in a dollars and cents jungle of inefficiency. Even in the case of the legally blind, the removal of a cataract sometimes improves the vision so that mobility is facilitated. A recent case came to my attention where such special classes were refused on the basis of a "nonemergency". The original lenses had been scarred and dropped, so that the recipient now suffers the discomforture of approximate total blindness. So far, the authorization is still being denied. Still another recipient represents the very dangerous practice of putting off surgery unless it fits the precise definition of "emergency" as defined by the health care medicos in Sacramento. A very serious case came to my attention where a ruptured disc caused extreme pain and an operation was necessary. The operation to this day is still pending. The patient is still suffering and Sacramento is sitting on an authorization.

Added to the difficulties of the blind person and their adaptation to the everyday task is the question of transportation. With the growing emphasis of referrals to the county hospital, this increases this load. The Welfare Department frequently requests the blind person to come into the office to settle a controversial matter. This necessitates cab fare. The Blind Division seems to have no case aides to go out to the older blind person's home to make the burden lighter. The Blind Division is the stepchild of all categories in aid. County home aides are not supplied to that division and the super-structure called "adult aides" do not furnish transportation. This particular division of adult aides claims they cannot get volunteer transportation. This is a very poor excuse because all the private blind organizations—Braille, the Foundation for the Junior Blind and Reap, my own organization—must get volunteer drivers and do. This particular division is allowed to pay their drivers up to 20 cents a mile for the first $7 in payment for

driving. This is hardly a volunteer driver and should be much easier to get. Furthermore, the private organizations such as Braille, the Foundation and Reap, have a non-paid staff who get volunteer drivers for us. The county supports highly-paid personnel all over the county who *fail* to get even paid drivers.

In addition to the cuts to Medi-Cal and the transportation issue, we must add the incredible administrative bungling. We hope that a committee meeting such as this is not only concerned with the high cost of social welfare, but also is interested in the improvement of the situation for the recipient. It seems unreasonable to conclude that such a hearing in a relatively affluent society could be concerned only with the tax burden.

To point out an example of administrative bungling, let us take only one case which, unfortunately, is quite typical. This is the case of Lelia Sharp. In August, 1968, this case should have been on Aid to the Blind. Instead, it was still in OAS. It took from August to January, 1969, to get the case transferred. These kind of delays are very common in the department. Why is this so? Now, to continue with this typical recipient.

Last year, the several welfare recipients brought suit to recover cost of living, increases of $2 monthly that should have been distributed to the blind. They won the case. But the pay-off did not come before 14 months later. In the case of Lelia Sharp, she had, by that time, been on Aid to the Blind for 9 months. Consequently, instead of receiving a check for $18, as any ordinary bookkeeping system would indicate, she received nine checks at $2 each. Now, let us take a look at this in relation to the entire department. This court decision affected approximately 3,300 blind recipients. Thirteen extra checks times 6 cents is 78 cents per recipient, multiplied by 3,300 equals $2,574. This is but one example of the crass stupidity of the administrative bookkeeping system in the county.

This particular case could be multiplied 50 times. If there is any kind of under payment where checks in arrears have to be issued, they are sent out individually on a monthly basis instead of in a single check. For example, let us once more take the case of Lelia Sharp to further illustrate some of the idiocy encountered. Last April, 1970, Lelia Sharp applied for food stamps. April and May passed, and along came June. We notified the head of the Blind Division that Lelia Sharp had not received her food stamps at a meeting of representatives of the California Council of the Blind with the Social Service Office. More months—July, August, September. Meantime, in calling the Blind Division, the process goes something like this: First of all in calling 746-0522, twenty rings is a short wait. I asked for Miss X but Miss X is no longer on the Lelia Sharp case. She has been transferred. So next I call Miss A., Mrs. Sharp's eligibility worker, but Miss A. is very busy. Doing what? Why working on a survey, of course! For the Federal Government to determine what are the characteristics of the average blind recipient. This stops me cold, as it was only about two months ago when I called the office and nobody could talk to me because they were looking up the characteristics of the average blind recipient for the State Government. Just for a matter of interest, I called only this week the Director of the Blind Division to find out just what were the characteristics of the average blind recipient. In spite of all the time consumed, he said he didn't know yet as all the findings had not been correlated. Today, however, I had an equally hard time getting either the Director or Deputy Director.

For the past week, the entire Blind Division has been researching the number of illegal entrants to the United States—not one or two people mind you—the whole department. Just two days ago, Cathy Dorrier, one of the recipients, reported to me that she had received three calls from the Welfare Office asking if she were a citizen. She reassured them that she had been one for 15 years, but that was not enough. An eligibility worker had to be or sent out to confirm this statement which was already on the record in the Department in the first place. But to get back to Poor Lelia. When I finally got to Miss A., she informed me that Mrs. Sharp's case was in the hands of a Miss B., a short-term social worker. The next time I called the case was in the hands of Mr. C., a long-time social worker. Then, in order to really trace things down, I had to talk to Supervisor D. Finally, it was December, 1970, and a Mrs. H paid a visit to Mrs. Sharp. They had a new application for food stamps and now felt it necessary to interview not only Mrs. Sharp, but her daughter. More forms. Now it is January, 1971, and Lelia Sharp still does not have her food stamps. But quite obviously EVERYBODY is working on it. I even got a call yesterday from the Appeals Division. They were shaken up not only by finding that Mrs. Sharp was filed in two catagories of Aid, but that four sticks of dynamite had been at their door that very morning. Now

there is the question of where Mrs. Sharp's OAS aid checks went, if there ever were any.

The blind are not militant enough to take the dynamite route, but the frustration of the bungling ineptitude is shattering. This morning, I learned that one of our recipients was supposed to have their aid grant reduced in October—the word "reduced" was translated somewhere in the Department "to cut off". So far, the client has not received a January check at all.

Just multiply some of the bureaucratic mish-mash and add the cost. Under the present system of having long and short term social workers and eligibility workers, nobody knows who is doing what for whom. The former system, wherein there was one social worker involved, was much more efficient. Now, nobody even knows where the recipient's file is. Of course, we understand that this present system is imposed by the State, but we are quite certain that it only adds to administrative costs and bungling. It seems that when an attempt is made to cut the budget in one department, another department is sure to grow. So many complaints come in from the recipient that the Department of Public Inquiry is adding desks every day. Now let's get down again to some of the monumental decisions made in the Department in the name of economy. Consider Mrs. Sharp. She is an older woman with diabetes, unable to walk for a full year. Her social workers knows this and so do quite a few other people. Were Lelia Sharp to have received the attendant care she should have had, every six months, she would have to be re-evaluated to see if she is still eligible. The doctor's fee for this is $6. In one's seventies people rarely regain their sight and there should be some guidelines to preclude this needless re-evaluation of services.

You, gentlemen, are trying to compile facts for the County Supervisors. The task is not easy and there is so much interrelation. However, if I, as a blind person, were running this department, I would sharpen my pencil and figure as follows:

How much does this enormous load of administration cost per blind person? Let us try to calculate. In the case of Lelia Sharp, we have involved about 15 people. Multiply this administrative cost by 4,500 blind people. Now try it this way. Take away the whole bureaucracy—in most instances—all it does is slow down the machinery. Issue the checks from Sacramento—add $125 per month to each blind person's aid, and the County and the State and the Federal Government have saved thousands of dollars. *This economy is what we are talking about, is it not?* Why not a flat grant for all the blind with a substantial increase to cover all special needs, and we would all be way ahead? Every time a blind person is born or becomes blind, a whole bureaucracy springs live on the back of that individual until his bureaucratic load is ten times greater than his cost to the government. Let us put some of the money the State saved by this method into training the blind for employment and educating the public to the fact that a blind person, in many instances, can carry his own load.

ITEM 2. REPLIES FROM MEETING OF SANTA MONICA SENIOR CITIZENS

FAMILY SERVICE OF SANTA MONICA,
Santa Monica Calif., June 11, 1971.

Subject: Cutbacks in Medicare and Medi-Cal coverage.

Hon. EDMUND S. MUSKIE,
Chairman, Subcommittee on Health of the Elderly, Special Committee on Aging, U.S. Senate, Washington, D.C.

DEAR SENATOR MUSKIE: Attached are replies received at a meeting of Santa Monica senior citizens, and which represent the opinions of the entire meeting and also those of most of the senior citizens in our community.

We note that some of these comments apply to high rent also which is another matter of concern to our seniors who live on a fixed income from Social Security. Rents are raised frequently which has made it impossible to keep up with the increases and also food and medicine, doctor bills, etc.

Please do all you can to ease the strain on these seniors of keeping well and being able to pay the cost of same.

Thank you.

Sincerely,

NAOMI GOLDSTEIN,

Coordinator of Senior Citizens Program, Family Service of Santa Monica.
Enclosures.

BEATRICE B. OPPENHEIMER, SANTA MONICA, CALIF.

Cutbacks in Medicare and medical coverage constitute a callous and cruel act toward the sick unable to secure proper medical attention and drugs. They are a short-sighted policy that shoved work to curb in war activities, that represent death over life.

MRS. NELLIE SAGAL, SANTA MONICA, CALIF.

If Governor Reagon paid his taxes and all the multi-millionaires it wouldn't be necessary to bilk the poor and destitute to support the State's medi-cal program.

NANNIE PHILLIPS, VENICE, CALIF.

The $60 is too much for Senior Citizens to pay.

EVA E. BRENDER, SANTA MONICA, CALIF.

Prescription drugs should be paid for by Medicare. They are so high-priced (and going up all the time) that many people on low and fixed incomes cannot purchase them.

PAULINE WIENER, SANTA MONICA, CALIF.

I'm paying $115 rent. With all the hopes of seeing the increase on Social Security the Welfare is so nicely taking it back.

HELEN ROSS, VENICE, CALIF.

DEAR SENATOR MUSKIE: As Chairman of Subcommittee on Health of the Elderly.

The cutbacks in Medicare and Medi-Cal coverage is an outrage and very unfair.

Therefore Honorable Senator Muskie, we look to you for action to correct this adverse situation. Sincerely.

ESTHER A. SOLOMON, SANTA MONICA, CALIF.

Senior Citizens have enough difficulties without adding more woes. There are plenty of methods of reducing expenses without curtailing benefits to the aged.

MINNIE R. TENENBAUM, SANTA MONICA, CALIF.

The cutbacks affect those who are least able to bear the lack of services heretofore given. We need more humanitarian treatment of the ill and financially deprived.

F. J. OPPENHEIMER, SANTA MONICA, CALIF.

They are inhuman and not to be counteracted by any human being.

ELEANOR KEEGAN, SANTA MONICA, CALIF.

I am against any cut in Medicare. At my age and my income, I could never pay the present charges for Medical care.

MARY ALLEN, SANTA MONICA, CALIF.

The $60.00 is too much for Senior citizens to pay.

JOSEPH KORITNY, SANTA MONICA, CALIF.

DEAR SENATOR MUSKIE: If there had been time for everyone to speak at hearing on "Cutbacks in Medicare and Medical Conference" in Los Angeles, Calif. on May 10, 1971, I would say, that we need more Social Security, as the last increase my Landlord took it away by raising the rent 20%. Respectfully yours.

MR. FANNIE KORY, SANTA MONICA, CALIF.

We need another increase in Social Security due to the fact that prices on food and rent are sky high and for people on Social Security it is very tough to get along.

HELEN L. YUDIS, SANTA MONICA, CALIF.

The $60.00 deposit for Hospital is too much for Senior Citizens to pay.

ITEM 3. STATEMENT OF THE EAST LOS ANGELES SENIOR CITIZENS VOCATIONAL TRAINING PROJECT

This is a unique Project because it is the only one of its kind in the United States. It is part of the War on Poverty of Los Angeles County and we are funded by E. Y. O. A. Our sponsor is the Greater East Los Angeles Senior Citizens Foundation, with Mr. William A. Botana as president.

The program began in 1968 after great difficulty. We struggled because our project deals with men and women age 55 and over. We encountered opposition and found it hard to convince many authorities at the County, State, and Federal levels. They considered it very impractical to train persons in this age bracket. They thought it was not feasible to train the senior citizen.

We went into the barrios and discovered many older shut-ins laying in their beds without a drink of water, without beds, and with sores on their bodies. We found people literally abandoned by relatives who were in need of medical attention. This opened our eyes to the need of training men and women as nurse's aides to help alleviate the suffering of the afflicted. With evidence in hand, authorities were able to see the value of such training and funds were made available through a federal grant. This grant enabled up to start the Project.

During 1969 we trained a good many persons as Family Aides, a program which consisted of purchasing, home management, personal hygiene, first aid and other subjects. At the beginning of 1970 we were prepared to extend our program to include the training of persons as nurse's aides.

We feel very proud in having helped in the advancement and the progess of 110 persons who took advantage of the course. This course was offered and continues to be offered by registered and dedicated nurses. These nurses believe that this older group can be taught and and made to become useful citizens. The success of our whole program was made possible by the high quality of instructors and the modern hospital facilities at our service. At the same time the trainees were devoted to the learning and attended classes with good attendance over a ten week period.

During 1970 we were able to train 110 persons and were able to place over 90% of them in hospitals and in private homes in the various areas. All of these persons have found a new career which is both dignified and profitable. Those who had never had an opportunity have been helped in this project in the growth and development of their lives. Today they are employed in a labor where they can help themselves and also help others. Those in this age bracket are enthusiastic about learning and are very stable in their work habits.

Our activity has taken us into the San Fernando-Pacoima and South-Central Los Angeles areas. We have established offices in those two communities. In all three areas we have been able to place our graduates in general hospitals, convalescent hospitals, and in private homes.

It is our purpose to extend our program to include persons of age 45 and over. We have found many people in this lower age which are unemployed and interested in receiving instruction in the para-medic field. These people are eager and capable and have many years of service ahead of them.

It is our hope also to be able to offer classes in Spanish for the benefit of those who do not speak English. We hope that soon this program may become a reality.

In the meantime our office is open to serve all the poor. We are a bi-lingual staff ready to help those who want to be lifted to a better and more dignified way of life. We serve those who feel rejected to feel a part of the community and help him to take an active part in his self determination. We help those who wish to better themselves by learning a meaningful career. We have an opportunity to offer the senior citizens who want to raise their economic level. It is our hope that the federal government will continue the funding and support of this fine project.

It is our feeling that the senior citizens who are poor in this country have been neglected for too long. We insist that they be given all of the service which they deserve and that these services should be a right and not a privilege.

ITEM 4. LETTER FROM DR. JAMES W. BROWN, WENATCHEE, WASH.

WENATCHEE VALLEY CLINIC,
Wenatchee, Wash., May 10, 1971.

DEAR SENATOR MUSKIE: I heard today over the radio that you are chairing a committee on health for the aged and the various problems involved. One thing that your group might explore is that many nursing homes and in particular the nursing homes in our area, have dropped out of the Medicare business. They have found that they cannot run their nursing homes depending on funds from the United States government that were allocated from Medicare for extended care purposes. As a result we practicing physicians are forced to either keep these elderly, unfortunate patients in the hospital at tremendous expense unnecessarily or they are forced to go to other inadequate situations. The reasons these nursing homes have been forced out of the Medicare-patient business is the lack of payment that they receive from Medicare and the United States government. Some of the nursing homes in this area had debts in the many thousands extending back to 1967 which they had not collected from Medicare, so it certainly is not the fault of the nursing home. I think that your committee would be wise to look into this type of inadequate funding.

Sincerely,

JAMES W. BROWN, M.D.

ITEM 5. LETTER FROM R. M. STERRETT, LOS ANGELES, CALIF.

MAY 10, 1971.

DEAR HON. SIRS: Your activity on the subject of Aging is highly commendable and most worthy. Of the many problems involved I imagine the problem of health care and its attendant relationship with Medicare is one of paramount importance.

Personally I am presently enmeshed in a controversial issue with Medicare which I would like to cite as a problem of Aging.

My wife, Audrey Sterrett, fell on December 3, 1970, and fractured her right femur just above the knee. On that date she was entered to St. John's Hospital in Santa Monica, California and surgery was performed by John F. McGonigle, M.D. on December 8th.

After 60 days in the hospital she was transferred February 2, 1971 under doctor's order, to the Santa Monica Convalescent Center at 1331 22nd Street, Santa Monica 90404 where she is at the present time although she is immediately due back to St. John's Hospital for additional surgery.

She is eligible under Medicare. On page 7 of the Medicare Handbook the benefits are clearly defined and her status is completely within those definitions with all conditions and circumstances in her favor.

The Convalescent Center had full knowledge of her status under Medicare and accepted the patient accordingly.

On April 30, 1971 I received a letter dated April 29, 1971 from the Department of HEW via The Travelers which disclaimed liability under Medicare to pay for any care whatsoever at the Convalescent Center from the date of her entry, February 2, 1971.

On April 30, 1971 I was handed a letter from the Convalescent Center reporting their notice from Medicare and a demand that I should pay the account.

On April 30, 1971 John F. McGonigle M.D., the surgeon who has full charge of the patient wrote a letter disputing Medicare's disclamation. Copies of the three mentioned letters are attached herewith.

Since April 30, 1971 the Convalescent Center has emphatically demanded that I pay their bill or remove the patient, to which I have repeatedly replied that through Social Security I had made a request to Medicare for a re-examination of the matter. The Administrator of the Convalescent Center has persistently and aggressively insisted that I pay the account or at least a substantial part of it or move the patient.

On May 7th (last Friday) when I entered the Convalescent Center to visit my wife I was confronted by the Administrator, a Mr. Mac W. Buhler, who told me I was notified to pay the account or a good part of it or to move the

patient today. I said I was not prepared to do either on such a short notice and would he please give me his notice in writing. His face turned red, he became temperamentally high strung and very belligerent and said if I didn't have her moved today, then he would. As he turned to enter his private office I started to go in with him but he slammed the door in my face.

His private office is a dead end section of the room and he could not emerge except in my view, so I waited. After some time he came out, walked pass me and down a hall toward a rear door of the building and I followed. I asked him who would pay the expense of moving and to where he would move her but he gave no answer. As we approached the rear door I said you can not move her without the doctor's order and he said he would get her out of here today if he had to set her out in the street. He left the building and slammed the door again.

I went up to my wife's bedside to see what would happen. After quite some time my wife's phone rang and when she learned it was Dr. McGonigle's office she gave me the receiver. The doctor's nurse asked me what all the trouble was about and I explained the matter. She said don't worry, she can not be moved without the doctor's order. So we left it at that.

I would trust that this is only one man's experience in Aging but I have heard of other somewhat similar cases in the Convalescent Center where my wife has been confined.

Respectfully submitted,

R. M. STERRETT.

Enclosures.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
April 29, 1971

Health insurance claim number 550-07-6080-A.

AUDREY STERRETT,
Los Angeles, Calif.

This refers to the claim for HOSPITAL INSURANCE benefits submitted on your behalf for services you received from:

Name and address: Santa Monica Convalescent Center, 1331 22nd Street, Santa Monica, Calif.

Provider number: 05-5741.

Date of admission: February 2, 1971.

We are unable to make payment on this claim for the reason shown below.

Your request for Extended Care benefits has been fully reviewed, including portions of the medical record and other related information when applicable.

We regret to inform you that the kind of care required by you as of February 2, 1971 does not constitute Extended Care Service and is non-covered care. Therefore, the Medicare Hospital Insurance Program cannot pay for this care.

If you believe that this determination is not correct, you may request that your case be re-examined. If you want this reconsideration, you must request it not later than 6 months from the date of this notice. You may make any such request through your local social security district office. If you go in person, please take this notice with you.

SANTA MONICA CONVALESCENT CENTER,
Santa Monica, Calif., April 30, 1971.

MRS. AUDREY STERRETT,
Los Angeles, Calif.

DEAR MRS. AUDREY STERRETT: This letter is to inform you that we have received notification from Medicare that you will not be covered under the Medicare program as of your admission date February 2, 1971.

In view of this fact, we must turn to you, the patient, for payment.

MAC W. BUHLER, *Administrator.*

Santa Monica, Calif., April 30, 1971.

Re Audrey Sterrett, Santa Monica Convalescent Center.

To Whom It May Concern:

The above named patient underwent surgery 12-8-70 for an open reduction and internal fixation with application of skeletal traction to the right femur. After adequate callous had been obtained she was placed in a long leg cast.

The patient had a prior prothesis to the proximal femur on the same side. She was sent to Santa Monica Convalescent Center for Skilled nursing care and also for physiotherapy. She fell while in physiotherapy and sprained her right ankle and therefore the physiotherapy was cancelled. She is still in the long leg cast and is still unable to resume physiotherapy for fear she will fall and fracture another bone. She needs the skilled nursing care to get her up into a chair since she can bear no weight of her own. She also needs skilled nursing care to answer for her needs as she is immobile and has no one at home capable of caring for her. We fear if we sent her home, she would fall and therefore, we would have another problem to deal with.

If I may be of any further assistance, please do not hesitate to call upon me.

Sincerely,

JOHN F. MCGONIGLE, M.D.

ITEM 6. PREPARED STATEMENT BY LOREN L. MERRITT, PRESIDENT, LOS ANGELES NURSING HOME ASSOCIATION

In the following facts I will not attempt to address myself to the mountains of figures compiled by the Health Care Services Department and our own Association of Nursing Homes.

I do wish to point out that the recent cut in the Medi-Cal program, and other proposed cuts, do not express clearly to the general public, that it will be costing the State of California an income of some $70,000,000.00 in federal funds this year, and untold millions in the future. These funds have been contributed by all of us in this state and we are entitled to have our share of them used here in California, the Department of Health Care Services has also threatened to lower the rates beyond the current rate of reimbursement. The figures used for this determination are very questionable. A small 25 bed facility I operate was one of the 76 that were quote, audited, unquote. I first question the ability of the accountants that made the audit in less than 1½ days, to make a proper audit, when a period of 3 weeks was required to audit the same books for Medi-Care, and their results showed a considerably higher cost. I also wonder why a facility, that was built during a period when construction costs were considerably lower, was reviewed, instead of my newer facility that was built at a later time, is directly across the street, but has a higher cost of operation.

I might point out at this time also, that new construction was undertaken as the result of a Federal program, that sent information to all of us in the profession, that the medi-care and medi-cal programs desired and needed thousands of additional beds that could provide a higher level of care. We were perhaps naive to believe that succeeding governmental regimes would have as much concern for the aged and helpless, as those of such great men as Eisenhower, Kennedy, and Johnson. In regards to the impact of the proposed lowering of rates, I must ask the following. We at present are providing a level of care that the Department of Health Care Services determines to be only adequate. At the same time the reimbursement at present dictates that many of our employees be paid at or near the existing minimum wage. Is it intended that we are to lower our standards of care to the point that will cause danger to the very lives of our patients, or that we attempt to lower our employee salaries to less than the minimum. I find it impossible to understand why our industry has been chosen for this cutback. Governor Reagan has not asked the highway contractors, or the contractors building our state buildings, the plumbers, the plasterers, hod carriers, and carpenters that certainly must be used on those jobs, and who are all paid hourly wages of $4.00 to $12.00 or more, and yet, Dr. Brian, personally told me at an open meeting that a salary of $1.65 was more than adequate for our help. Many of our employees are members of minority groups, with the black community in the majority. These employees are performing one of the most difficult and important services to the community today, but because of an apparent lack of concern for the helpless and the aged. They have not had an increase in income for the past 3 years. Is not the care and comfort of a human life as important as the joining of pieces of steel and brick and mortar. The lack of insight of the governors figuring is forcing many of our fine employees on to the welfare roles, and instead of decreasing the problem, he is increasing it. Our employees do not want welfare, they want to earn their way, but with these cutbacks, they will now be denied that right.

I will assume that you will present an opinion that the current rate is so plentiful, that if we are so concerned about our employees, why don't we pay them more. The answer is very obvious. If we are so appreciably reimbursed, please explain the tremendous number of bankruptcies this past year and why at this moment, many more are on the verge, although having an occupancy of 90%.

We have heard this program described as a welfare program only. I deeply resent that description, as each and every patient is there for medical care. It is not the fault of the aged that costs of living have risen to the point that their personal savings will not provide the needed care. Neither is it possible for the average family to provide for their mother or father and maintain their family also.

I believe that given honest understanding, the general public will show more concern for their fellow citizens than those of you in power believe. If they do not, I will be ashamed to be a member of a society that makes the almighty dollar more important than the comfort and dignity of our sick and aged, and I shall certainly have nothing but disgust for a National Political Party that places oil rights, subsidies, foreign aid, and military weapons at a higher value than the lives of our citizens. Perhaps the general public does not realize that the apparent saving of welfare money is false, when in essence, they are transferring the burden to the individual counties and costing the county tax payer, many times his needed cost, than if you were to take advantage of the federal funds. The patients and employees that will be forced onto the individual county welfare roles, will once again force our property taxes to another high.

ITEM 7. LETTER FROM DEPARTMENT OF HEALTH CARE SERVICES

SACRAMENTO, CALIF., *June 11, 1971.*

DEAR MR. AFFELDT: Thank you for sending me a copy of the transcript of the Senate Committee on Aging's hearing on health care coverage for older Americans. As you requested, I am returning the transcript copy.

Much of the testimony in this transcript expresses concern about the Medi-Cal program restrictions that have been in effect since December 15, 1970. These restrictions, which were unavoidable under California Statute, are scheduled to terminate at the end of this month.

What the Medi-Cal program will include for the coming fiscal year—and how much money will be appropriated for it—are now being considered by the State Legislature. We hope the outcome will be a stable program that will enable us to provide, without recurring crises, essential health care for all eligible beneficiaries.

Sincerely,

EARL W. BRIAN, M.D.,
Director.

APPENDIX 4

MEDI-CAL CUTBACKS, LOS ANGELES COUNTY

ITEM 1. LETTER FROM WARREN M. DORN, CHAIRMAN, BOARD OF SUPERVISORS, COUNTY OF LOS ANGELES

LOS ANGELES, CALIF., *May 10, 1971.*

DEAR SENATOR MUSKIE: At the request of your staff I am transmitting herewith the position of the County of Los Angeles regarding the Medi-Cal cutbacks implemented by the State of California. Also presented are our comments regarding recent changes in the Medicare program as they affect the County of Los Angeles.

The testimony concerning Medi-Cal cutbacks was presented earlier this year to a California State legislative committee. I believe this testimony will be pertinent to the hearings the Subcommittee on this testimony will be pertinent to the hearings the Subcommittee on Health Care is holding regarding California's Medi-Call program.

Your Subcommittee should be aware that in this State, counties have the responsibility of providing medical care to indigent persons. With the advent of Medicare and Medicaid, substantial progress was made in improving the level of care in county hospitals while at the same time minimizing the tax burden on the local property taxpayer. This recent progress is now being threatened through Medi-Cal cutbacks by the State which will result in a reduced level of medical care for indigents or an increasing burden on local property taxpayer.

I wish to thank you for the opportunity to present Los Angeles County's position on this important subject. If I can be of further assistance, please let me know.

Very truly yours,

WARREN M. DORN,
Chairman, Board of Supervisors.

Enclosure.

EXHIBIT A—STATEMENT PREPARED FOR U.S. SENATE SPECIAL COMMITTEE ON AGING, SUBCOMMITTEE ON HEALTH CARE

Recently there have been a number of changes in the Federal Medicare Program. Of these changes, the only one which has had a substantial effort on Los Angeles County has been the revisions in the co-insurance and deductible provisions of the program.

At the beginning of the Medicare Program, for Part A services, Medicare patients had to pay a deductible of $40 plus coinsurance of $10 per day from the 61st to 90th day of each spell of illness. The total cash-out-of-pocket for each Medicare patient for a full 90 days was to be $340.

Now Medicare patients must pay a deductible of $60 plus coinsurance of $7.50 per day from the 31st to the 60th day and $15 per day from the 61st to the 90th day. The total cost to each patient is now $735 for a full 90 days of care. This represents a 116% increase in the patent's share of cost.

In Los Angeles County hospitals, the majority of patients on Medicare also qualify for Medicaid (Medi-Cal in California). The Medi-Cal Program picks up the deductibles and coinsurance amounts which are in excess of the patient's liability to the Medi-Cal Program. The State also pays the monthly Part B premiums for Medicare/Medi-Care patients who cannot afford the monthly premium of $5.60. As a result of this Medi-Cal coverage, the effect on any Medicare patient who is eligible for Medi-Cal is minimal.

However, the effect of deductible, coinsurance, and premium increases on Medicare patients who do not qualify for Medi-Cal is tremendous since they are responsible for the full $735 for a 90-day spell of illness. In this case, if they can-

64-350—71——7

not afford the cost of care they become the responsibility of the County and must be treated in County Hospitals. This results in increased costs at a time when substantial State costs are also being shifted to the County as a result of the Medi-Cal cuts.

EXHIBIT *B*—STATEMENT PRESENTED TO ASSEMBLY SPECIAL COMMITTEE ON MEDI-CAL BY I. A. WITHERILL, CHIEF DEPUTY DIRECTOR, LOS ANGELES COUNTY DEPARTMENT OF HOSPITALS

I have been asked to speak on the impact of the MediCal cuts on Los Angeles County and its Department of Hospitals. The MediCal Program cuts have effects in three areas: fiscal, patient care, and the mechanisms of providing care and billing for services. I will address myself to these three areas, and in conclusion give brief consideration to future directions of the MediCal Program.

FISCAL EFFECTS

It is only possible to comprehend the fiscal impact of the MediCal cuts by reviewing the fiscal predicament of the County under the Option method of State-County sharing prior to the regulation changes of December 15th. You will recall that the original MediCal law had an Option under which counties could elect to continue their 1964–65 level of medical care expenditures, with the State to fund increases from that point on. For several years the Option appropriation has been insufficient to fulfill the State's obligation under the original law, and for the past two years the State budget has not provided any increase in the Option appropriation despite obvious increases in County costs due to inflation and additional patient care needs. (The 20,000 medically needy person dropped from the MediCal rolls in Los Angeles County by changes imposed earlier this fiscal year are certainly part of these increased needs.) In the current fiscal year this unfulfilled State obligation amounted to $17.4 million; Los Angeles County has funded, through a property tax increase, almost the entire amount, leaving the Department of Hospitals $3.3 million under-financed. Since early in the fiscal year, the Department has been attempting to meet this deficit through internal measures, including an almost total freeze on hiring. The recent cuts were thus imposed on a hospital system which was already precariously under-financed.

The program restrictions of December 15, 1970 will have fiscal implications for the County which are difficult to predict accurately at this time. We have estimated that together with the costs imposed by the Schedule of Maximum Allowances, to which I shall refer shortly, they will impose an additional burden on the County of $15.6 million on an annual basis, and $9 million for the balance of this fiscal year. On December 1, 1970, the State Administration imposed a Schedule of Maximum Allowances for hospital outpatient care. It will require Los Angeles County hospitals, which have been on a flat rate billing system, to develop detailed, itemized bills at an additional clerical cost of $2.1 million annually. While the State has allowed us until July 1, 1971 to gear up, we have no assurance that they will not disallow portions of bills submitted for the remainder of this fiscal year when you conduct a post audit.

While it is still too early to accurately estimate the shift of patients from the private sector to our hospitals, a two-day survey of patients in emergency rooms of two of our hospitals indicated that between 10% and 15% of the MediCal patients present were there because of refusal of care by private physicians; in the Pediatrics and Womens Units of our largest facility, MediCal visits have jumped 18%. For example, the Pediatric Emergency Room is seeing 256 patients a day so far this month, compared with 199 a day one year ago; of this increase of 57 patients daily, 40 are MediCal patients. A recent letter from the President of the Los Angeles County Medical Association, sent to all member physicians in the County, stressed that physicians who can't cope with the new regulations in any other way can always refer their patients to County hospitals, so we think these trends will certainly continue.

Included in the new regulations is one which will cost Los Angeles County taxpayers $2 million annually due to a change in reimbursement for approximately 100 patients from a long-term inpatient care rate to a nursing home rate. Yet these are not ordinary nursing home patients, but severe problem cases which nursing homes will not accept because of the amount of care they require. They include Multiple Sclerosis patients with paralysis and spasms of all fours

extremities, requiring frequent turning and time-consuming positioning, and Quadriplegic patients with pressure sores who require two persons to turn them every two hours around the clock. We think this change is particularly unfair.

Los Angeles County's fiscal condition is just as severe as the State's if not more so. The County has already absorbed a shift of costs from the State and in mid-year, with an established budget, cannot legally run a deficit. Our Board of Supervisors has instructed the Chief Administrative Officer to seek an urgent deficiency appropriation from the Legislature to relieve the already over-burdened local taxpayer, and I, as a member of the Health Review and Program Council, the Advisory body to the State Administration, have urged in a recent letter that the Director of the State Department of Health Care Services and the Council go on record to the same effect. The shifting of State costs to the County, first by putting an unrealistic ceiling on the Option, and then by treating the County as merely another provider when cuts take place, forcing the County to provide the denied care out of County funds, is so manifestly unfair that we think the Legislature should give its early and serious attention to this urgent problem.

EFFECTS ON PATIENT CARE

While it is obviously too early to fully document the expected effects on patient care, the experience of the Department of Public Social Services indicates that great hardships are already occurring, particularly in the areas of prescriptions, eyeglasses, dental care, and nursing home placement. Certainly the patients are confused and disillusioned by the division of their care in a ping-pong like manner, bouncing between the private sector and the County. It should be stressed that putting off needed care does not save money, it only delays having to meet the bill. Some patients will come to the County for their care, others will merely delay, with hopefully no harm, while at least some (and who can foretell how many?) will develop more serious, and hence more costly, ailments as a result. The County is and will be doing all it can to alleviate these unfortunate effects; certainly the State should at least recognize the reciprocal relationship between cutbacks in private sector care and increased County load, rather than persisting in regarding the County as merely another provider of care.

AUTHORIZING AND BILLING MECHANISMS

The requirement of prior authorization for so-called elective, that is, non-emergency, hospital inpatient admissions, and all inpatient stays beyond certain periods was first imposed in April, 1970. The December 15th cuts imposed similar requirements for almost all outpatient services. Due to the impossibility of the State performing the prior authorization function for the enormous MediCal workload of the Los Angeles County hospitals, we have been performing it as an internal service under guidelines established by the State, and subject to State review and audit. Recently, the State announced that on February 1, 1971 it will assume this entire function, setting up a special unit in Los Angeles County to perform it. We can only approach that date with fear and trepidation: the State will be hiring new personnel to perform the work, the flow of paper and the flood of telephone calls between our hospitals and the State unit will be enormous, and our physicians will insist upon rendering obviously needed care regardless of whether some distant figure in a State office authorizes the care in time, if at all, and regardless of the economic consequences for Los Angeles County.

Increases in useless paperwork, which add tremendously to cost but nothing to patient care, have, of course, been a feature of the MediCal program from the very beginning. The program has occasioned such enormous changes and cost increases in accounting practices, itemizing and documenting practices, and, finally, billing practices, that some have dubbed the Medicaid program "The Accountants' Full Employment Act of 1965." In Los Angeles County we estimate that, since the advent of the program, these increased costs have amounted to over $5 million a year.

FUTURE DIRECTIONS FOR THE MEDI-CAL PROGRAM

Turning now, briefly, to the future of the MediCal program, I think certain problems must inevitably be considered:

First, the problems of the counties in financing the non-MediCal medically needy population, those persons who are self-supporting, but who cannot meet the costs of necessary medical care. These problems were supposedly met by the Option, but, as we all know, this solution did not last.

Second, the incongruity of providing so-called "mainstream," that is, private sector, care for the welfare population, and only public hospital care for the large number of medically needy persons. It is well known that the Medicaid program originally contained the goal of providing care for all who could not provide it for themselves by 1975. A later amendment put off the goal until 1977, and it is certain that it will be deleted entirely in the Social Security Amendments of 1971, soon to be enacted. Third, in my opinion it should be emphasized that an insurance approach to welfare medical care, with a limited set of benefits, is doomed to failure. There are two main reasons: typical insurance controls, such as cost sharing through deductibles and co-insurance features, cannot realistically be applied to persons who are without funds for their own support; further, such persons totally lack the self-imposed restraints which employed persons place on their medical care purchases. Thus, under a limited insurance program, the private sector will skim off some of the benefits, and the counties will have to pick up the rest, while the patient will be lost in the gaps between the private sector care and the county coverage.

A NEW DIRECTION

A separate and more adequate system of care for the poor must emerge, for, even if this nation passed a National Health Insurance Act, there would still have to be specialized arrangements for those in need in order to provide, in an economical manner, for the benefits not covered by the insurance. Such a system should provide for:

1. Full utilization of county hospital systems, with provision for private sector back-up under adequate local controls;
2. Putting all the indigent and the medically indigent into a single financial system, with costs to be shared by the State and the counties;
3. The new system must eliminate the vestiges of poor-law medicine and the stigma of charity care, at the same time reversing the justifiable distrust, and even hatred, held by the poor, through the development of effective community participation;
4. Finally, the new system should work toward the goal of prepayment on a capitation basis, with controls to insure adequate utilization and comprehensiveness of care.

ITEM 2.—RECOMMENDED 1971–72 PROPOSED BUDGET

CHIEF ADMINISTRATIVE OFFICER.
COUNTY OF LOS ANGELES,
Los Angeles, Calif., April 27, 1971.

HONORABLE BOARD OF SUPERVISORS,
County of Los Angeles,
Hall of Administration.

GENTLEMEN: Uncontrollable welfare cost increases, State underfunding of health care commitments, inflationary trends, and general economic decline once more set the stage for a vastly increased budget recommendation for the next fiscal year, 1971–72. An increase of $426,526,401 to $2,358,986,745 in General Fund requirements contemplating a tax rate increase of $.7533 per $100 of assessed valuation will be necessary to provide for the basic services required by law and by policy of your Board.

An overview of this budget clearly shows the plight foreseen over a year ago when the full impact of the major social service programs began to hit the narrow property tax base of this County. Far overrunning any reasonable estimates of growth at that time, the double effect of burgeoning welfare caseloads and the severe State revenue cutbacks in health care services is literally squeezing out all other County services. Welfare alone moves from 47.5% of the current budget to occupy 59% of all projected County General Fund expenditures.

All Special County Funds including Flood Control, Fire Protection, Library, Sewer Maintenance, and Road will require $278,069,651 making a grand total budget of $2,637,056,396.

Even though the total requirement is higher, 56 of the 155 General Fund budget units are less or the same as this year in net County cost, and most of the increase in over-all service workload is being absorbed by the existing organization. This is a direct result of the stringent curtailment program initiated on January 1, 1971, and the extensive efforts of this office and the department heads to meet the budget guidelines laid down by your Board earlier. Without this effort, the tax rate, I am sure would have at least equaled the record increase of this year.

Substantial efforts are being made on a State and Nation-wide basis for reform in the two critical areas of welfare and health care services. However, none of these measures has been adopted nor are we able to predict the fiscal effects of any of the proposed reforms. I am left in the unfortunate position, therefore, of preparing and presenting this budget as if no reform were possible before you must adopt the Final Budget.

In general terms, welfare costs will increase 54% as compared to an increase in the Justice System of only .9%; Health Services, a 3.6% increase; and all other operations, a 3.6% increase. Figure 1 shows the relative differences and clearly depicts the flattening out of prior year's growth curves in all other County functions.

The number of additional budgeted positions in the General Fund is even more dramatically illustrative in that 91% are allocated to welfare with all other operations sharing the remaining 9% of the total increase of 2,933.1. Figure 2 traces a four-year growth in County personnel and again shows a significant flattening of all but the welfare function.

The total number of budgeted positions in the General Fund reflects several severe cuts in current department budgets. However, these cuts are offset by additions involving three categories—those additional positions needed to staff new facilities, those approved in mid-year becoming fully funded for the first time and those which are offset by revenue. This is best illustrated by the following:

General Fund—Budgeted positions—1970–71	68,983.7
Positions added for new facilities chiefly for Martin Luther King Jr. Hospital and service departments	1,748.6
Positions deleted	(—2,189.0)
Positions already authorized during this year and added for full-year funding	171.8
Positions offset by revenue including 2,679 for welfare	3,201.7
General Fund—Budgeted positions—1971–72	71,916.8

Only 25 budgeted positions were added to all of the Special Districts, principally in the Fire service, raising the total number of this category from 6,348 to 6,373. Thus, the grand total for General and Special County funds increases from 75.331.7 to 78,289.8.

Briefly, the other highlights of this budget in the General Fund are as follows:

1. *Revenue Losses.*—Cost shifts from the State and a sharp drop in interest income will cost the County $75,400,000 and have had to be made up in program cuts and the increase in property taxes. Due to general economic conditions as well as anticipated regional decreases in property values because of the recent earthquake, we are estimating only a 2% increase in the assessment roll as compared to 5.6% for the current year.

2. *Inflation.*—Inflation accounts for at least $55 million or 25% of the total net budget increase and includes proposed salary raises to be submitted by the Personnel Director on May 14, an anticipated telephone rate increase, postage increases to be effective May 15 and various other rate increases.

3. *New Facilities.*—New facilities opening during this year and those projected for 1971–72 will stretch the meager resources of many County departments. Twenty-one park projects, Martin Luther King Jr. Hospital and 28 other buildings, including two health centers, containing 1,700,000 square feet of space will be largely absorbed by the various maintenance and using departments with provision made only for the bare minimum of additional personnel.

4. *Public Buildings and Facilities.*—The capital projects program will increase only in the leasing section with a substantial reduction in construction of County-owned facilities. Rent costs will go from $26,758,920 to $33,696.970 for Retirement Board, Joint Powers Authorities, Nonprofit Corporations and other leases for new projects being completed this year and next. A decrease from $73,321,416

COMPARISON OF INCREASES - GENERAL FUND OPERATIONS

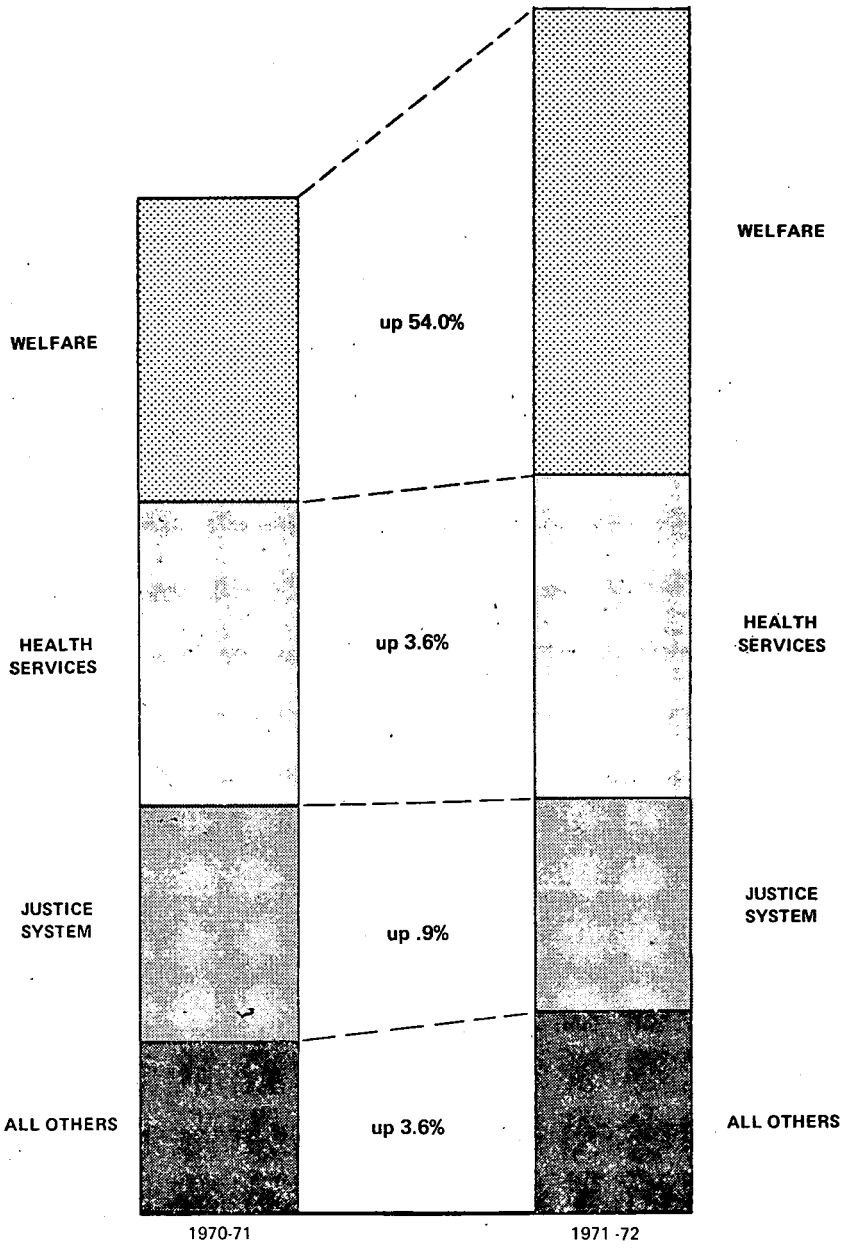

Figure 1

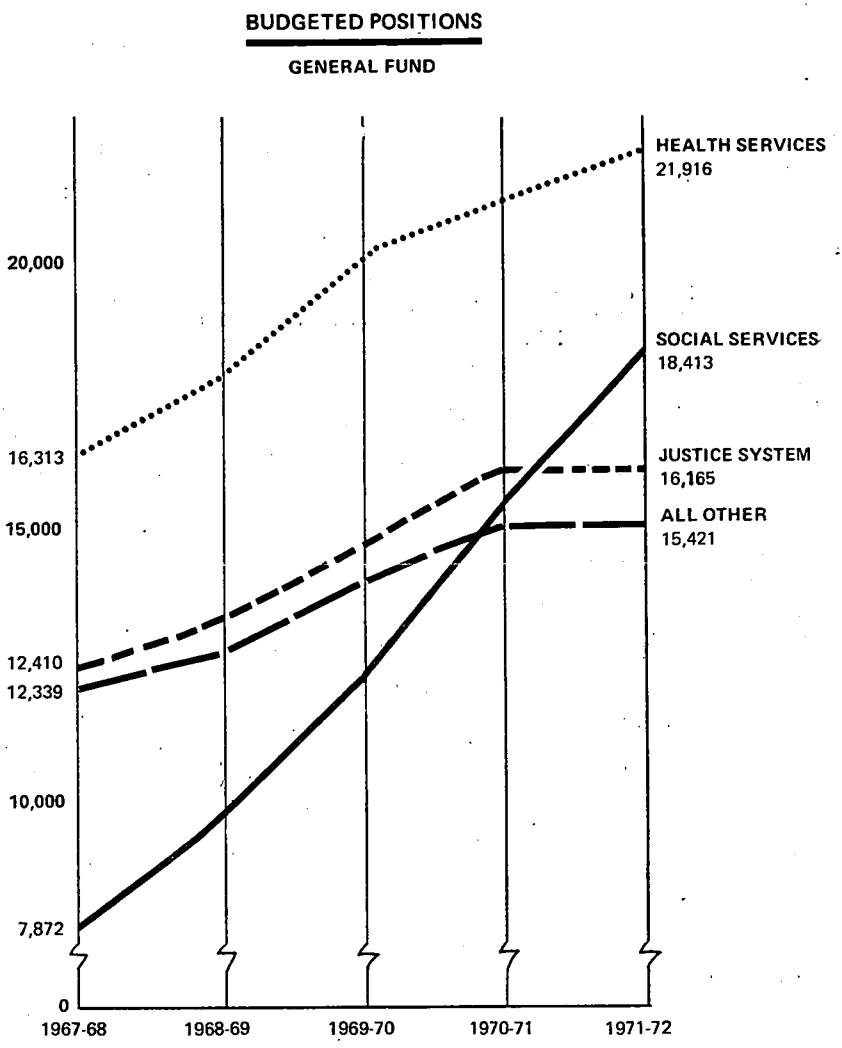

Figure 2

to $53,852,081 in pay-as-you-go construction is a result of the austerity program requiring further postponement of critically needed projects.

5. *Emergency Expenditures—Reserve Fund.*—Natural disasters and civil disturbances have cost the County $5,751,218 this fiscal year over and above normal operations. We have attempted to anticipate these emergency requirements in several departments, but can do so only to a limited degree. We are therefore recommending the first installment of $7,000,000 for the establishment of a General Reserve fund of eventually $20,000,000 which can be used to absorb the cost of these unforeseen emergencies and help to prevent the financial crises we have experienced this year.

6. *Reducing General Fund Functions.*—Removal of financing for certain functions from the General Fund tax rate has been one of our objectives this year, and all department budgets were scrutinized on this basis. The Superintendent of Schools has suggested the establishment of a separate budget unit for this purpose which can be done under existing State law and still leave the Board of Supervisors with the power of appointment to the School Board. This could remove $3.6 million from the General Fund tax rate and we are preparing the necessary actions for your consideration at an early date.

Cultural Arts has been separately identified in this budget with tax rate equivalent noted for comparison. You may wish to seek legislation for a separate tax levy for this function thus removing $7,279,464 from the General Fund in future years.

7. *Reduction of Service Levels and Future Curtailment.*—While mandatory programs continue to increase, most other County operations will be performed at reduced levels and we are filing a list of these service cuts in a separate document for your review and information. Also contained in this document is a list of functions identified for potential curtailment as a policy matter for your Board. Due to deletion of large numbers of positions in most departments, any further reductions will almost certainly entail layoff of employees. If this is to be done, full functions should be eliminated or curtailed to avoid the crippling effect of partial cuts which always result from flat across-the-board changes.

While supporting your Board's guidelines on maintaining austere budgets, several department heads have great concern about the reduction of service levels in several areas. Consequently, you will receive several letters from individual department heads stating these problems in greater detail, and a few may wish to address your Board on items which we did not include in our budget recommendations.

Two main functional areas require more detailed treatment in order that all have a full understanding of the main budget problem this year. Following, therefore, is a discussion of the welfare and health care services.

WELFARE

The temptation to remove the cause of the County's eventual financial destruction by the simple act of arbitrarily cutting down our share of the welfare funds is almost overwhelming. I am compelled to issue a warning at this point, therefore, and remind you that welfare expenditures have been consistently *underestimated* for the last five years and further that unilateral action by local and State agencies to limit their financial commitments to the system have met with failure in the courts and with Federal authorities. Sanctions which can be applied by Federal agencies for noncompliance with regulations and statutes have been demonstrated recently in this State and there should be no doubt in anyone's mind as to the lack of control a County Board of Supervisors has upon operation of the system. This budget contemplates meeting all existing standards of both the State and Federal governments, and counts upon the full-funding of their share of the total cost. A loss of a significant portion of either the Federal or State share through non-compliance would be catastrophic. Internal administrative improvements have been made to achieve cost savings and these will continue during the year. Meaningful help, however, can only come through legislative change.

The welfare growth rate in caseloads has been accelerating so fast over the last years we have almost doubled and redoubled the annual net increase in people receiving cash assistance. Figure 3 shows the total number of people receiving aid from the County increasing from 485,000 in January 1968 to 907,000 at the beginning of this year and then shooting up to an estimated 1,222,000 in 1971–72. This results in moving from a current ratio of 1 in 8 persons in Los Angeles County on welfare to 1 in 6 in the next fiscal year for a net cost increase of $100,000,000.

The net County share will increase from $185,033,851 to $285,247,062 requiring a 57.8¢ property tax rate increase. As in the past by far the fastest growth areas are in the Aid to Families with Dependent Children category due to family breakup increase, increase in unemployment, increased awareness of welfare eligibility, further liberalization of the system through court action and many of these functions at the State and Federal level contemplate shifting a portion of this load off the County's tax rolls.

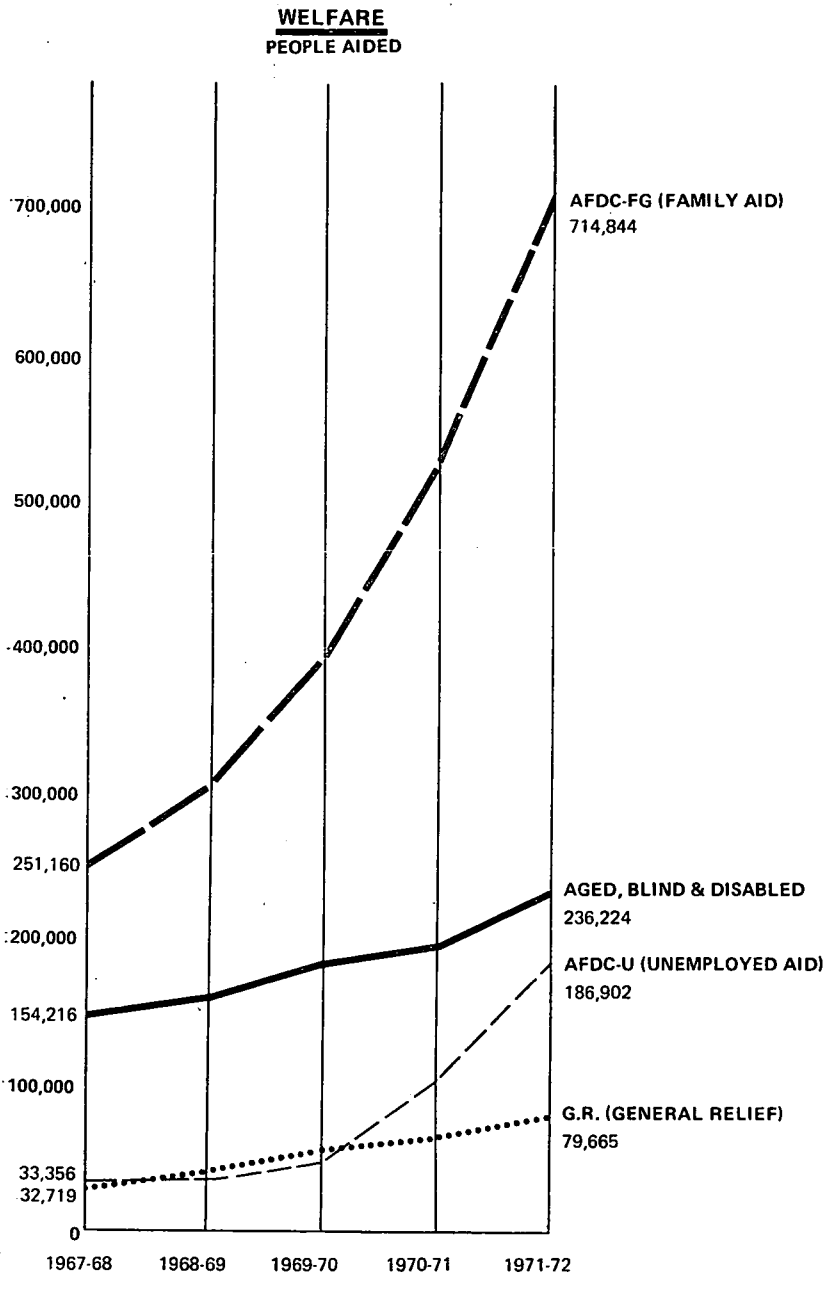
WELFARE
PEOPLE AIDED
700,000
600,000
500,000
400,000
300,000
251,160
200,000
154,216
100,000
33,356
32,719
0
1967-68
1968-69
1969-70
1970-71
1971-72
AFDC-FG (FAMILY AID)
714,844
AGED, BLIND & DISABLED
236,224
AFDC-U (UNEMPLOYED AID)
186,902
G.R. (GENERAL RELIEF)
79,665

Figure 3

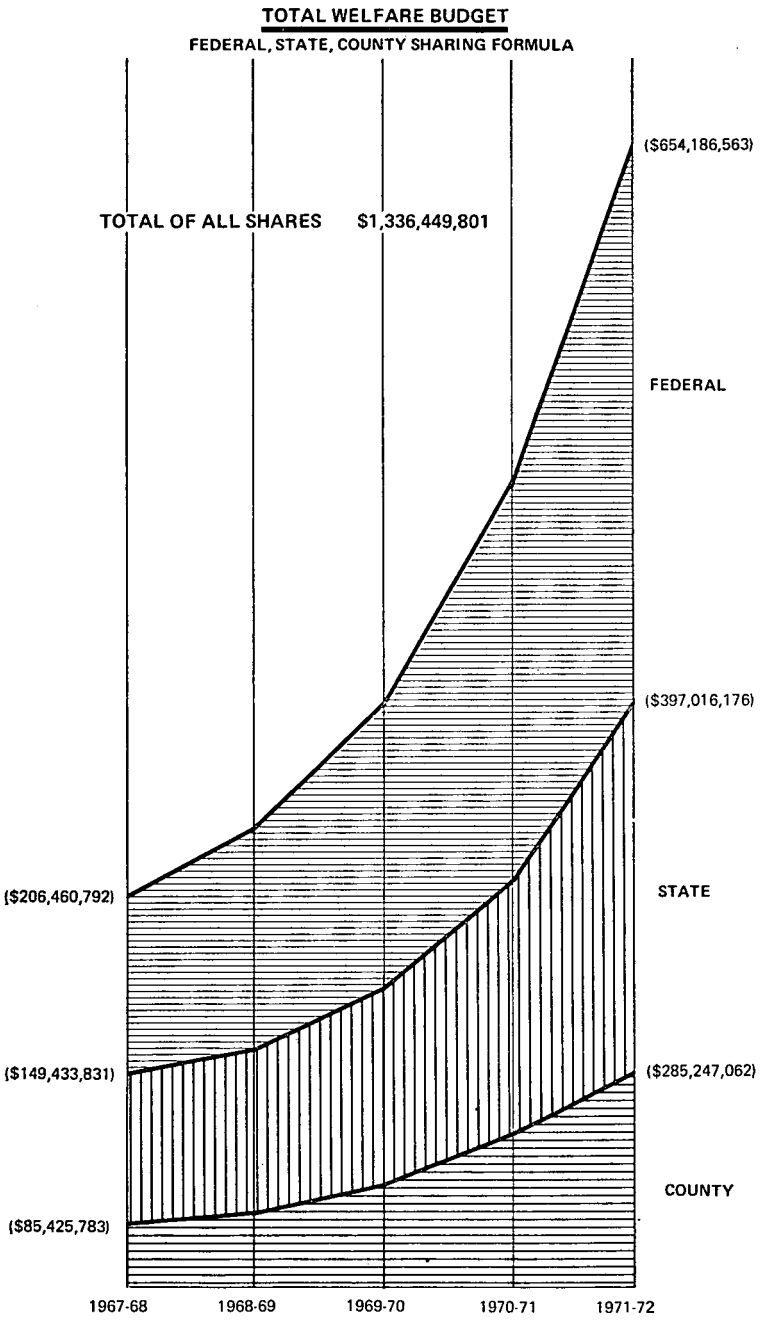

Figure 4

Figure 4 shows the sharing formula in terms of dollars for this County based upon our projected caseload. While it may appear to be equitable and not change appreciably as costs go up, two significant factors should be noted: 1)

the Federal and State increases go against the broad tax bases of each jurisdiction while the County must make up its own increased share from the very limited and regressive property tax, and 2) the formula of 50%-Federal 30%-State, and 20%-County has been relatively constant since 1969–70 except that the County's share has crept up from 19.9% to 21.34% while the State has declined from 31.60% to 29.71% in the same period—minor changes to be sure, but a considerable cost shift when applied to sums of over one billion dollars.

HEALTH CARE

The Medical and Mental Health programs present very serious service problems due mainly to underfunding of the State commitments. We have funded all services wherever possible to meet the Governor's Budget recommendations without affecting critical patient care programs. Lowered service levels are an inevitable result throughout the system, however, and we must accept the fact that experience this year clearly shows that to increase services is at our own hazard since State funding can be removed or substantially modified at any time. Legislative reform in this area is critical to put these programs on a predictable and equitable basis.

REMEDIAL ACTION

Your Board is well aware of the many major problems which control or otherwise impinge upon our financial plan for County operations and have long led the efforts to gain some relief. Insofar as action to alleviate our current crisis, therefore, I can only repeat what you have done and intend to continue doing during the next few months.

1. *State and Federal Legislative Action.*—Obviously, this is the only source of significant assistance to obtain fiscal relief in the areas of welfare and health care and to achieve some meaningful reform in the tax structure supporting County government. I believe we have seen the last year where we can "get by" without completely shutting down major services to continue to support these uncontrollable mandatory functions. All of our efforts should continue to be directed to securing passage of reforms in these areas by the Legislature and the Congress.

2. *Management Improvements.*—This office and your department heads have initiated and will accelerate the further development of management improvement activities along a broad front in County government. The first and most important effort since January has been the development of effective budget expenditure control procedures which are now in force, and will be actively operated throughout the year. We will, therefore, be budgeting year-round and will be in a position to take whatever action is necessary on any changes which may occur in revenue receipts or budget expenditures at the earliest time. This will obviate one of the biggest problems which the County had this year in that certain expenditure overruns went undetected for the first critical months of the fiscal year. Long-term budgeting is critically needed to forecast County government requirements beyond the traditional 12-month cycle and we will make some inroads in this direction in major service areas. Management audits in County departments and acceleration of the work measurement program will continue, and we will make our first efforts in implementation of the "agency plan" form of organization of County operations.

You will note this budget document is organized in functional groupings of departments rather than in alphabetical order. It has been developed along the lines of functional services and programs and will leave the maximum flexibility to department heads to operate within the total budget figures approved finally by your Board. With the implementation of adequate management information systems, we expect to have a completely "new look" in County administration by one year from now.

It is recommended: That your Board conclude its hearings with the department heads on the Proposed Budget recommendations for 1971–72; order such adjustments as it deems necessary and approve the revised figures as the Proposed Budget for 1971–72; order the publication of the necessary notices; instruct the Auditor-Controller to proceed with the reproduction; and set June 7 as the date on which public hearings will begin.

Respectfully submitted.

ARTHUR G. WILL,
Chief Administrative Officer.

SUIT TO ENJOIN CUTBACKS IN MEDI-CAL

APPENDIX 5

PREPARED STATEMENT OF PETER D. COPPELMAN, PROJECT DIRECTOR, CALIFORNIA RURAL LEGAL ASSISTANCE, SENIOR CITIZEN'S PROJECT, LOS ANGELES, CALIF.

My name is Peter D. Coppelman. Together with Sheldon Greene of California Rural Legal Assistance. I am co-trial counsel in a law suit awaiting decision in Sacramento Superior Court to enjoin the sweeping set of cutbacks in the California Medical Assistance Program (Medi-Cal) enacted by the State Administration on December 15, 1970. (*California Medical Association, et al.* [plaintiff], *Olga O'Reilly, et al.* [plaintiffs in intervention] v. *Earl W. Brian, et al.*, Sacramento Superior Court No. 208390.) It is my understanding that the Senate Special Committee on Aging wishes to hear testimony on the impact of these cutbacks on the delivery of health care services to the poor in California under Medi-Cal. Because of the litigation we are uniquely situated to inform the Committee on this subject. In connection with the litigation we conducted a random state-wide survey of the impact of the cutbacks on Medi-Cal recipients and doctors of all specialties. Ultimately we submitted to the Court a total of 110 affidavits and sworn declarations of patients, doctors, and related health professionals.[1] Our testimony today consists primarily of a document which we submitted to the Court entitled "Plaintiffs in Intervention Memo in Support of Preliminary Injunction", which is attached hereto (cited as "Memo" hereinafter). That "Memo" succinctly summarizes our evaluation of the impact of the December 15 cuts, and the grounds for our contention that the cuts violated numerous applicable provisions of state and federal law.

The State enacted the regulations of December 15, 1970 as emergency measures without holding prior public hearings. The so-called emergency was based upon a projected $140 million deficit in the Medi-Cal program for fiscal year 1970–71. The facts which are claimed to establish the existence of a fiscal emergency are contained in defendant's "Findings of Emergency" filed with the December 15 regulations. Our position, based upon information provided by defendants themselves at trial and in three solid weeks of depositions prior to trial, was that there was in fact no emergency; the Administration manufactured an emergency out of thin air. Pages 1 through 22 of the attached "Memo" spell out our analysis of the fiscal status of the Medi-Cal program as it existed on December 15, 1970, and explained why we contend that on the basis of information available to the Department of Health Care Services at that time no substantial deficit could reasonably be projected.

Pages 26 through 50 of the attached "Memo" provide a summary of the contents of 67 of the 110 declarations and affidavits submitted to the Court. The Committee should note that the "Memo" also contains an index consisting of charts summarizing the contents of each declaration, including a description of the declarant, the type of medical service affected by the Medi-Cal cuts, and the harm to the particular patient (where applicable). Thirty-seven of the declarants are Medi-Cal patients; 19 are doctors who participate in the Medi-Cal program. Geographically the declarations give a state-wide perspective to the impact of the Medi-Cal cutbacks, ranging from urban population centers such as Los Angeles and San Francisco, to more rural locations such as Santa Cruz and Napa counties. Pages 29 through 50 of the "Memo" discuss in detail the horrible

[1] We eventually withdrew these declarations from evidence when all parties stipulated to an expedited full trial on the merits.

impact of the cutbacks in starkly human terms. Provision of care to elderly recipients has been particularly disrupted by the limitation on physician visits to two per month. The elderly sick have been forced to play Russian roulette with their health—foregoing visits to the heart doctor in order to obtain treatment for diabetes, for example. (See "Memo", pp. 29-34.) It is impossible here to boil down further the many specific illustrations cited in the "Memo". If the Committee wishes to obtain some idea of how Medi-Cal recipients have suffered under these new restrictions, it is urged to read that portion of the "Memo". We shall also be glad to provide to the Committee copies of the 110 declarations, if the Committee so desires.

Our investigation disclosed that the most devastating impact of the cuts was also perhaps the most intangible. The cuts have destroyed the confidence of doctors and other providers in the State's commitment to providing any decent level of health care to the poor, and they have destroyed the doctor's ability even to undertake to treat Medi-Cal patients in good conscience. Many providers have simply refused to deal with the new restrictions. And who can blame them? First, there is a complicated set of regulations. These regulations are then interpreted and even significantly rewritten by a set of guidelines. These guidelines are then reconstrued by Medi-Cal letters which are issued irregularly. The definitions used in each of these sets of instructions are not definitions that make sense medically. For example, a doctor would consider a "significant disability" requiring immediate medical treatment any condition which would prevent a patient from working or going to school. But if he provides treatment, he will find that under the new regulations a "significant disability" does *not* include a disability which prevents gainful employment or education, and he will not be reimbursed for the treatment. A vast number of doctors throughout the State have indicated that they will take no new Medi-Cal patients. Some doctors have even simply dropped all of their current Medi-Cal patients.

The Administration argues that it has merely substituted for the old Medi-Cal system a new, more restrictive system—but a medically rational and reasonable system nonetheless. But what kind of system is left if some doctors abandon their patients in the middle of treatment, if others refuse to submit authorization requests and follow through on all the red tape, if some patients just stop going to doctors because they think they can't receive drugs and treatment, and if some patients cannot even find a doctor in their town who will give an appointment to a Medi-Cal recipient?

The State Administration is now attempting to make further inroads in the State Legislature into the care given Medi-Cal recipients. They base their case on a totally absurd argument. They say that it is unfair that the average Medi-Cal recipient receives $500 worth of medical care per year, whereas the average working man can afford only about $300 worth of medical care in a year. This argument ignores the fact that the average Medi-Cal recipient is by no means a person of average health. In order to qualify for welfare and Medi-Cal a person must be over 65 years of age, totally and permanently disabled. blind, or a member of an AFDC family. The highest cost categories under Medi-Cal are people who are so ill that they must either be institutionalized or can subsist minimally in the community only with an extraordinary amount of medical attention. The average annual cost per recipient in the AFDC category, the only category which does not require a significant disability as the basis for eligibility, is only $270 per year.

The great irony is that the new Administration program, including the cuts already made, is being trumpeted, even by Washington. as a possible model for the Nation. Already the Secretary of HEW has indicated that he will grant some of the waivers of federal restrictions necessary to implement certain aspects of the Administration's proposal for Medi-Cal. Any such steps will transform Medicaid from a national system for delivering quality health care services into a national disaster. We have seen in California that the cutbacks enacted here have had a devastating impact on what formerly was one of the most comprehensive health care delivery systems for the poor in this country. While changes in Medicaid are necessary, the model for change must not be destruction.

Medi-Cal was not an ideal system. It was over utilized by some providers and some patients. No doubt, a new system of some sort will soon be instituted. But is it really necessary to destory the old *before* instituting the new? Is it really necessary to create this suffering in the name of economy?

Enclosures.

IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA FOR THE COUNTY OF SACRAMENTO

No. 208390—P. I. Memo in Support of Preliminary Injunction

CALIFORNIA MEDICAL ASSOCIATION, ET AL., Plaintiffs,

OLGA O'REILLY, ET AL., Plaintiffs in intervention,

v.

EARL W. BRIAN, M.D., ET AL., Defendants.

PART I: NO EMERGENCY EXISTED

I. THE FINDINGS OF EMERGENCY ARE UNFOUNDED AND INVALID

Introduction

The findings of emergency underlying the regulations at issue are based upon a projected financial deficiency. Plaintiffs contend that the projected financial deficiency is unfounded. In order to weigh the validity of this contention it is necessary to understand the financial structure of the Medi-Cal program. The information presented was derived from the testimony on deposition of California Department of Health Care Services officials and official documents and reports of the D.H.C.S. which will be proffered into evidence.

Explanation of the administration of the Medi-Cal program

Simply stated, Medi-Cal is a process of paying for medical services furnished by providers to eligible recipients. At present eligible recipients fall into two categories: (1) those who are receiving cash grants through public assistance; Aid to Families with Dependent Children (AFDC), Old Age Assistance (OAS), Air to the Blind (AB), and Aid to the Totally Disabled (ATD); and (2) those persons who receive medical assistance only. These are either people who are eligible for but receive no cash grant, or people who have express income or property preventing them from receiving a cash grant of public assistance.

Claims processing is handled by a fiscal intermediary for the Department of Health Care Services (DHCS), specifically, Blue Cross and Blue Shield. These intermediaries bill the DHCS for the amount of claims which are to be paid and the DHCS forwards to them a check drawn from the Health Care Deposit Fund. This latter fund includes all monies allotted for Medi-Cal services, from State general fund and federal sources.

As a governmental entity dependent upon public funds, the DHCS and the Medi-Cal program operate on a fiscal year from July 1 to June 31. The budget for the coming fiscal year is presented to the legislature in the Spring or Winter. A revision of costs is submitted to the legislature in June and the budget is either augmented or reduced in conformity with these new estimates.

The Medi-Cal budget is substantially the cost of services furnished to eligibles. The subsequent fiscal year budget is determined by providing the legislature with a forecast of costs for the coming year. As with conventional cost accounting methods, the three components of the forecast are (1) caseload (number of eligibles), (2) utilization, (a) how often eligibles require services, (b) what services they require and in what proportion, and (3) the cost of the services provided.

The DHCS does not develop its own data for these projections. Rather, it is dependent upon the State Department of Social Welfare (SDSW) for caseload data, and upon the fiscal intermediary for cost data. Costs per category of provider vary, but the overall costs per eligible have remained constant, increasing only modestly. Cost ceilings have been imposed on virtually every major category of provider except in-patient hospital costs.

The critical and volatile variable in cost projection, therefore, is the caseload. The Department of Health Care Services adopts *in toto* the cash grant caseload estimates made by the SDSW. Insofar as these estimates provide a projected number of eligibles by category, they are increased slightly to provide for necessary differences in accounting. For instance, eligible for public assistance but receiving a zero cash grant, must be added to the cash grant category in computing Medi-Cal caseloads since they are not included in SDSW caseload figures. AFDC zero cash grant recipients are reported by case rather than individual in

SDSW figures so that this category must be multiplied by the average number of persons in the family to come up with an actual nose count. With the basic exceptions, the DHCS accepts the cash grant caseload estimates and statistics of the SDSW.

However, the DHCS makes its own projection of the medical assistance only caseload. Again, the source of the data used to make the projection is SDSW figures. Caseload data is provided on a monthly basis on a form designated 237. This form summarizes caseload information by categories submitted monthly to the State/SDSW by each county Social Welfare Department. Inasmuch as not every county reports promptly, preliminary data is prepared and submitted monthly as well.

Definitive caseload estimates are undertaken by the SDSW and DHCS three or four times a year. Projections are made by category to obtain a trend. Starting from a base—the actual caseload of a given month—the trend is projected for ward to obtain the estimated increases in caseload per category for the given fiscal fiscal year. The estimated monthly caseload per category for the given fiscal year are then totaled and divided by 12 to obtain the estimated monthly average caseload which is designated the average annual caseload. By this means of computation, the average annual caseload is not the highest or lowest caseload point but, assuming a relatively stable projection, would be the equivalent of roughly the fifth, sixth or seventh month caseload level in the coming fiscal year.

In making projections consistent with statistical premises, the most recent data, including preliminary data, should be and usually is given greater weight since it reflects all of the adjustments due to changes in the program including changes in caseload per category of eligibles. The remaining two factors in cost projection utilization and cost of services, are secondary. Utilization per 100 eligibles has been declining. Caseload increase, rather than increased use, has caused increased expenditures.

Similarly, overall casts remain stable althoug costs per category of service and costs per category of eligibles vary. For example, the average cost per AFDC recipient eligible is $270.00 per year. On the other hand, average annual costs for the totally disabled exceed $1200.00.

The Department of Health Care Services is accountable to the legislature to provide annually, a monthly schedule of projected payments and they provide monthly, a report showing payments actually made during the previous month for all services. The function of this report, when compared with the annual schedule of payments, is to determine whether the funds allocated for the fiscal year will be sufficient. In the event of a deficiency, the Director of the DHCS is empowered to make certain programmatic cuts in conformity with the legislatives mandate. One such section, W&I Code § 14120, provides such guidelines and is at issue in this case.

Reporting payments is complicated by the need to package payments on a fiscal year basis to conform with the annual appropriation. The method of accounting employed therefore is important particularly at year end, because it determines whether the bill is paid out of current fiscal year funds or money appropriated for the following fiscal year. Under cash accounting, all bills paid by June 30, the end of the fiscal year, would be considered obligations of that fiscal year. Under a straight accrual method, the agency would consider obligations for the fiscal year to be all costs for which services had been rendered during that fiscal year, even though the bills had not been received by June 30. Modified accrual, the system employed by the DHCS, is a hybrid. The DHCS counts as an obligation of the fiscal year all claims received prior to June 30, the end of the fiscal year. A variation which would affect the amount accrued would be the number of claims received but returned because of errors or deficiencies in reporting.

The annual schedule of payments and the monthly payment reports are based upon all payments made during the month for current fiscal year obligations. Claims paid in the current fiscal year which were *received* during the prior fiscal year are *not included* in the fiscal year payment report, since they are paid from accrual reserves set aside out of the prior fiscal year funds.

A third factor in claims flow which affects the transition from one fiscal year to another is a carryover of claims which are received in the current fiscal year but for which services were rendered during the prior fiscal year. An adjustment is made to the prior fiscal year payment schedule to account for these carryover obligations as well.

With this background in mind several initial facts should be considered as a framework for evaluating the alleged emergency precipitating the December 15 regulations.

Cost-expenditure data

	Millions
Fiscal 1969–70 total monthly payments per 1084 payments reports	$899.0
Fiscal 1969–70 accrual payments	91.0
Fiscal 1969–70 total level of payments of cost of services	990.0
Average monthly cost of services in 1969–70	82.0
Fiscal 1970–71 budget including accrual reserve	1,058.0
Fiscal 1970–71 budget less accrual reserve	1,017.3
1970–71 average monthly cost projection, including accrual	88.2
Average estimated 1970–71 monthly payments without accrual	84.7
Projected 5 months payment level July–November 1970–71 per assembly bill 1084 payment schedule	437.5
Projected average cumulative monthly cost 1970–71 for 5 months	441.0
Actual cumulative payments through November 1970–71 per November 1084 payment report	414.3
Average monthly payment 1970–71 July–November	82.2
Actual fiscal 1970–71 monthly payments per 1084 monthly payment report:	
July	48.9
August	74.9
September	99.8
October	95.7
November	96.0
December	88.8
January (estimated)	[1] 88.0
1970–71 7-month total	591.9
Actual monthly average costs 7 months 1970–71	84.5
Remaining funds for payment excluding accrual for 5 months	425.4
Remaining funds for cost 5 months 1970–71 with accrual (5 months)	466.4
Monthly average payments remaining without accrual	85.0
Monthly average with accrual (5 months)	94.0

[1] Camilli deposition.

From these facts it is apparent that on the basis of payments made in the first five months, and ultimately the first seven months, that the program had encountered no deficiency. Monthly payments were as scheduled and the DHCS was, according to its own projection, presumably able to meet its obligations for the current fiscal year. The Court could, therefore, go no further than this fact and conclude (1) that no emergency existed, and (2) that there was no need to cut back in the program.

Assurance of that conclusion is confirmed by analysis of the several documents prepared by the DHCS in justification of its declaration of emergency. These three reports are, (1) Finding of Emergency filed with the emergency regulations, dated December 11, 1970 (Ex. 17), (2) Letter of Richard L. Camilli, Deputy Director, DHCS, dated December 4, summarizing the additional costs (Ex. 25), and (3) Fiscal projection for 1970–71, dated 12–1–70 (Ex. 18). The emergency finding is a mere summary of two other reports. etailed analysis of these three reports in light of data available to the Department at the time and subsequent data, provides a substantial repudiation of both the emergency itself and the conclusions underlying it.

The conclusions underlying the finding of emergency may be summarized as follows:

1. Expenditures. "Expenditures to December 1, 70 show an increase of 30.6% over expenditures during the same period in the prior fiscal year." Since the program budgeted for only a 17.7% increase, "expenditures to December 1, 1970 exceed the amount budgeted by 12.9 percent (Ex. 17, pp. 1 and 2).

2. Claims flow and cost per claim. "The rate of claims flow continues to show a rising trend both in terms of total claims received and claims per eligible. It is currently estimated that total claims for the current fiscal year will total $40 million." (Ex. 17, p. 2, ex. 18 p. 2).

3. Cost. "Average cost of $500 per annum" per eligible. (Ex. 17, p. 1, ex. 18, p. 2).

"The average cost of claims continues to remain fairly constant with slight increase being projected for the current year of $30.20 per claim as opposed to $29.70 per claim for fiscal 1969–70" (Ex. 18, p. 2).

4. Estimated caseload increase.

A. Mix of eligibles.

"The mix of eligible . . . has shown a shift to eligibles who utilize higher cost services." (Ex. 17, p. 1, ex. 25)

B. Delays in imposing program controls and reduced projected savings (Ex. 17, p. 1)

C. (1) The appropriation for fiscal 1970–71 "was based on an estimated average of 2,200,294 . . . eligible persons . . . the December caseload estimate of the State Department of Social Welfare projects a revised average of 2,402,900 persons eligible . . ." (*Ex.* 17, p. 1)

(2) The dollar impact of this increase computed by multiplying the estimated caseload change times the average annual cost is estimated at $98,887,700. (Ex. 25)

The above statements are the distillate of the conditions allegedly substantiating the cutback. The following consideration of each component demonstrates that the representations are either in error, false or irrelevant to the declaration of emergency.

A. The expenditure level was scheduled by DHCS at the outset of the fiscal year and is not an emergency.—"Expenditures to December 1. 70 show an increase of 30.6 percent over expenditures during the same period in the prior fiscal year." Since the program budgeted for only a 17.7 percent increase . . ." expenditures to December 1, 1970 exceed the amount budgeted by 12.9 percent." (Ex. 17, pp. 1 and 2).

"The rate of claims flow continues to show a rising trend both in terms of total claims received and claims per eligible. It is currently estimated that total claims for the current fiscal year will total $40 million." (Ex. 17, p. 1, ex. 18, p. 2)

Fact: As indicated, the cumulative expenditures through November, 1970, were 6.7 percent under the scheduled expenditures. The cumulative expenditures level for the first five months of the preceding fiscal year were known to the DHCS in December, 1969. The payments schedule for fiscal 70–71 was prepared in August or September of 1970. Therefore in September the DHCS anticipated and projected and expenditure level in excess of 30.6 § over the previous year for the first five months. As such, the discrepancy in expenditures, rather than being an emergency, was *programmed* by the Department at the outset of the fiscal year and has no bearing on the capacity of DHCS to come within its payments schedule for the duration of the fiscal year.

The fact that the expenditure level question does not constitute an emergency was admitted in deposition by Richard Camilli, Deputy Director of the DHCS:

Q. Then last summer or in September when you prepared the 1970–71 AB 1084 payment schedule, you knew that the payments as scheduled for October, November and December of 1970 were more than 30 percent over the expenditure levels of the previous year?

A. I don't know that. We would have to calculate that. We have not calculated that. Well, wait a minute. The scheduled amounts were more than 30 percent over the actual payments of the previous year?

Q. Right.

A. Let me think about that. Let me see. Yes. For November that is true. . . . (p. 45. 9–20)

Q. You have discovered from your records that your schedule of payments for November, 1970 exceeds your actual payments of November of 1969 on a cumulative basis by more than 30 percent. Is that fact taken alone indicate to you that you have a problem?

A. This fact, just comparing this schedule with last year's expenditures?

Q. Yes.

A. No. if you just looked at that one schedule. But, as we indicated to you any number of times, that schedule is not a particularly valid device in estimating where you are fiscally in this program because of a whole variety of factors.

Q. Well, aside from that, does the fact that the amount that you plan on paying cumulative in November, 1970 is more than 30 percent over than the amount that you paid for the same period in the previous year create an emergency?

A. If I understand the question, *no*, I don't think so. The fact that the scheduled amount is more than 30 percent over the actual payment amount of last year? Does that create an emergency? No, because the schedule in it doesn't

really create an emergency except if it is to be exceeded by more than 10 percent. Other than that, the schedule doesn't have too much relationship to the real world.

Q. Now let's change it around and say we assume that in November you paid according to your schedule, that your payments were as scheduled 437.5 million dollars and that that amount represented more than 30 percent in excess of the previous year for the same period. Would that in itself represent an emergency?

A. *No*, not if you ignore all the rest of the factors that might be considered and where the program is. And you could say the same about any individual factor most likely if you want to ignore the rest of what is happening. If you could find some convenient point, I would like to take about a ten or fifteen minute break and relax a little." (Pp. 46, 47, 1–10)

The expenditure level therefore is not an emergency factor and was in fact scheduled by the DHCS in September.

B. The rate of claims flow is an inaccurate criterion for gauging program costs.—The invalidity of a projection of program costs by claims received flow is demonstrated by a brief computation from figures provided by the DHCS in their December 1, 1970 report. (Ex. 25) Chart 2 of the letter provides the basis for the conclusion that a projection of the claims flow will result in program costs of 1.2 billion dollars for fiscal 70–71.

The chart states that the average cost per claim in 1969–70 was $29.70. The chart also states that in 1969–70 the Department received 34.5 million claims. 34.5 million times $29.70 equals $1,024,650,000.

The invalidity of using this method of projecting costs is demonstrated when it is recalled that the total level of payments for 1969–70 was $989.9 million, or approximately $34 million less than the total arrived at using claims received as a base. Since the $989.9 million payment level is a hard statistic based upon published monthly reports and accrual figures provided on deposition by Alan Monsano, DHCS Assistant Director, it is clear that the claims computation is irrelevant to a determination of an emergency.

One explanation for the inaccuracy of this method of account computation is the fact that claims received is not an accurate gauge of program costs on a fiscal year basis since a proportion of the claims received may be returned to the provider for errors, omissions and recomputation, thus reappearing as received claims eligible for payment in the subsequent fiscal year.

C. Utilization per 100 eligibles is declining.—Overall utilization of services would increase as caseload or users increase. However, removing the factor of increased caseload, utilization per 100 eligibles is declining. This isolated factor would have the effect of muting overall costs and possibly overall claims flow. A final study of the last quarter of fiscal 1969 and 1970 (Ex. 19) and the statement of Philip Newlin, Chief Management Analysis Bureau DHCS confirms that while the extent of declining utilization varies from the category to category, overall utilization declined:

O. Then utilization was down across the board, costs of services varied?

A. Utilization per 100 eligibles was down, right.

D. Overall costs of services remain constant, p. 42–21.—While the costs per category of service vary, the latest final data for April–June 1969 indicates that overall costs per services per eligible, increased only 33 percent over the final quarter of the previous fiscal year (Depo. of Philip Newlin):

Q. And returning to your first point, which is a composite of utilization and cost per services; the costs per eligible for the period studied increased about one-third of one percent over the same quarter in the previous year?

A. Yeah—where was that reference, I remember that.

Q. I am referring to page three, payment averages.

A. Right, okay. Payment averages, the overall second quarter, 1970, average monthly payment per eligible indicates a slight increase, right. We roughly computed it as .3 per cent per eligible in monthly payments for three-month period April through June. P. 42–24, 43–8

Most recent estimates lead the Director of the Department of Health Care Services to report in a letter to providers that costs had actually decreased this year. (Ex. 16).

Deposition of Camilli, p. 16, 26, 17.1:

Q. Was that a true statement?

A. I believe it was on the overall average.

E. The mix of eligibles is shifting toward those utilizing lower cost services in contrast to the representations of DHCS.—Findings: The Findings of Emergency

recited that the "Estimated increase in average caseload is compounded by a change in the mix of eligibles which have shown a shift to eligibles who utilize higher cost services . . ." (Ex. 17, p. 1)

Fact: The exact opposite is true since higher cost categories of recipients such as OAS and ATD have leveled off or declined, while the greatest growth is in AFDC, the category with the lowest cost per eligible. This shift is confirmed both by the analysis of caseload data as well as the conclusion of Allan Monzano, Assistant Director, Division of Administration:

Mr. Greene: Q. Digressing from the many small details to the gross statistics, I suppose you must have some grasp of general trends per category of recipient and category of services. Can you indicate just generally which way various categories of services are going at this time?

A. There are two kinds of trends in costs. One is related to how much we pay for a service. In virtually all of our services except those rendeded by hospitals we have established fee schedules. Therefore there is very little movement in cost. The only other kind of cost trend we would encounter would relate to utilization after a particular service by a given eligible group. Overall the cost per eligible has shown a slight decrease from the preceding fiscal year as far as we had projected it for 1970–71. This decrease is probably related to the fact that as this program gets older a larger proportion of our population is in AFDC, (which is a relatively) low cost group. So the cost per type of eligible has not really had any major fluctuations in the course of the program. There are slight fluctuations. P. 69.11–70.3: * * *

Q. You indicated previously that the trend was towards an increase of AFDC categories and that this was a low-cost category of service?

A. Yes.

Q. Would that indicate then that the mix of the caseload would tend to be gravitating towards the lower end of the cost spectrum?

A. Yes. The mix would tend to gravitate as the AFDC caseload becomes a greater and greater proportion of the total caseload.

Q. That would have been true as well prior to the current cutback, is that correct?

A. Yes. That is a general historical trend." P.71.19–72.5.

Therefore the statement concerning the higher cost mix of eligibles in the Finding of Emergency is false.

F. A projection of program costs based upon average caseload estimates reflects either a moderate deficiency or no deficiency when adjusted by late caseload data.—Since the other elements which make up a cost projection have been demonstrated to be either invalid, irrelevant or static the decisive variable is that of caseload. The emergency finding is based solely upon a revised caseload estimate applicable to the current fiscal year reflecting an increased average annual caseload. (Ex. 17, page 1.)

Finding: In the words of the finding of emergency, "The December caseload estimate of the State Department of Social Welfare projects a revised average of 2,402,900 persons eligible for Medi-Cal coverage. . . .", an increase of 108,400 over the previous estimate upon which the current fiscal year appropriation was based. (Ex. 17, page 1.)

If the finding of emergency is predicated on a December SDSW caseload estimate it is unfounded since SDSW made no such estimate in December.

In December 1970, SDSW did prepare its usual subvention estimates which are the basis for the proposed 1971–72 budget. These were submitted to the Department of Finance on December 23, 1970 and were presumably available to the DHCS prior to that date. As indicated in that report (Ex. 28.2), the *August caseload estimate was re-submitted* in lieu of December revised caseload estimates.

Significantly, SDSW reported that analysis of current data, reflected that current caseload trends offset one another requiring *no change* in the August caseload estimate, from a cost effect standpoint. "Analysis of current data indicates that the growth in the children's caseload appears to be greater than anticipated in our August estimate. However, this is offset by a slower and anticipated growth in the adult programs. *Therefore our August estimate of State Welfare costs remains valid.*" (Ex. 28.2)

Joy Gee, Assistant Chief, Program Estimates Bureau, Research and Statistics Division, SDSW provided copies of all caseload estimates and costs projections prepared by her bureau of the SDSW during calendar 1970. Depo. Gee, pages

6 and 7. The August 12 caseload estimate (Ex. 27.1) was the last one prior to the reference in the December subvention.

In summary, the August estimate of caseload was the basis for the alleged revision of caseload rather than the December caseload estimate and the statement in the finding of emergency is false.

As indicated, the DHCS makes its own projection of medical assistance caseload relying upon data furnished by the SDSW. Similarly, the foundation for the finding of emergency regarding Medical Assistance caseload estimates was a report prepared by the Fiscal Bureau of the DHCS, report No. 221, no. 1 dated September 23, 1970 entitled "Projected Medi-Cal Caseload Fiscal Years 1970–71 and 1971–72". (Ex. 7).

On deposition Mr. Manzano confirmed that the September 23, 1970 projection is the latest caseload estimate for medical assistance categories and that the declaration of emergency is based upon that data.

Q. Are you saying this is the latest projection?

A. Right.

Q. There have been no caseload projection since this September 23 projection?

A. That's right. There has been no caseload projection since then.

Q. Now, in December, was there a caseload projection to any extent?

A. No, because we haven't received any further projections on social welfare.

Q. Then the data on which the declaration of emergency was based is found in this Exhibit 7, is that correct?

A. Yes. (P. 41, Deposition, Manzano A., p. 41.2–15)

Therefore, data which is the foundation of the December 15th finding of emergency was caseload estimates known to the DHCS by the end of September, 1970.

Ultimately deponents talk about confirming the estimates of September, 1970; however, no specific data is discussed. Significantly the finding of emergency relates *only* to the caseload estimates and is based only upon the caseload estimates. If the DHCS had awaited confirmation in November or December it would have been necessary to take into account more recent data, specifically actual preliminary caseloads for August, September, October, possibly even November, necessitating a re-estimate of the caseload and revealing a substantial reduction of the projected deficiency.

Significantly, taking into consideration the most recent data would reflect a temporary but consequential reduction in the number of medical assistance only eligibles. This reduction, commencing in August and continuing through December according to preliminary DSW reports, even if only temporary, would have the effect of reducing the average annual MA only caseload causing a concommitant reduction in the estimated costs for that category. This supposition would be exactly contrary to the position of the DHCS in the December 4, 1970 estimate which reflects an increase of $73 million in program costs attributable to the increase in average annual medical assistance only caseload projected in September over April estimates.

A re-computation of the caseload change based upon the actual preliminary November, 1970 caseload compared to SDSW caseload estimates for August and September, 1970 results in a net cost *reduction* of $119.2 million. The reduction is the antithesis of the $98.9 million increase in costs proffered by the DHCS lowering the cost *reduction* to account for 1) a possible rapidly increasing medical assistance only caseload, 2) the fact that November, 1970 falls approximately one month short of the average annual caseload figure, and 3) is a preliminary rather than a final total, still eradicates the projected deficiency in its entirety.

Additionally the subjectivity of comparing estimates is demonstrated by an alternative projection of caseload estimate employing methods generally confirmed by both the SDSW (deposition, Joyce Gee) and the DHCS (deposition, Manzano).

The estimate, calculated as an example, resulted in a total projected cost for 1970–71 of less than $1,120,000,000; $80 million less than the projection of the DHCS. As indicated, this estimate must be reduced by final and preliminary monthly caseloads subsequent to August. These months reflected cost saving trends diminishing the estimate by as much as $119 million. Using these figures, 1970–71 program costs should not have exceeded $1,060,000,000 without the December 15th cuts and would possibly be lower.

It must be concluded that relying on both a caseload estimate using August as a base and latest actual caseloads that the average annual caseload is overall

much closer to the initially projected April caseload than the DHCS represents, obviating the alleged increases in program costs attributable to caseload change. This conclusion is fortified by the acknowledged trend toward lower cost categories of eligibles in contrast to the representations of the findings of emergency.

In summary the caseload estimates are reduced by the latest preliminary actual caseloads thus repudiating the validity of the September caseload revision. Considered with the cost of service, the decline in utilization per 100 eligibles and, significantly, the trend in the caseload mix toward categories of eligibles using lower costs of service, the conclusion is inescapable that the findings of emergency lack a foundation in fact and fail to support the December 15 cuts.

II. Since Caseload Estimates, the Foundation of the Findings of Emergency, Were Known to the DHCS in September, 1970, No Emergency Existed

The ancillary rationalizations for the findings of emergency having been discredited, the full justification for the findings of emergency are the caseload estimates. Since the DHCS, published no new caseload estimates in December, the sole basis for the findings were available in August and September for the cash grant and medical assistance only categories, respectively. It must be emphasized that *estimates* of projected caseloads are the foundation of findings of emergency. Therefore, the DHCS has determined that a caseload estimate which reflects a prospective deficiency of funds is "reason to believe" that the appropriation will be insufficient for the current fiscal year.

IT therefore follows that if the Court finds that the caseload estimates in which the findings of emergency are based are sufficient reason to believe that a fiscal deficiency will occur the Court must similarly make the finding that the DHCS had sufficient reason to project an insufficiency in September, 1970.

Therefore in early October, 1970, at the latest, the DHCS could have noticed a hearing of proposed reductions in the Medi-Cal program for the first week in December, presented evidence and given interested parties an opportunity to appear in opposition to the program reductions. If the data known in September is sufficient in the eyes of the Court to satisfy W&I Code Section 14120(c) the Court must find that no suddent and unforeseen circumstances appear justifying the adoption of precipitous emergency regulations in December.

If, on the other hand, the Court finds that the caseload estimates were *insufficient* reason to believe that a fiscal deficiency would result in September then the findings of emergency must fall since the findings are lacking in factual basis.

Finally, even if the Court finds that an emergency existed, or rather that the facts known to DHCS in latter November constituted an emergency and were sufficien foundation for findings of emergency, the Court must find that subsequently developed factual data rather than speculative estimates justify a timely invalidation of the regulations.

III. Because Emergency Regulations By-Pass Fundamental Due Process Protections of Prior Notice and Hearing, Emergency Action Must Be Beyond Dispute

The usual procedure for the adoption of administrative regulations in California requires full hearings upon adequate notice prior to the adoption of the proposed regulations. Govt. C. § 11420 et seq, Govt. C. § 11423. The requirements of notice and hearing establish basic, minimum procedural safeguards against arbitrary or irrational rule-making by administrative agencies. The emergency exception to the basic notice and hearing requirements is a radical departure from the norm. Such a departure can be justified only if there is a genuine "emergency"—only if, per Govt. C. § 11421, the regulations in question must be adopted without notice or hearing in order to insure the immediate preservation of the public peace and welfare. A mere declaration to that effect is no more than prima facie evidence of "emergency" based upon factual allegations which must be proven de novo. *Morgan* v. *City of Long Beach*, 57 CA 134, 207 P 53 (1922) and *In Re Hoffman*, 155 Cal 114, 90 P 517 (1909).

A. An "emergency" in law means an unforeseen occurrence.—In *San Christina Inv. Co.* v. *City and County of San Francisco*, 167 C 762, 141 P 384 (1914) the California Supreme Court provides a very instructive definition of "emergency":

> "An unforeseen occurrence or combination of circumstances which calls for an immediate action or remedy; pressing necessity; exigency."

The definition approved by the *San Christina* court was earlier approved in *People* v. *Lee Wah* 71 Cal 80, 11 P 851 (1886). A similar definition was adapted by the court in *Spreckels* v. *City and County of San Francisco* 76 Cal App 267, 244 P 919 (1926) and by another panel in *Burr* v. *City and County of San Francisco* 186 Cal 508, 199 P 1034 (1921). In all these casts, declaration of "emergency" or actions taken in reliance on an allegel "emergency" were reviewed, found to be without factual support, and stricken. As the *San Christina* court emphasized, "emergency" in law has not esoteric meaning but rather a common sense one:

> ". . . the meaning of the word that obtains in the mind of the lawyer as well as in the mind of the layman." 141 p 384 at 388.

These cases simply underscore the common-sense definition of "emergency" provided by Black's Law Dictionary:

> "a *sudden, unexpected* happening, an *unforeseen* occurrence or condition, specifically a perplexing contigency or compilation of circumstances, a *sudden* or *unexpected* occasion for action."—Black's Law Dictonary, 4th ed. 1957, p. 615 (emphases added).

The critical element in all these definitions of "emergency" is that the event in issue be *unforeseen or unexpected.* An event one knows or has reason to believe will occur is precisely the opposite of an emergency. When one actively engages in arranging circumstances to insure that a certain result will obtain he cannot thereafter claim that the occurrence is, as to him, an "emergency" such as to justify waiver of certain procedural protections prior to his "emergency" response.

B. Notice and hearing requirements were introduced to protect the public against the abuses of "emergency" adoption of regulations.—As early as 1957 the state legislature amended the Administrative Procedure Act to include Govt. C §11422.1. which requires that certain notice and hearing provisions be satisfied even in the case of emergency regulations. This amendment was adopted to curb widespread abuses by administrative agencies of the provisions for adoption of so-called "emergency" measures (See 15 Hastings Law Journal. History of the Administrative Procedure Act).

C. It is the duty of the court to make a finding as to the validity of conclusions recited in support of a declaration of emergency.—As a matter of evidence. defendant's prima facie showing of "emergency" is subject to rebuttal. As the Supreme Court wrote in *San Christina, supra.* in a comparable case involving a declaration of "great emergency" by a local legislative body:

> "Does the charter of San Francisco in terms or by necessary implication make the determination of the supervisors as to the existence of a great emergency or necessity conclusive? Manifestly not. The language of the charter is not that the dollar limit may be suspended upon the declaration of the supervisors that a great emergency or necessity exists. It is that this limit may be suspended 'in case of [the existence of] any great necessity or emergency.' Moreover. and as persuasive to this view. even were it not so plain as it appears. is the added fact that the supervisors are required to spread upon the journal 'the character of such necessity or emergency.' If their determination was to be conclusive. this recital in their journal would be meaningless. It can have significance and value only in contemplation that the determination of the board is subject to review." 167 C 762. 141 p. 384 at 388 (1914).

The duty of the reviewing court then is to examine the declaration of emergency to see whether or not it rests on well-established facts, and if it does not, to strike it down.

An example of a legislative declaration of emergency which was indeed founded on well-established fact appears in *Marcus Brown Holding Company* v. *Feldman* 256 US 170 (1921), a case upholding post war rent control provisions. The court recounted numerous studies relied upon by the New York Legislature in support of the declaration of emergency and concluded that:

> "Perhaps no legislation was ever passed by the legislature which was the subject of more exhaustive investigation."

By contrast to *Marcus Brown Holding Company*, the declaration by Defendant Brian depends upon a doubtful caseload projection and facts affirmatively repudiated on several grounds.

Finally *In Re Kazas* 22 CA 2d 161. 70 P 962 (1937) is a useful guide to the weight accorded a declaration of emergency on review. In essence. the *Kazas* court states that a legislative body should go no further in declaring the exist-

ence of a condition of emergency dependent on the truth of certain facts than a court in taking a judicial notice of a general factual condition. Citing *Wood* v. *Kennedy* 117 Cal App 53, the *Kazas* court notes:

> "judicial notice is thus limited, 'that the matter be one of *common and general knowledge*, that it be *well-established* and authoritatively settled, be practically *indisputable*, and that this common, general and certain knowledge exist in the particular jurisdiction.' "

The conclusions recited by defendant in the Findings of Emergency are neither well-established nor authoritatively settled and they are by no means indisputable. Under the test set forth in *Woods*, and adopted by *Kazas*, the facts underlying the alleged emergency must be proven. As the court wrote in *Kazas*, *supra:*

> "little importance should be attached to the declaration of an emergency by the defendant . . . "

PART II: SUMMARY OF PLAINTIFFS IN INTERVENTION EXHIBITS IN SUPPORT OF PRELIMINARY INJUNCTION

I. INTRODUCTION

Plaintiffs in intervention have submitted a total of sixty-seven declarations and affidavits in support of their motion for a preliminary injunction against the emergency Medi-Cal cutbacks effective December 15, 1970.* These declarations were gathered randomly throughout the State of California from approximately January 19, 1971 to February 8, 1971. They were submitted to the Court in four separate collections, denominated Exhibits 1 through 4. Since they were gathered by many people having differing degrees of knowledge about the Medi-Cal regulations issue, the declarations obviously vary in their quality and their ability to explain the impact of the new Medi-Cal restrictions on the primary beneficiaries of the Medi-Cal program, the recipients.

The purpose of this summary is to aid the Court in evaluating plaintiff intervenors' declarations by cataloguing and analyzing them in the context of the law. Also provided for the convenience of the Court are an index of the declarations by subject matter and a chart summarizing the contents of each declaration.* We begin by noting that of the sixty-seven declarations and affidavits, thirty-seven are of patients participating in the Medi-Cal program, and nineteen are of doctors who treat Medi-Cal patients. Most physician declarations discuss specific cases of difficulties incurred by Medi-Cal patients as a result of the new regulations.[1] The elevent remaining declarations are of other people directly involved with medical problems of Medi-Cal recipients, such as public health nurses and social workers. In addition to the sixty-seven declarations and affidavits, this summary refers, where applicable, to depositions of plaintiff intervenors and defendants.

The total number of "cases"—defined as individuals who experienced difficulty under the Medi-Cal program—discussed in these declarations, is seventy-eight.[2] Geographically the declarations give a statewide perspective to the impact of the Medi-Cal cutback, ranging from urban population centers such as Los Angeles and San Francisco, to more rural locations as Santa Cruz and Napa Counties. Quantitatively, the number of problems created by the new regulations documented in these declarations breaks down as follows:[3]

1. Inability or difficulty in obtaining needed drugs because of the restricted drug formulary: 37.
2. Interference with or denial of needed psychiatric treatment: 21.
3. Inability to obtain needed medical services because of the restriction on physician services to two visits per month: 15.
4. Denial of required eye examinations or visual appliances: 5 (or 30 if the 25 denials referred to *supra* are included).

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*Hereafter these declarations and affidavits will be referred to as "Plaintiff Intervenors' Declarations" and cited as P.I. Exh. I.

*Attached hereto as Appendixes A and B.

[1] Some of the physician declarations generally analyze the difficulties which physicians have in practicing medicine under the new regulations. There are only a few such declarations enclosed because plaintiffs in this action, California Medical Association, et al., will explore this aspect of the new regulations in much greater detail.

[2] This number is 103 if the 25 optometric denials, discussed in P.I. Exh. 3.5, are included.

[3] This total is greater than the total number of "cases" above because a given individual defined as a "case" may require more than one type of medical service.

5. Denial of speech, occupational or physical therapy : 5.
6. Inability to obtain needed dental work : 4.
7. Denial of needed surgical procedures : 3.

The illegality of these difficulties encountered by Medi-Cal recipients will be discussed in this summary by category of service (physician's services, psychiatric services, drugs, etc.).

II. TWO PHYSICIANS VISITS PER MONTH

A. No Priorities Established Among Elective Services.—The new Medi-Cal regulations, Section 51305(a)(1) provide that "more than two visits [to a physician] per month are elective services and require prior authorization, other than for emergency services as defined in Section 51056" (hereinafter referred to as the two-visit restriction). Plaintiff-Intervenor's declaration show that this regulation conflicts with the statutory requirement that "such changes [postponing of elective services] shall be designed to insure that those recipients *most in need of elective services receive them first . . .*". (Emphasis added.) W&I Code § 14120(c). No provision is made in the new regulation for patients who require more than two physician visits a month for essential treatment that does not rise to the narrow definition of an emergency or a significant disability contained in the new regulations.

To illustrate, Mrs. Thelma Hopkins (P.I. Exh. 1.21) has diabetes, cancer, a rare spinal disease, and a kidney disease. In January, 1971, she had to see her Urologist because of acute kidney failure. She now wears a catheter and her kidney condition requires that she receive treatment, including stretching of the urethra, every two weeks. The two-visit restriction prevented her from seeing the doctor who treats her heart and diabetes problems. Earlene Taylor (P.I. Exh. 1.15) suffers from severe muscle spasms in her back, migraine headaches and ulcers. She requires frequent cortisone shots to alleviate her pain. In January her doctor informed her that she had two rotted teeth which were draining pus throughout her system. She was then faced with a difficult situation :

> "I knew then that I should have this treated by a dentist, but since I had already had two doctor visits in January, I couldn't make an appointment with a dentist until February. Since I saw my regular doctor again on February 1, my dentist appointment on February 6 will be my second and last allowable medical appointment for February. This means I won't be able to get any further treatment for my rising blood pressure, headaches, or back problems until March, or else I can risk the chance of upsetting my specialist by asking him to get a prior authorization to see me for my cortisone shots this month." [P.I. Exh. 1.15]

See also the Declaration of Barbara Truss who was unable to obtain the necessary medical examinations prior to entering the hospital for a major operation (P.I. Exh. 1.7).

Other Medi-Cal patients are unable to receive weekly treatments necessary to relieve pain and aid in minimal functioning. Vera Haile, a social work supervisor at Self-Help for the Elderly in Chinatown (San Francisco) explains the case of a mother who was severely injured in a car accident and now needs shots once a week to alleviate pain. (P.I. Exh. 1.8). Another client of hers, an elderly Chinese man on ATD, has not been able to receive his weekly enema. He cannot administer the treatment himself and, living alone in a hotel room, has no one to care for him. *Ibid.*

It must be remembered that the population of welfare recipients suffers more illness than the norm for the general population. Those who are in the category of Aid to the Totally Disabled (ATD), as are Thelma Hopkins and Earlene Taylor, suffer from a combination of debilitating diseases that renders them totally and permanently disabled. The limitation to two doctor visits a month per patient is thus forcing those with the greatest need for medical treatment to play Russian roulette with their health.

B. Medi-Cal Patients Forced Out of Mainstream Medicine and Subjected to Inferior Treatment.—Ultimately the two physician visit restriction is most dangerous because it forces doctors to practice inferior medicine on Medi-Cal patients contrary to law. See. e.g., W&I Code § 14000(b). Normally when one is ill, he goes to a doctor who examines him and prescribes certain drugs. The doctor then periodically re-examines the patient to evaluate any changes in his condition. This normal procedure in medicine is inoperable under the re-

striction of two physician visits per month per patient. Doctor Ben Chaffey (P.I. Exh. 1.29), a surgical urologist, gives two striking examples of how his ability to practice medicine according to reasonably acceptable standards has been impaired. The first example is that of a woman who had symptoms which indicated either a urinary tract infection or urethritis. The usual procedure in such case is to rule out the urinary tract infection first and then proceed in a later visit to diagnose and treat the urethritis. However, the patient had already used her two physician visits for the month. According to Dr. Chaffey:

> "It was not possble to do this [i.e., diagnose for a urinary tract infection first] within the necessary time for detection of this condition. Thus, although risking serious medical complications, such as bacteremic shock and other problems, we treated here with a dilatation at the same time we treated her infection. This was done because in our prior experience requests for Medi-Cal prior authorization for such procedure were denied. *This is very bad medicine.*" (Emphasis added).

Doctor Chaffey also notes that the patient herself was nervous about the two visit requirement. The patient seemed "in near panic" that she might need more treatment for here condition before the next month's visits were at hand or before prior authorization could be obtained. (P.I. Exh. 1.29).

Sharon Meyer's experience is also disconcerting to her and her doctor (P.I. Exh. 1.12). She contracted a persistent illness in the nature of a cold. Because of the two visit requirement, the illness, which has forced her to drop out of school, has not been effectively treated. She needs additional help but says, "I have been unable to return for additional help and have just been waiting for February to come for a chance to see him [my doctor] again." She knows that her persistent cold is posing a health hazard for her five young children. See also Declarations of Staph Kalpoulsos (P.I. Exh. 1.14) and Janice York (P.I. Exh. 1.16).

Perhaps the effect of the two visit per month limitation is best summarized by Dr. Fabian Labat, a General Practitioner:

> "The limiting of visits to a doctor to two per month per patient presents serious difficulties. In the first place, some of my patients are understandably reluctant to use their allotted two visits per month and delay coming to see me, thereby allowing their conditions to get worse. In the second place, if the patient, on his second visit to me in a month, must be referred to a specialist, as frequently happens in dermatology cases or chronic cases of lower back pain, the patient must either get special permission to see the specialist or wait until the next month then count that as one of his two visits to a doctor." (P.I. Exh. 4.1).

Technically, of course, it is possible to receive prior authorization for more than two physician visits per month. In practice, however, once a patient has exhausted the two visits, any doctor who agrees to see that patient on the third visit for diagnosis of a possible "significant disability" does so at the substantial risk of not receiving Medi-Cal reimbursement for his services. It s a classic "Catch 22" situation. Until the patient is actually seen by a doctor, he cannot receive prior authorization to be treated under Medi-Cal; yet a doctor will not risk seeing him to diagnose whether the patient is in fact entitled to Medi-Cal treatment.

Finally, defendant's definition of who is entitled under Medi-Cal "prior authorization" for more than two physician visits a month, conflicts with established minimal standards for the practice of decent medicine. Only those who suffer a "significant disability" qualify to receive more than two physician visits per month; and "significant disability" is defined as one that—

> "Precludes essential basic activities of day-to-day living. In this context, recreation, educational activities, engaging in employment, driving an automobile, and other such out of home activities are not included under essential basic activities of day-to-day living." *Medi-Cal Consultant Guidelines*, January 11, 1971, p. 2.

Application of this restrictive definition explains why Barbara Truss's daughter (P.I. Exh. 1.7) has been unable to obtain her asthma shots more than twice a month under the new regulation, despite the recognition that the absence of this needed medication causes her severe asthma attacks and forced absences from school. Under acceptable standards for the practice of medicine, Barbara Truss's daughter would be deemed to be in need of "elective services" because to go without the asthma shots is to be unable to function in a school or work

situation. The definition of elective services entitled to prior authorization under Medi-Cal falls significantly below this accepted standard in excluding the ability to continue gainful employment or education from the ambit of a "significant disability." See the Deposition of Dr. Sandrock, Medi-Cal Consultant to the Lassen District.

III. PSYCHIATRIC TREATMENT DENIED

A. Mandatory Psychiatric Services Interrupted.—Psychiatrists are "physicians" as that term is used in state and federal law. 42 U.S.C. § 1396(a), 1396(d); W&I C. §§ 14105, 15056, 14053. Consequently provision of psychiatric services under a state Medicaid program is mandatory. Under the new Medi-Cal Regulations, § 51035(a)(2), psychiatric services are eliminated where the patient is not a danger to himself or others or is not in immediate peril of hospitalization:

> Outpatient psychiatric services are elective services and require prior authorization for more than one visit within a six month period, other than for emergency services as defined in § 51056.

Medi-Cal Interim Authorization Guideline § 1305.2 (11) elaborates on this regulation:

> Authorization will be granted only for treatment of major mental health disorders when deferment of such treatment would preclude the beneficiary from participating in essential, basic daily living activities, or result in bodily harm to the beneficiary or others.

To provide psychiatric help only under these conditions is to render a mere token service in violation of federal regulations:

"A token service which can be only ineffective on the one hand and wasteful of funds on the other will not be considered satisfactory," Federal Handbook on Public Assistance. Social Security, Supplement D, § D–5140.

The regulations have seriously undermined if not eliminated effective psychiatric treatment under the Medi-Cal program. Psychiatrists are concerned with emotional and mental disabilities that in many cases are much more difficult to diagnose and treat than are physical ailments. The initial difficulty with the regulation is whether a psychiatrist can determine in one visit if a patient is indeed certifiable for treatment under the regulations. Dr. Edgar Rosen is Chief of Medical Services in the Department of Health Care Services and the man primarily responsible for medical judgments reflected in the new regulations. In his Deposition of Tuesday, February 4, 1971, he rather cavalierly asserted that it is easy for a psychiatrist to determine in one session whether a patient qualifies for further treatment (Rosen Deposition, p. 32):

Question. But under the regulations, is it not true that he [the psychiatrist] can only get authorization if he is in a position to say that the patient requires treatment within 90 days or else will suffer a significant disability as a result of not being treated?

Answer. Oh, yes, *he can make that determination within the first visit or in the first few minutes,* even though he may not have arrived precisely at an accurate diagnosis. He may be able to say that this patient obviously is disturbed and needs further care, I don't know yet exactly what diagnostic label applies, and I need to have further visits with him for a diagnosis and for treatment. [emphasis added].

Question. Would say, then, that in virtually all cases that a psychiatrist can tell from one vistit that a patient does or does not need further treatment as defined in the regulations?

Answer. He can make a judgment just as physicians in other fields of medical practice make similar judgments. I certainly did in practicing internal medicine.

Yet, Dr. Tod Mikuria, a psychiatrist, flatly contradicts Rosen's facile claim: "In many cases it is impossible to make a definitive diagnosis in just one visit." (P.I., exh. 1.3).

Of course, Dr. Rosen is, by training, an internist. And he testified that there was no psychiatric input into the drafting of the regulations. There are only three physicians on his staff—a general practitioner, an internist, and a surveon. (Rosen Deposition, p. 27). He also testified that his staff did not consult psychiatrists outside of the Department of Health Care Services in drafting the regulations. (Rosen Deposition, p. 27)

Patients undergoing psychiatric treatment are in a delicate mental state. Dr. Theodore Sabot states: "A patient who can recover needs the stability and

security of a reliable and predictable treatment program in order to maintain and continue her progress." (P.I. exh. 3.12, p. 3). Dr. Marshall O. Zaslov, a psychiartist, asserts that two of his patients suffered setbacks because of the threat the Medi-Cal cuts posed to continued treatment (P.I. exh. 3.11). One patient, a Mr. S., "became so intensely disturbed by the threat to his treatment that he suffered a total regression into psychosis, was admitted to a hospital and there received one moth of treatment." (P.I. exh. 3.11). A mother of a 29 year old mentally retarded girl who cannot read or write, similarly expresses fears about the Medi-Cal cutbacks (P.I. exh. 2.1). Even a patient who has been able to obtain authorization for a short time is being caused considerable anxiety because she has reached a critical point in her therapy and is uncertain that her treatment will be allowed to continue. (P.I. exh. 1.30).

B. New Medi-Cal Patients Unable to Obtain Psychiatric Services.—Because of the severity of the cuts in psychiatric services, many psychiatrists simply will not accept new Medi-Cal patients. John Jory's psychiatrist went into the Peace Corps on December 15, 1970. (P.I. exh. 4.2). None of the three doctors to whom he was referred would accept him as a patient because of the Medi-Cal cuts; neither could he receive treatment at Herrick Hospital in Berkeley. He was then referred by the East Bay Psychiatric Association to seven more doctors. None of these doctors would accept him as a patient because of the cuts. Again, Herrick refused to accept him. Finally he was given the names of three more doctors and one of them agreed to request authorization. The authorization was granted on February 8, 1971. This patient, a chronic schizophrenic taking stelizine and cogentin, drugs which must be regulated by a doctor, went two months without a doctor's supervision. Similarly, Dr. Joyce Rubissow, Director of the School Problems Clinic, Division of Neurology, Children's Hospital Medical Center, Oakland, asserts that because of the cutbacks it has been "extremely difficult" to refer children who have learning disorders due to various emotional problems for further psychiatric help. (P.I. exh. 4.11).

As indicated in the Jory case, *supra*, the attempt to effect cost savings can result in the dangerous practice of authorizing psychiatrists to administer drugs without authorizing the necessary treatment to supervise and monitor the effects of these drugs. Dr. Demitri Polites describes at some length a client for whom authorization to treat was denied with instructions to maintain the patient on medication. Dr. Polites remarks that he finds this ruling "contradictory to say the least." (P.I. exh. 4.8).

C. No Priorities Established for Elective Psychiatric Care.—The limitations on psychiatric treatment, like the two visit limitation per month for physicians, violate the requirement in W&I C. § 14120(c) that any cutbacks must insure that "those recipients most in need of elective services receive them first . . ." The regulations deny treatment to all psychiatric patients who do not have major mental disorders. The folly of requiring a deterioration in the condition of a psychiatric patient to the point that he is either a danger to himself or others, or imminently in need of hospitalization, is easily seen in cases described in Plaintiff-Intervenors' Declarations.

Dr. Sabot tells of a severely neurotic young mother of two children who was on her way to becoming a self-supporting person. Because this woman was not suicidal, her treatment had to be abruptly terminated. In another case a woman who had made five suicide attempts in the last few years, but who was making progress under therapy, had her treatments cut off. Only when the patient became suicidal again was treatment approved. (P.I. Exh. 3.12). Dr. McKirdy, a psychiatrist, reports the case of a mother and her daughter, both schizophrenics, whose treatment was discontinued. "It was only after the girl had made a very serious attempt at suicide that I was given permission to continue treatment. The interim period when permission was refused has done both mother and daughter a considerable amount of harm." (P.I. Exh. 4.12, p. 2). (See also Declaration of Dr. Roger Owen, P.I. Exh 4.3, and Treatment Authorization Request denials attached to Affidavit of Larry Hamilton, P.I. Exh. 1.34).

IV. DRUGS

A. Only Token Drugs Allowed.—Medi-Cal regulations § 51313 and § 59999 place a large number of drugs and medical supplies on prior authorization which were formerly available under the Medi-Cal program on prescription of the attending physician. To assure that Medi-Cal will pay for the drugs which he prescribes,

the attending physician must make a special request for authorization for any drug not provided in the new Medi-Cal formulary without authorization. The physician's request to use such a drug will only be granted when the following conditions are met:

"(1) The clinical condition of the patient is of such severity that it mandates the use of an unlisted drug of a drug subject to prior authorization to prevent significant disability or death, and

"(2) Listed drugs covered without prior authorization have been adequately considered or tried and were not effective." Regulation § 51313(b)(1) and (2).

This emergency regulation has had a widespread and debilitating impact on the Medi-Cal program, both from the point of view of doctors and patients, throughout the State of California. In the treatment of virtually all physical and emotional diseases, medication is essential. As noted in the Federal Handbook of Public Assistance Administration, Social Security, Supplement D, § 5140:

"A variety of noninstitutional services is needed to assure continuity of care. A system which provides the patient with appropriate care when and where needed not only promotes quality, but is also economical. For example, to provide physicians but not drugs is self-defeating and costly in both human and fiscal terms."

A number of the doctors who have submitted declarations in support of the motion for preliminary injunction express dismay at the restrictive drug formulary. The formulary has, in their opinions, severely hampered the ability of the physician to practice decent medicine (see P.I. Exh. 1.32, 1.3, and 4.1 for general analysis of the drug formulary). Dr. Bernard Gordon, a dermatologist who has treated children in the Hunter's Point area of San Francisco one day a week for the past seven years observes:

> Comparing the drugs that remain with the drugs that have been eliminated from the formulary (without prior authorization) I can ascertain no medically cognizable principle of selection. In general, I would characterize the drugs now available to us as cheaper and older than other drugs. They are not the newer and better drugs. The drugs now on the formulary are virtually worthless for treating children with fungus and bacterial skin infections. (P.I. Exh. 1.32, p. 2).

Similarly, Dr. Fabian Labat notes the particular absence of medications suitable for treating children's diseases, such as asthma. (P.I. Exh. 4.1). And Dr. Tod Mikurya, a psychiatrist, strongly criticizes the elimination of all anti-psychotic major tranquilizers except chlorpromazine without prior authorization. (P.I. Exh. 1.3). There are other equally glaring deficiencies in the drug formulary, but this issue will be more fully explored by plaintiffs in this action, California Medical Association.

B. Defendant's Announced changes in Drug Formulary for February 17, 1971 Underscore Need for Declaratory Relief.—Plaintiff intervenors are informed that a number of changes are contemplated in the drug formulary as it now exists, effective approximately Febuary 17, 1971. The contemplated changes by no means render moot the following discussion of the severe problems caused Medi-Cal recipients by the present drug formulary. To the contrary, the proposed changes constitute an admission by defendants that the severely restrictive formulary caused great hardship for Medi-Cal recipients. The contemplated changes make even more necessary a declaratory judgment by this court that the procedures followed in adopting the emergency regulations effective December 15, 1970, and especially the drug formulary contained in regulation § 59999, were illegal. The legislature has recognized the critical importance of a drug formulary adequate to meet the needs of practicing physicians. With respect to the formulary there are two requirements of consultation before any restrictions are enacted, not just the one section applicable where other restrictions in the Medi-Cal program are contemplated:

> "Prior to including or excluding any drug from the program, the Director shall have given adequate notice to those California associations of health professionals and those recognized national associations of pharmaceutical manufacturers that are affected by such action and shall seek and consider the advice of those associations." W&I C. § 14053.6

And, in 1969 the legislature enacted yet another provision to assure that no debilitating restrictions in the drug formulary would be enacted by defendants. W&I C. § 14120.2 provides in part:

"This act is an urgency statute necessary for the immediate preservation of the public peace, health or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting such necessity are:

"In order that prescribed drugs will not be drastically cut or eliminated from the Medi-Cal program for the 1969-70 fiscal year, it is essential that this act go into immediate effect."

It is clear that the legislature intended that prior to any restrictions in the drug formulary physicians and pharmacists knowledgable in the needs of practicing physicians would have an opportunity to provide meaningful input into any selection procedure regarding drugs. Hence, the consultation requirements.

C. Defendants, Contrary to Law, Failed to Consult with Anyone in Preparation of Drug Formulary.—The facts in this case clearly demonstrate that there was no attempt whatsoever to allow pharmaceutical groups to participate as required by law in the drug formulary selection process. George Pennebaker, Pharmaceutical Program Coordinator of DHCS is the man primarily responsible, in his own words, for working "with the Medi-Cal therapeutics and drug advisory committee in preparation of the formulary and to coordinate the activities of that committee." He also does "liaison work with the professionals, primarily with the pharmacists that are concerned about the drug program." (Deposition of George Pennebaker, Wednesday, February 3, 1971, p. 13). Yet Mr. Pennebaker admitted that there was no consultation before the drug formulary was finally adopted. There was only a meeting of the Medi-Cal Therapeutics and Drug Advisory Committee on December 4, 1970. (Pennebaker Deposition, p. 42). The proposed changes in the formulary were not submitted to this Committee prior to the December 4th meeting. (Pennebaker Deposition, p. 42, 43). There was no formal submittal of the proposed changes in the formulary to provider groups for review or comment prior to adoption. (Pennebaker Deposition, p. 46).

Mr. Pennebaker testified that the only changes that were made in the formulary between December 4th and the date of filing of the regulations with the Secretary of State were changes that were either recommended by people within DHCS or on the Advisory Committee (Pennebaker Deposition, p. 61). No attempt whatsoever was made to consult with any other provider groups. (*ibid.*). This failure to consult, together with the tactic of declaring emergency regulations and thus preventing any public hearing prior to adoption of the emergency regulations, accounts for the enactment of a formulary which doctors found impossible to work with, and which caused a great deal of suffering among Medi-Cal patients.

D. Prompt Treatment Denied.—Federal law requires that treatment provided under Medicaid be prompt, without any delay attributable to the administrative process. 42 U.S.C. §1396(a) (8) and (9). The prior authorization procedure for drugs, when utilized, often caused lengthy delays in patients' obtaining needed medication. Dr. Melvin Britton reports that two of his patients had to wait three or four weeks for prescriptions to be authorized. (P.I. Exh. 3.14). One woman on Butisol went without the medication for this period of time. Mary Pimentel (P.I. Exh. 1.4) had difficulty obtaining four medications, including an antidepressant. She says that she was out of medication sometime in January and she had a blackout which she has not had for more than a year when she was able to obtain her medication. Andrew Livers, a 27 year old epileptic (P.I. Exh. 1.31), had to wait over three weeks for authorization for his epilepsy medication. See also Declarations of Dr. Marshall Zaslove, (P.I. Exh. 3.11) and Norma Colby, (P.I. Exh. 3.7).

A number of Medi-Cal recipients have had to pay for medicines they can ill afford while awaiting authorization. Welfare grants are calculated to meet only the basic needs of food, clothing, and shelter. There is no calculation in the grant for drugs or medical expenses. Mae Michael is 77 years old. She lives alone on a total income of $190 a month. Recently she has suffered from widespread arthritis and gout. In January she had to purchase the drugs necessary to control her pain: "On my income I simply can't afford to buy these medicines myself." (P.I. Exh. 1.6). Other examples include a total epileptic who was twice forced to buy mellaril, a very expensive drug (P.I. Exh. 1.28) and a man with cancer of the throat who had to pay for codeine, the only medicine which makes it possible for him to eat. (P.I. Exh. 4.7).

E. Substitute Drugs Have Proven Inadequate.—Plaintiff Intervenors declarations are replete with examples of Medi-Cal recipients who have been taken off

their usual medication and given substitute drugs which are available on the formulary without prior authorization. In numerous cases the substitute drugs have proven ineffective or have even provoked adverse reactions, such as nausea. One doctor switched one of his Medi-Cal patients, a chronic schizophrenic, to thorazine because it was his understanding that he was forced to use this drug instead of other drugs formerly used. The patient had an adverse allergic reaction to the thorazine. For similar instances see P.I. Exh. 1.7, 1.14, 3.18, 1.33, 1.11, 1.9, and 1.8 (at p. 2).

Any assertion by defendants that their prior authorization system works fails to take into account the fact that the system has broken down. Doctors, reading the regulations, see that they can obtain drugs not on the formulary only where necessary "to prevent significant disability or death." Many physicians are, consequently, unwilling to go through the bureaucratic red tape of submitting authorization requests which they can only reasonaly assume will be denied. One doctor states that instead of going through the red tape required to obtain authorization, he has "frequently used less drug treatment for symptomatic relief." (P.I. Exh. 3.13). In many cases doctors feel that they simply have to use a second or third best drug.

Jose Villalobos (P.I. Exh. 1.26) has a severe case of epilepsy. His seizures were controlled only by using a combination of the latest available drugs. Toward the end of December the doctor prescribed only the drugs available on the formulary without prior authorization. Subsequently Jose has had two seizures. Dolores Suddith (P.I. Exh. 1.22) is a blind epileptic. She has run into a stumbling block in obtaining needed medication for her epilepsy. Her doctor simply does not have the time to write authorization requests for all of his Medi-Cal patients. Moreover, a number of recipients, as documented in Plaintiff-Intervenors' Declarations, have gone to their pharmacists to refill prescriptions for drugs no longer available without prior authorization. The recipients are not sophisticated enough to understand the complicated mechanism of prior authorization. Often they merely assume that Medi-Cal will no longer pay for their medications. See for example, P.I. Exh. 1.10, 1.20, 3.17, and 1.23.

V. OTHER SERVICES

A. Surgical Procedures: The Nonsystem at Work.—Under the emergency Medi-Cal regulations, all non-emergency surgical procedures are subject to prior authorization. The criterion used by the Medi-Cal consultant in ruling on authorization requests is as follows:

"Authorization for in-patient hospitalization shall only be granted when the service to be performed in the hospital is essential for the basic health care of the beneficiary, and the service cannot be postponed 90 days or more without such postponement causing a significant disability or death." Medi-Cal Interim Authorization Guidelines, January 11, 1971 § 1327 (11).

The case of Plaintiff Olga O'Reilly graphically illustrates how seriously the above test has interferred with the delivery of mainstream medicine to Medi-Cal patients and seriously jeopardized their health.

On January 4, 1971, Dr. Frederick Osterman submitted a treatment authorization request for a "total abdominal hysterectomy" for Olga O'Reilly. The justification given on the treatment authorization request was, "persistant menomehorhagia despite harmonal Rx and two dilatation and curettages." The authorization request was denied by Dr. Mayer with this comment: "Elective—will okay if develops chronic anemia below 10gm hemoglobine."

Dr. Mayer has testified that he personally considers active bleeding and pain as "significant disabilities." He admitted that this interpretation was entirely his own, as there were no guidelines to this effect beyond the general definition of a significant disability as "one that precludes essential basic activities of daily living." Medi-Cal Consultant Guidelines, January 11, 1971, Page 2. (Deposition of Dr. Adrian Mayer, February 10, 1971).

Dr. Mayer recognized that the words on the treatment authorization request for Olga O'Reilly (persistent menomehorhagia") meant "continued bleeding." (Deposition of Dr. Mayer, Page 14.) He also acknowledged that the authorization request for Olga O'Reilly's hystorectomy was contrary to his own standards for "significant disability" and was denied outright without any attempt to find out how persistent or serious was the bleeding.

Dr. Ronald W. Smith, one of Mrs. O'Reilly's doctors at San Francisco General Hospital, found inexplicable the requirement that Mrs. O'Reilly develop chronic anemia below 10gm hemoglobin before the operation would be permitted:

"The precondition upon this patient's admission set by the Medi-Cal Consultant, that she be required to develop an anemia with a hemoglobin of less than 10gm, I find extremely difficult to understand. It is the policy of the Department of Anesthesiology at San Francisco General Hospital not to administer anesthesia to a patient with a hemoglobin of less than 10 gms. Thus, in order to fulfill the requirements set by Medi-Cal, this patient would have to become so severely anemic that she would require a whole blood transfusion before any operative procedure would be undertaken. It is well known that the administration of whole blood carries a definite morbidity and this sort of precondition to medical care is extraordinarily difficult to justify." (Declaration of Ronald W. Smith, M.D., entered into record during deposition of Dr. Mayer. (P.I. Exh. B at p. 21).)

Dr. Mayer acknowledged that he might have made a mistake, but he insisted that an appeal procedure was available to Mrs. O'Reilly's doctors. This appeal procedure, he said, consisted of two options: (1), the doctor could call up the Medi-Cal consultant and object to the denial; (2) the doctor could resubmit the treatment authorization request. Yet the only authority that Dr. Mayer could cite for the alleged first option was the Medi-Cal Consultant Guidelines permitting telephone requests only for initial authorizations, not appeals. Guidelines Jan. 11, 1971, P. 3.

The second alleged appeal option is equally useless to the physician. Every denial of an authorization request is accompanied by a notice to the physician regarding possible appeals. This notice introduced into the deposition of Dr. Mayer as Plaintiff Intervenors' Exhibit "C" at page 16, clearly states:

"You may submit a new authorization at any time for reconsideration: (1) if you believe the patient's condition has changed sufficiently to meet the above criteria; (2) if you believe that you have additional information that justifies the authorization of this service."

Inasmuch as no further information was requested by the Medi-Cal consultant in denying the authorization request outright, the doctors reasonably assumed that no further information would alter the decision. Thus, a woman, suffering internal bleeding and in pain, was denied a surgical procedure much needed to restore her to good health.

This case illustrates the following points: (1) to allow for the practice of decent and humane medicine under the new Medi-Cal regulations, a consultant must invent a standard of "significant disability" that substantially departs from that set forth in the Medi-Cal Consultant Guidelines; (2) to make the emergency regulations operable the consultant must invent an appeal procedure that is nowhere enumerated in the guidelines; (3) even these steps are of no avail because the revised standards and appeal procedures cannot legally be communicated to practicing physicians; (4) despite the best intentions of medical consultants to make the entire system workable, only wholesale appeal of the regulations can restore the ability of physicians to render adequate medical care under Medi-Cal.

(See also the declaration of Mrs. Hillman (P.I. Exh. 1.24), whose children, unable to obtain authorization for a tonsillectomy, have been constantly ill and have missed many days of school.)

B. Dental Services and Optometric Services.—Under the new regulations both dental and optometric services that are not defined as emergencies under the guidelines are subject to prior authorization and are to be postponed for 90 days unless such postponement would preclude the beneficiaries from participating in essential daily living activities. Regulation § 51307 (Dental Services); Regulation 51309 (c) (optometric services). Once again plaintiffs' declarations reveal that these regulations utterly failed to conform with the mandate of W & I Code § 14120 (c) that those recipients most in need of elective services receive them first.

Mrs. Miller (P.I. Exhibit 1.1) has a gum disease and began having her teeth removed preparatory to putting in dentures. She currently has six upper teeth and six non-matching lower teeth. Her dentist has been told by the Medi-Cal consultant that he will authorize payment only for filling cavities in the remaining twelve teeth. He will not authorize payment to remove the remaining teeth or to insert partial or total denture plates. Mrs. Miller is scarcely able to eat. See also the declaration of Renee Thompson (P.I. Exh. 4.4) whose son has missed at least one week of school because of a toothache. Marian Webster's son has waited three weeks for authorization to have his broken molar repaired. (P.I. Exh. 3.15).

A similar situation exists with regard to optometrist servies. Marie Demeglio (P.I. Exh. 1.10) is attempting to get off welfare and become self-supporting. She states that her doctor cannot authorize eyeglasses for her because of the new regulations. She is scheduled to begin school, and without the glasses it will be impossible for her to attend school. Dr. John Daly, an optometrist, tells of 25 authorization denials. He states that nine of these denials were, in his opinion, emergencies. (P.I. Exh. 3.5).

VI. IRREPARABLE INJURY—THE UNDERLYING THEME

The underlying theme throughout has been the continuing and irreparable injury being caused to Medi-Cal recipients as the result of the December 15 emergency regulations. The regulations have changed Medi-Cal from a working, though imperfect, system for delivering health care into a non-system.

For all the foregoing reasons, Plaintiffs in Intervention respectfully request that the Court enjoin the emergency regulations and restore medical benefits to those who so desperately need them.

Respectfully submitted,

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BEFORE THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

Petition to Revoke Accreditation

SELF-HELP FOR THE ELDERLY; CALIFORNIA LEGISLATIVE COUNCIL FOR OLDER AMERICANS; and CENTRO DE SALUD, individually and on behalf of low-income, elderly persons who are dependent upon San Francisco General Hospital for medical care, Petitioners,

v.

SAN FRANCISCO GENERAL HOSPITAL, Respondent.

I. INTRODUCTION

This is a petition to revoke the accredition of San Francisco General Hospital and to cut off its annual $2.1 million Medicare subsidy until it complies with the Standards for Patient Care established by the Joint Committee on Accredition of Hospitals (hereinafter Commission).

Petitioners represent elderly low-income patients at San Francisco General who are being deprived of the quality of medical care to which they are entitled under the Medicare Act of 1965 and will continue to be deprived unless and until the hospital complies with the standards of this Commission.

KCBS, in an editorial, recently criticized San Francisco General for its failure:

> San Francisco General is sick.
>
> The ancient facility is once more being charged with what can be called dehumanizing practices . . . some of which may border on the criminal. This situation would be bad enough if it was happening for the first time. Regrettably, it has been the subject of similar scathing reports for the past two decades.
>
> . . . In our opinion, San Francisco General needs a thorough, immediate overhaul. (KCBS, *Editorial*, March 30, 1971.

In the following paragraphs, petitioners will document 286 instances in which the patients at San Francisco General received inhumane, inadequate, and at times criminal treatment.

II. JURISDICTION

This petition is filed pursuant to 42 U.S.C. § 1395 bb and 20 C.F.R. 405.1001 *et seq.* which confer upon the Joint Commission on Accreditation of Hospitals the authority to determine whether San Francisco General Hospital shall be terminated as a provider of medical care to the elderly under Title 18 of the Social Security Act (Medicare) because it has failed to comply with the minimal standards for medical care established by the Commission.

III. PETITIONERS

Petitioners are SELF-HELP FOR THE ELDERLY, a non-profit corporation the serves and represents San Francisco's elderly poor population; and the CALIFORNIA LEGISLATIVE COUNCIL FOR OLDER AMERICANS, an association primarily composed of elderly low-income members with its principal office and largest chapter located in San Francisco. These petitioners represent the 150,000 residents of San Francisco who are 60 years of age or older, many, if not most of whom, are poor. CENTRO DE SALUD is a community health clinic operating in the Mission District of San Francisco where it serves and represents low-income persons, mostly Spanish-speaking.

IV. RESPONDENT

Respondent San Francisco General is an acute care facility constructed in 1916. It is the primary medical care center for San Francisco's elderly and poor and treats on an in-patient basis more than 20,000 persons annually. San Francisco General has received over $8 million in Medicare monies since 1965 to provide quality medical care to San Francisco's senior citizens. (*C.f., Annual Report*, San Francisco Department of Public Health, p. A–15 (1969–70).) As a condition of receiving Medicare monies, San Francisco General must render medical care that meets the standards established by the Commission. (42 U.S.C. § 1395 (bb).) Notwithstanding this influx of Medicare money, San Francisco General has, through a combination of administrative indifference and incompetence, failed to meet these standards and as a consequence subjects its patients to substandard medical care.

V. THE EVIDENCE

As will be more fully described below, the conditions at San Francisco General are as bad, if not worse, than those at Santa Rita Prison. A federal district court recently described the prison as "unfit for human habitation." Documents attached to this petition show *no less than 286 violations of the Standards for Patient Care.* These documents include reports compiled by a Select Committee of the hospital's administrative and medical staff, including the Director of Public Health for San Francisco and the Dean of the University of California Medical School as well as studies by interns, nurses and members of the Community.

VI. UNSANITARY CONDITIONS

San Francisco General is dirty, unsanitary, and unfit for habitation. After surveying the hospital, the Select Committee reported that:

"(T)here is a . . . basic lack of cleanliness throughout the hospital. The City of San Francisco and the . . . hospital must take responsibility for the unnecessarily unsanitary atmosphere here." (Report of the Select Committee, March 26, 1971, p. 1 attached as Exhibit "A" and incorporated by reference).

The Commission requires that, as a condition of receiving federal Medicare monies, a "hospital shall be equipped, operated and maintained so as to sustain its safe and sanitary characteristics" (Commission Standards, October, 1969, p. 56). The Select Committee has compiled numerous instances of unsanitary conditions at San Francisco General, of which the following four are representative examples:

(1) "The present system for disposal of contaminated material is entirely inadequate! The manner in which contaminated material is disposed of exposes the hospital staff, patients, the City scavengers and the community as a whole to infectious disease and sickness." (Exhibit "A," p. 3);

(2) "In some wards, plastic tubes used for intravenous injections as well as disposable syringes and needles were thrown in with the general material. Bloody dressings, sheets with fecal material, wet sheets, wet towels, wash cloths, et cetera, are thrown down the laundry chutes." (Select Committee Report, February 24, 1971, p. 13 as Exhibit "B," and incorporated by reference);

(3) "The stench emanating from the dirty utility rooms was in some instances a mixture of raw urine and stale, dirty water"; (Exhibit "B," p. 14) and

(4) "In the surgical suite, it was found that this area, even though it had been cleaned in April of last year, was once more an unsafe area. The floors are dirty, the areas in which sterile supplies are kept are dirty, and the fans have much lint on them." (Exhibit "A," p. 29).

The Select Committee concluded that, at San Francisco General:

"there were two things that appeared self-evident and which seemed interrelated: The general run-down appearance and basic lack of cleanliness throughout the hospital and the general low moral (e) of the majority of department heads and their personnel." (Exhibit "B," p. 2).

VII.

Additional violations of the Commission standard on hospital sanitation, not found in the Select Committee Reports, have been documented by the petitioners herein: Reverend Edward Peet, a minister of the Glide Memorial Methodist Church in San Francisco and President of the California Legislative Council for Older Americans, reported on March 24, 1971, that:

1. Patients on Wards 15 and 25 are confined to beds which are no more than 18 inches from window ledges laden with 2 inches of pigeon feces; and

2. The only source of ice for the entire hospital is an icemaking machine that the Director of the San Francisco Department of Public Health has condemned as "unsanitary and antiquated" and promised to remove a year ago. (Statement of Reverend Edward Peet to Commission, attached hereto as Exhibit "C," and incorporated by reference); and

3. Elizabeth Bruin, a community worker for Self-Help to the Elderly, reported on March 24, 1971, that "open, overflowing garbage bins and cans litter hallways and corridors where patients pass." (*San Francisco Chronicle*, March 25, 1971, p. 1 attached hereto as Exhibit "D," and incorporated by reference.).

VIII. FOOD AT SAN FRANCISCO GENERAL IS A THREAT TO PATIENT'S HEALTH

Eating at San Francisco General is, by the hospital's own admission, dangerous to the health of patients. For example—

1. Ward refrigerators for keeping patient food are also used to store medications and specimens (Blood, urine and stool) (Exhibit "B," p. 23).

2. The meat grinder in the main dining room had green mold on the lock that holds the grinders in. (Exhibit "B," p. 18).

3. The kitchen is infested with cockroaches. (Exhibit "B," p. 18).

Plates and silverware present additional health hazards to patients. In a report dated March 9, 1971, the San Francisco Department of Public Health found that 28% of the silverware and dishes at San Francisco General had an unacceptably high bacteria count. On Ward 15, the bacteria count was 2000 organisms per utensil or 20 times the maximum allowable under Public Health standards. Ward 43 had a bacteria count of 830, or 8.3 times greater than the maximum acceptable level. (A copy of this report, prepared by George Bush, inspector for the San Francisco Department of Public Health, is attached hereto as Exhibit "E," and incorporated by reference.)

The dishwashers are largely responsible for the unusually high and unsafe bacteria count on the hospital's plates and silverware. The dishwashers do not move slowly enough nor is the water temperature hot enough for sterilization. (Exhibit "B," p. 18). Moreover, "*even after being fixed*," the infection control nurse reported that, "the dishwashers (still) do not meet state licensing requirements." (A copy of this report is attached as Exhibit "F," and is incorporated by reference.)

Even if there were no other violations, the conditions in the kitchen compel revocation of accreditation in that the hospital's dietetic services do not have "adequate equipment and supplies to effect the efficient, safe and sanitary operation of all functions assigned to it." (Commission Standard II, Dietetic Services).

IX. LAUNDRY AND LINEN FACILITIES VIOLATE STANDARDS

In order to minimize the spread of infection, the Commission requires hospitals to keep an adequate supply of linen and to take precautions in the cleaning of soiled linen, including the segregation of dirty linen into bags at the site of collection. (Commission Standards, pp. 57–58).

The Chairman of the Epidemiology Committee recently documented the hospital's violation of this standard. His findings included the following:

1. "Material other than linen are dropped down the laundry chute. These include razors, needles, surgical instruments, bedpans, urinals, dishes, paper materials and old plastic-backed pads and dressings";

2. "Hot water soluble bags should be obtained for bagging of linen from patients who are on isolation because of infections . . . The Epidemiology Committee has previously requested the water soluble bags but the support of the Administration has not been obtained"; and

3. "Individual carts should be used for transport of dirty laundry and other contaminated utensils. Dirty laundry carts should not be used for the transport of ice." (Report of W. K. Hadley, March 12, 1971; a copy of this report is attached hereto as Exhibit "G," and is incorporated by reference.)

Dr. Hadley's report confirmed the earlier findings of the Select Committee regarding violations of the Commission's Standards on the Supply and Handling of hospital linen:

1. Wet and dirty linen—some containing feces—is all deposited in the same laundry chutes throughout the hospital. (Exhibit "B," p. 35)

2. Linen is in constant short supply in the hospital. While a hospital's normal inventory is 5 to 10 times the patient census, San Francisco General has an inventory of only 2½ times the patient census. (Exhibit "B," p. 36).

3. Rubber gloves, forceps, masks, plastic tubing and syringes—all disposable materials—are frequently found mixed in with soiled hospital linen. (Exhibit "B," p. 35); and

4. Clean sheets and bedspreads are frequently dragged across the floor as they are put in the machine dryers. (Exhibit "B," p. 36).

X. FIRE AND SAFETY HAZARDS

In interpreting its standards on fire safety, the Commission states that "the existence of gross fire hazards, . . . ineffective fire protection and/or inadequate maintenance and housekeeping practices *shall* constitute grounds for non-accreditation." (Commission Standards, p. 55).

The Select Committee in its February 24th report found 18 specific instances in which San Francisco General is failing to meet JCAH's standards on fire safety. Examples of these violations are as follows:

1. "Many of the fire extinguishers throughout the hospital have tags missing from the time of previous inspection. About 50 to 60% of the fire extinguishers have tags dated March 1967." (Exhibit "B," p. 25).

2. "The fire nozzle in the basement of the 50, 60 and 70 building does not fit the water valve." (Exhibit "B," p. 25).

3. "Many of the fire hoses . . . gave the impression that if high pressure was applied they would burst." (Exhibit "B," p. 25).

4. "We have no fire drills or no drills of any kind. We are not aware of a well-planned plan of evacuation in case of emergency." (Exhibit "B," p. 23).

An independent study by petitioner California Legislative Council for Older Americans showed that as of March 18, 1971, the hospital had not had a fire-drill in eight and one-half years. (Exhibit "C").

The refusal of the hospital to conduct fire drills is a direct violation of Commission standards which require that "fire, internal disaster and evacuation drills should be held at least quarterly for each shift of hospital personnel. . . ." (Commission Standards, p. 66).

XI. HAZARDOUS STORAGE OF OXYGEN

The Commission standard on oxygen storage states that: "Oxygen and flammable gases or liquids must be stored separately from each other outside the building or in rooms that are vented to the outside. . . . Oxygen and other gas cylinders must be secured and capped." (Commission Standards, p. 60).

Notwithstanding this requirement, the Select Committee reported on February 24, 1971, that "In many of the wards we found free standing oxygen tanks." (Exhibit "B," p. 26).

One month later (March 22, 1971), the Select Committee reported that "a visual check of the basement where oxygen tanks had been previously stored reveals that as of 3:45 P. M., Friday, March 19th, there were still 33 free standing oxygen tanks. (Exhibit "H," p. 3). This report also states that "gauges were not always on oxygen tanks and this could be dangerous."

XII. RADIATION HAZARDS

Two years ago, the operating room supervisor at San Francisco General requested protective lead linings for the dental X-ray room in order to protect the staff and patients in the adjacent areas. (Letter of E. Farrington, operating room supervisor, March 27, 1969, attached as Exhibit "I," and incorporated by reference.) [Commission Standards on radiation require that "proper safety precautions shall be maintained against . . . radiation hazards." (Commission Standards, p. 105).]

Notwithstanding a two-year standing request by the operating room supervisor that San Francisco General comply with Commission Standards, no action has been taken to reduce radiation hazards from dental X-ray. (See letter of Walter Coulson, Chief of Staff, March 15, 1971, attached as Exhibit "J," and incorporated by reference.)

XIV. DANGERS FROM OPEN LAUNDRY CHUTES

Commission Standards require that laundry chutes "should be equipped with a door having a self-closing device and a positive latch." (Commission Standards, p. 56). On February 24, 1971, the Select Committee reported that "laundry shutes (sic) throughout the wards did not close." (Exhibit "B," p. 10). On February 26, 1971, this Committee reported that patients attempted suicide by jumping down five story high laundry chutes. (Exhibit "A," p. 2).

XV. MEDICAL RECORDS

As a condition of receiving Medicare money, a hospital must keep "an adequate medical record . . . for every person admitted as an in-patient, out-patient or emergency patient." (Commission Standards, p. 70). All significant clinical information pertaining to a patient must be incorporated in the patient's medical record. (Commission Standards, p. 70; see also Standard VIII, p. 86).

Respondent's refusal to comply with this standard is unprecedented:

> Approximately one-half million laboratory reports, X-ray reports, EKG's and other special service reports are not appended to the medical records on an in-patient level at San Francisco General. (Exhibit "A," p. 40).

This means that the medical staff cannot properly diagnose and treat thousands of patients without running new tests. New tests require additional and needless suffering by patients and an unwarranted expense to the taxpayer of at least $1,000,000 to re-run lost test results. (Exhibit "C," p. 4).

When test results are appended to medical charts, the charts are often misplaced. On March 12, 1971, for instance, the department of medical records at the hospital was unable to retrieve the records for 12 out of 72 out-patients. (Report of Dr. Tom Bodenheimer attached as Exhibit "K," and incorporated by reference). Moreover, the GYN Clinic Reports that "half of (the) out-patients are seen without charts because they are unavailable and even if available do not arrive in time." (Statement of Judith Bernolun, March 12, 1971, attached as Exhibit "L," and incorporated by reference.)

Even worse, when patient records are found in time they frequently are of little use. On March 4, 1971, the Select Committee reviewed 50 randomly selected medical records. Their findings show a general refusal and unwillingness by the staff to keep adequate medical records. For example:

> *File No. B24-21-76*—Psychiatric patient. Admission and discharge summary form not completed. Application for 72-hour detention form inadequately filled out. Inadequate physical examination by intern. No medical supervision. No progress note by physician staff. . . Only progress note is one on nursing note. . . . (Report of Select Committee, March 4, 1971, p. 2 attached as Exhibit "M," and incorporated by reference.)

XVI. THE PHARMACY—THE NON-DISPENSARY

The pharmacy at San Francisco General is inadequate and dangerous. Many patients who need drugs often leave the hospital and purchase their drugs at the Rexall store, four blocks away.

Reports on the pharmacy document the following inadequacies:

1. There is inadequate inventory control. (Exhibit "B," p. 28; See also report on E. Chilgren, Chief Pharmacist, attached as Exhibit "N," and incorporated by reference.)

2. In early March, the pharmacy ran out of thiamine for over 36 hours. Thiamine is an essential drug in the treatment of alcoholism and other diseases. On other occasions the pharmacy has run out of, among other items, issonicid, isopril and plasma. (Exhibit "C," p. 6);

3. The pharmacy service has always contended that it is not equipped to prepare sterile solutions. (Report of Chief Pharmacist, E. Chilgren, February 26, 1971, attached as Exhibit "O," and incorporated by reference);

4. Pre-packaging at (the hospital) for Pediatric Clinic after hours is pathetic because the M.D.'s will not keep records as they should and record giving out legend drugs. (Exhibit "N," p. 2);

5. The pharmacy does not have a drug supply sufficient to treat patients in the event of a disaster. (Exhibit "N," p. 1).

The above examples demonstrate that the pharmacy is violating the Commission's standard which require that the pharmacy "ensure patient safety through the proper storage and dispensing of drugs," and that "emergency drugs are in adequate and proper supply." (Commission Standards, pp. 90–91.)

XVII. REFUSAL TO DEVELOP ADMINISTRATIVE AND PATIENT CARE POLICIES

As a condition of accreditation the Commission requires that "written administrative and patient care policies and procedures must be developed for each of the physical medicine services to guide the personnel." (Commission Standards, p. 98). San Francisco General has refused to comply with this requirement in that no written plan or procedure whatsoever has been developed for physical therapy. (See affidavit of Stephanie Newman attached as Exhibit "P," and incorporated by reference.)

The Commission's requirement that "the hospital shall have a written and rehearsed disaster plan for the proper and timely care of casualties arising from disaster, both external and internal" (Commission Standards, p. 64), has been with one exception totally and callously ignored by SFGH. (Exhibit "A," p. 27). The one exception is an emergency supply of water which also serves as a swimming pool for physical therapy patients. (Exhibit "P").

In order to insure that each patient receives appropriate nursing care the Commission requires a "brief and pertinent nursing care plan for . . . . each patient." (Commission Standard p. 33). On February 24, 1971, the Select Committee found that "only 2 (out of 9) wards have workable nursing plans." (Exhibit "B," p. 33). In a memorandum to the hospital administrator, the director of nursing stated that she could not implement nursing care plans on all units by March 24th but hoped that it would be completed by July, 1971. (Memorandum of Irene Pope, Director of Nursing, March 12, 1971, attached As Exhibit "Q," and incorporated by reference.)

San Francisco General had also refused to comply with the Commission's standard which requires the participation of the medical staff on committees concerned with patient care. (Commission Standards, p. 22):

1. The Transfusion Commitee has had no meetings in fiscal 1970-1971 (Exhibit "B," p. 43).

2. The Medical Records Commitee has no record of membership (Exhibit "B," p. 32).

3. The Nominating Committee of the Executive Committee has no list of members nor is there any evidence that the Committee has met. (Exhibit "B," p. 43).

4. Medical Staff Appointments Committee, has not met. (Exhibit "B," p. 43).

5. Disaster Committee—no indication of teaching. (Exhibit "B," p. 43).

6. Advisory Committee to Mission Emergency hasn't met (Exhibit "B," p. 43).

7. Abortion and Sterilization Committee—one meeting since July 1, 1970. (Exhibit "B," p. 43).

XVIII. EQUIPMENT SHORTAGES IN EMERGENCY ROOM

Standard III requires that "facilities for the emergency service shall be such as to ensure effective care of the patient." (Standards, p. 97). The excellent

medical and nursing staff in the San Francisco General Hospital Emergency room are not only confronted with trauma cases but also with devastating equipment and supply shortages and long delays in X-ray and laboratory results. For example:

1. On December 21, 1969, the Mission Emergency defibrillator broke and there was no replacement for 30 minutes (Exhibit "K," page 3);

2. On December 20, 1969, both EKG machines in Mission Emergency broke and there was no replacement (Exhibit "K," p. 3);

3. On February 26, 1971, at 12:15 P.M., a GYN consultation was requested. The patient was required to wait until 3:55 P.M., or three hours and 40 minutes for the consultation. (Exhibit "P");

4. On February 26, 1971, a skull and chest X-ray was requested at 5:15 P.M. The results were received at 10:40 P.M. (Exhibit "P").

Greg Powell, a nurse in the Emergency Room, reports the following examples of inadequacies:

1. The walls in the treatment room had not been scrubbed for one year. On March 3, 1971, "the nursing staff took it upon themselves to do it. One of the persons involved was later reprimanded for his part in cleaning the rooms."

2. "The hospital (including the emergency room) reuses disposable supplies. Irrigation syringes clearly stamped "destroy after use" are resterilized and issued from central supply for reuse. Disposable surgeon's gloves are wrapped in brown paper and used again. Most notably is the reuse of disposable Foley catheters.

3. Recently, Mission Emergency was for some time completely out of large and medium intracaths. At that time, there were no other large intravenous lines available. There have been times when there was not a single cut-down tray in Mission Emergency. (Statement of Greg Powell, March 24, 1971, attached as Exhibit "R," and incorporated by reference.)

XIX. DISCRIMINATION AGAINST NON-ENGLISH SPEAKING PATIENTS

Federal law provides that "no person . . . shall, on the ground of race, color, or national origin be excluded from participation in, be denied the benefits, or be subject to discrimination under any program or activity receiving Federal financial assistance . . ." (Civil Rights Act of 1964, Title VI; see also 20 C.F.R. § 405.1001(e). The Commission, recognizing the importance of this law, stated in its August 8, 1970, Preamble that "[i]n the matter of communication, ethnic and cultural considerations are highly significant, and should be taken into account by providing interpreters where language barriers exist."

San Francisco General treats a large number of non-English speaking patients (over 2,000 annually) but has few, if any, interpreters in its employ to communicate with these patients. This absence of translators in the hospital causes consternation to patients they often cannot understand what ails them or communicate their injuries to medical staff. One representative of San Francisco's Chinese community, referring to the effect of no interpreters, compared San Francisco General to Red China, "You go in, you disappear, you never come back." (Statement of Elizabeth Bruin, March 24, 1971, Exhibit "S," incorporated by reference).

A doctor at San Francisco General recently observed a "well-meaning but frustrated English-speaking nurse . . . trying to explain to J.M., a Spanish-speaking patient, how to (1) go to the laboratory for blood tests, (2) find the X-ray department to make an appointment for an X-ray, (3) get a tuberculin test, (4) make a new appointment for next week, and (5) go to the pharmacy. *No interpreter was available.* (emphasis added). (Exhibit "K," p. 4).

The refusal of San Francisco General to employ interpreters for the specific purpose of enabling hospital staff to communicate with non-English speaking patients is long-standing, medically inexcusable and unlawful. The thousands of non-English speaking patients who are treated at San Francisco General cannot help but receive second class medical care when they cannot make themselves understood or understand what is happening to them.

XX. HARM TO PATIENTS

The foregoing violations of Commission Standards are only illustrative and representative of the more than 286 violations which are found in the attached exhibits.

The Standards of the Commission, as adopted by the MediCare Act of 1965, provide an invaluable safeguard not only to the elderly but to all patients in that these standards require hospitals to:

(*a*) apply certain basic principles of physical plant safety and maintenance, and organization and administration of function for efficient care of the patient;

(*b*) promote high quality of care in all aspects in order to give patients the optimum benefits that medical science has to offer; and

(*c*) maintain the essential services through coordinated effort of the organized staffs and the governing bodies. (Standard, p. III).

The refusal of San Francisco General to comply with these standards has an immediate and adverse effect upon the patient. For example:

During October 1970, two out of every five patients in surgery ICU suffered hospital-associated infections. In November six out of every 10 patients suffered such infections. During the same month, three out of every ten trauma surgery patients suffered hospital-associated infections. (Report of Grace Lusby, Infection Control Nurse, February 22, 1971, attached as Exhibit "T," and incorporated by reference.)

This is at well above the acceptable rate and is at least partly attributable to the hospital's refusal to comply with the Commission's Standard on sanitation and safety.

On March 25, 1971, Dr. Robert Marvan reported that:

(1) for three straight days ants were observed in a patient's bed and his I.V. bottle which leads to his bloodstream;

(2) in October 1970, a patient who had a gunshot wound on his neck needed a tracheotomy. Worms were found on his head and maggots were noted around the tracheotomy area. (S.F. Examiner, March 25, 1971, attached as Exhibit "U," and incorporated by reference.).

Prayer for Relief

The petitioners, pursuant to HEW regulation and federal statutory requirements, seek the following relief:

1. A declaration that the allegation made in this petition (including the attached exhibits) concerning violations of Commission Standards by San Francisco General Hospital are true;

2. Revocation of San Francisco General's accreditation and Medicare payments until the hospital submits documentary evidence that it is in full compliance with the Standards for Patient Care as established by the Commission.

Respectfully submitted,

Fred Hiestand.
Peter Coppelman.
Philip Neumark.
Sidney Wolinsky.
Stanley J. Zaks.
By Philip Neumark,
Fred Hiestand,
Attorneys for Petitioners.

Dated: April 14, 1971.

APPENDIX 6

STATEMENTS SUBMITTED BY THE HEARING AUDIENCE

During the course of the hearing a form * was made available by the chairman to those attending who wished to make suggestions and recommendations but were unable to testify because of time limitations. The form read as follows:

Dear Senator Muskie: If there had been time to speak at the hearing on "Cutbacks in Medicare and Medi-Cal Coverage," in Los Angeles, California, on May 10, 1971, I would have said:

The following replies were received:

VIRGINIA FRANZLICK; TORRANCE, CALIF.

Have socialized medicine, and preventive health care education.

Business that creates much of the smog and pollution and the problems of sickness should contribute to this.

Many other countries have this. We use our resources to fight wars instead of building and saving lives.

Don't just talk, but act or the people will not vote for either one of the major parties.

FREDERICO HERNANDEZ, LOS ANGELES, CALIF.

I have been paying Medicare 1969 and 1970 and in 1971 I went to see a Doctor and my Doctor was $114. and all the Medicare help me was with $31. and I am not happy.

BEULAH BLACK, LOS ANGELES, CALIF.

We who need help now and depending on it at our age—now is the time to help the aging. Please help us to help ourselves. Now is when we need your help.

FRANK PENSAVALLE, MONTEBELLO, CALIF.

Cut out the unnecessary frills of offices and constructions and projects in foreign countries, and duplication of agencies. Tax real estate holdings of banks and of insurance companies. Think of the fixed income elderlies than can not survive on Social Security. Support Senator Mills bill, and Senator Kennedy on government insurance. God bless you.

ALMA HOOTEN, LOS ANGELES, CALIF.

It seems a shame that the elderly and sick citizens should be cut back in their help in Medi-Cal and Medicare. They are the ones that have built this country.

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*See statement, p. 29.

I myself have been able to keep up my Kaiser Health Ins. Others have been less fortunate and I feel it is our duty as Americans to see they are taken care of properly when they are sick and needy.

MARR R. CANALES, LOS-ANGELES, CALIF.

If only everybody would believe in my motto "LIVE AND LET LIVE" this world would be entirely different and everybody would be for the people, especially the elderly. For we have done our job the best we could without the aid of Welfare and raised our children to become decent citizens of America, and I believe now is the time to help the aging group. Senior citizens deserve a helping hand on Health, Medicare and Medical. Please give it to us. We are only young once. Lot of us are not fortunate enough being lonely in Convalescent Homes, waiting for our last days and it should be made happy for those more unfortunate. We're here today and gone tomorrow—one never knows does one?

MR. AND MRS. VINCENT CIOFFI, PICO RIVERA, CALIF.

After years of paying taxes, when we need help the most—it is to be denied us. This is one of the most unfair proposals—with all the waste of funds—I'm sure some other less worthy project could be cut back.

NELL MCGEE, MONTEBELLO, CALIF.

DEAR FRIEND: I am a member of the Montebello Friendship Club Senior Citizens.

As a senior citizen seventy seven years old I am writing to protest the cutbacks in Medicare.

Thank you for your interest in older people.

CARMEN TELLY AND MRS. THOMAS C. TELLY, MONTEBELLO, CALIF.

Dear SENATOR MUSKIE: As a member of the senior citizens:

There is nothing that I can say contrary to the reformation for Medicare and Medi-Cal.

The official incarnation existence coverage and regulation, is already here.

Faithfully yours in Christ.

MRS. CLARA D. INGLE, MONTEBELLO, CALIF.

May we please have some of our Medical coverage restored to us so we can have our teeth and our eyes taken care of by the proper doctors. Also if those of us who are on the Pension, could only be placed in a separate category from Welfare, we would be most grateful.

I have personally resided in Montebello, California for sixty three years and have paid taxes for almost fifty of those years. I lost my son, my only child, sixteen years ago and am completely alone. I am seventy-four years of age and think it is very wrong to have my Social Security check deducted from my pension check. I receive four-nine dollars on my son's death from Social Security but my pension check is that much less. I thank you so much for listening to my story—God bless you and may you be our next President. We need *Peace.*

MRS. ERNESTINE MCTYRE, LOS ANGELES, CALIF.

A family of four children, products of a divorced home, were suffering a severe emotional problem. Two of the children were referred by a doctor for psychiatric help, only to be told that Medi-Cal would no longer cover such needs.

Two of the children have at, one time, been able to maintain excellent grades in school, but recent school records reflect harm in children's progress.

Mother has severe physical problems and much medication is necessary for treatment which is not being covered by Medi-Cal. This family is suffering both mentally, emotionally, and physically from recent drastic cuts in Medi-Cal.

MARION HEFFELFINGER, MONTEBELLO, CALIF.

No we should not be cut for I do not get enough Social Security that I must pay a big hospital bills if I take sick.

HAZEL RESCINITO AND JOHN A. RESCINITO, MONTEBELLO, CALIF.

Please don't make the Senior Citizens suffer, when all the heads of states even to the Presidents pay has been raised in the thousands of dollars when all we want is enough to live on. Millions of dollars are being spent needlessly in my opinion when just a few dollars can do so much for the sick and elderly. Please help us and don't allow the cutback on us. Do the cutting down somewhere else. Thank you Mr. Muskie.

JUANITA GONZALES, LOS ANGELES, CALIF.

That the cutback on the Medi-cal allowances to 3 appointments per month is not enough because if an emergency happens where more appointments are required it would be hard for us to make the payment and still be able to support my family.

MRS. H. C. YUDIS, SANTA MONICA, CALIF.

I think eye care, foot care, dental care should come under Medicare. Also the $60.00 deposit when entering Hospital is a great hardship for many S/C who only have Social Security Income. S/C should have a special discount rate on Rx's under Medicare.

MR. AND MRS. BIAGIO PENNINO, MONTEBELLO, CALIF.

I live on Social Security and this is not enough to keep me living. If we should get a sickness we would have to go on welfare. Please give us 60 days hospital care as before. If we were on Welfare we would make more than we are getting from Social Security Please help us out.

DOMINIC POLIMENI, ALHAMBRA, CALIF.

No—there should not be a cutback for many of the elder are on social security. Since they are on social security many do have a limited income and with the rates of hospitals and doctors if they do have any savings it would draw all their life saving just to pay medical bills. I feel that other resources should be cut back—some of the areas are aero-space, welfare—(especially food stamp programs should be looked into). If cutback of programs is not advisable, then distribution of funds equalized.

ANNIE R. RAINER, LOS ANGELES, CALIF.

I would say as human being, are very anxious that we do hope that this Medi-Cal and Medicare is not voted out because it is so many people who would suffer, and by the help of God we hope that this considered to be continued, so those peoples can still live. We are praying that this request is considered.

LOUIS S. NICKS, LOS ANGELES, CALIF.

I got Medicare and Medi-Cal I am not able to pay the first $50 I have to see a doctor from 3 to 4 time a month. My wife is totable she got heart conditions. i get social aid also my wife but it not enough to take care of I expence. I am 65 year old and I cant get my oldage pense. I dont think that fair at all. I think man work till he get 65. I think he should get his pence. My social worker turn me down, she say I get to much. I only get my social security. I think when a man lucky enough to make 65, he should get what hes intitled to.

MRS. OPHELIA NICKS, LOS ANGELES, CALIF.

. . . it been well said at this hearing.

Thank you dear Senator Edmund Muskie. I have a hart condition, needs money for diet food an medical. I am 63 years old. My husband is retired, he is ill. We get Social security $221 togeather. The state give me $107. With food, and medical bill, house rent—its hard to live.

EDNA WILLIAMS, LOS ANGELES, CALIF.

That I'm a senior citizen on Medicare and Medi-Cal I can't have the medicine that the doctor use to prescribe unless I pay cash for it I can't use that cheaper medicine my complaint is high blood pressure, hard arteries, enlarged heart I do need the care I was getting.

HARRY F. DELO, LOS ANGELES, CALIF.

Because of the high and rising costs of medical treatment I am in favor of the federal government taking over the health care of the entire population.

The financing could be handled by means of payroll taxes and individual income taxes. The individual in turn would save by not having to buy costly "ambiguous and confusing private medical insurance" or have his life savings wiped away because of an intensive care illness.

The twenty five billion dollars a year we have spent and are spending in Vietnam could be put to better use in providing better health care for all our citizens.

Good bless you for taking an interest in health care for older American citizens.

MRS. MARY CURTIS, LOS ANGELES, CALIF.

I need some glasses and I also need some teeth and I make regular trips to the doctor three times a month. I really need my glasses in the worst kind of way. An it would really help if they would not cut the money.

WILLIAM H. ANDREWS, LONG BEACH, CALIF.

In a very short time my wife and I will be in very short supply. And we will have to decide between food and drugs. My wife's Social Security is now up to $149.20 and mine is $66.10. We have a small monthly payment coming in each monthly, but this will end next year.

I received my injury on the job, February 27, 1953. I was a Flight Electrical Inspector for Douglas Aircraft. Because of my injury (leg) I received a California Worker's Compensation rating of 85% plus 10½% making a total of 95½% disabilty, because of the date of injury, this rating pays only $11.54 per week. I worked very little under Social Security, having worked for Long Beach City College, City of Los Angeles and others that were not under Social Security.

The following I hope will become part of the record, so what happens to me

will be corrected, so that others will not receive the same treatment at the hands of the state, federal government and others.

In all departments of government and private industry I was not employable because I and many others are discriminated against because of our worker's compensation ratings. If your rating is over 50% you can not get a job with industry or government. The insurance companies will not cover. It appears that insurance companies penalize everyone with a Worker's Compensation rating over 50%. To me this is discrimination.

The following is a case in point: At Aeronautics I meet all Quantifications as a technical writer and I was asked by the employment officer (this man was in a wheelchair because of polio), how I became injured and why. When he found that I had been injured on the job and I was covered by worker's Compensation. He said if I had been injured in any manner he could put me to work. He said that he could not hire anyone with a compensation rating of over 50%.

I was not able to get my Social Security frozen because of my education and degrees, Social Security says I could do desk work and other types of jobs. But all goverment departments and industry says *no*. Teachers, Electronic designers and writers has been in very short supply. I have not been employed since 1953. What a loss to all.

I have been very active in many service and professional groups. I am now secretary of Local #11 IBEW Retirees Club. This Local has over 600 retirees. Charter member of blue lodge and Shrine in Long Beach, I was charter officer in the blue lodge.

CARRIE V. PICKARD, LOS ANGELES, CALIF.

I believe the doctors are more interested in money than the welfare of people period, and they charge so much for their services and very often do nothing but give you a lot of drugs. I was injured by a display falling on my head and the doctor did not even examine my head closely because blood was not streaming down he did nothing and when a scab formed I went back to him and he said it was mostly dandruff, very untrue. Also I was beaten on the shoulder by a mentally disturbed person and he did nothing but give me drugs. I, also, had a man to be thrown on my foot by a bus driver starting the bus with a lunge and about that time medical was cut to two times a month and he thought I did not have medicare and he was about to stop me from taking treatments and refused to make out a statement for bus company saying "It's too much paper work". I hear the doctor tell of his 88 yr. old mother that he was able to give her the treatment needed; fortunately; yes because he charges so much. I have decide to not go to a doctor any more; to look to God for my health, eat the best I can and put myself completely in God's hand; for "What the World needs is Love sweet Love" etc. "For I will restore health unto thee, and I will heal thee of any wounds", saith the Lord. Jeremiah 30:17. "And God is able to make all grace abound towards you; that ye always having all sufficiency in all things, may abound to every good work". 2 Corinthians 9:8. I would rather die than go to a doctor again for I would be better off dead than be used anymore by doctors just after money that is all they care for and people need to turn to God and trust Him and He will heal us.

"The history of the world is a record of the rise and fall of great nations. Their average age has been 200 years! That should bring us to some rapid mathematics—1776+200=1976! Could it happen to US? Let us review the stages of development progressed in their rise and fall: From Bondage to Spiritual Faith . . . from Spiritual Faith to Great Courage From Courage to-to Liberty . . . from Liberty to Abundance . . . from Abundance to Selfishness . . . from Selfishness to Complancency . . . from Complancency to Apathy . . . from Apathy to Dependence . . . from Dependence back to Bondage.

In which phase of progress are we? We have Abundance—but is there not alarming evidence of Selfishness, Compancency, Apathy and Dependence in our midst? Have we let ourselves be so lulled by Abundance that we have come to think it is our just due, without any effort on our part other than its enjoyment?

Will we have to find outselves in the shackles of bondage before we wake up to the realization that, solely by our own complancency, we have let the real values slip past us and have settled for "comfort" a vicarious security?

We need not complete history's cycle, if we do something right now about the tranquilized state into which we have drifted. And there is something each one of use can do, and we must do it!

We must return to the deep Spiritual Faith from which the Great Courage was born to establish Liberty! And it must begin with individuals, for enough individuals of Faith—unashamed, deeprooted Faith in God through which His Power can flow—can stop this decay and replace its weakness with Courage and Strength.

This is the challenge I accept today. It is the challenge I throw out to you, for it is a call to Faith for all, wherever you may be in the world, as well as in America. God calls you to be HIS agent of power. We must accept it TODAY, and go forth in his wisdom and might to bring victory of "justice and liberty for all."

LOIS V. HAMER, DIRECTOR, PROGRAM OF RETIRED CITIZENS, LOS ANGELES, CALIF.

The elderly in the inner city poses a unique situation. The poorest of housing, the most inadequate of services (grocery, pharmacy, medical, etc.) and the loneliest of living are all bound up with the smallest incomes. The pride of people is a magnificent American quality. It gets in the way of adequate living.

There is the lady who has $11.00 per month after board and room, to get a bus pass, to buy non-prescription drugs—e.g. aspirin, to go to church, and even to buy a pair of hose or shoes. She is 82 years of age.

There is the gentleman who has $75.00 a month social security and just will not think of "welfare," who eats 2 meals a day, pays $45.00/mo. for a room. What does he do for medical care?

Attached are some ways in which the program of retired citizens is working to meet these needs. In just central city, Los Angeles are 60,000 older people living, of whom about 20,000 are in real need. It is to these that PRC ministers, and for these that PRC has a real concern.

GOAL

The purpose of the program of retired citizens is to help older people live lives of dignity and independence.

The means to accomplish this goal will be found in natural clusters of neighborhood churches who have grouped themselves around common needs and interests.

Adherence to the program of retired citizens' goal will keep the focus of program activity on those persons who are most isolated, most hurt.

RATIONALE

Even a cursory comparison of rough figures will show that an enormous percentage of older persons are not known to the churches and do not feel the church's concern as expressed in traditional ways.

There are many reasons why this is so. Once survival needs have been met individuals haven't enough energy left to reach out to other people. Thus, a process of isolation begins which leaves many with only a stubborn pride to sustain them. The church must interrupt this process.

The only vehicle through which God's love can be felt by these lonely people is another individual. A group, a pamphlet, a newspaper invitation is too diffuse and impersonal an expression.

A church cluster can recruit laymen to call at the doors of people in their own neighborhood. It can train the layman to recognize the person in whom this process of isolation has begun. It can support the layman in staying with the person until his individualized help is no longer needed.

Though entirely necessary, this extension of the minister's pastoral concern is highly inefficient and attention to the physical neighborhood situation is also needed. How far must people walk to the market to buy food? Do they have a refrigerator so they don't have to go every day? Is there adequate weekend transportation? Et cetera. Satisfying survival needs should not take all one's energy.

METHODOLOGY

A. Task

1. *Finding*: Finding the individual who is effectively isolated can only be done by knocking at his door.

2. *Establishing a Relationship*: A relationship must be established. This may mean as brief an encounter as the acceptance of the caller's card, or it may mean

repeated friendly calls until the volunteer can be assured that, in case of need, the individual will ask for help.

3. *Identifying Needs*: In many cases, the individual will be unable to assess his own needs and/or will be unable to articulate them. The volunteer will need to be sensitive to this problem and concerned enough to guide the individual in making the choices open to him.

4. *Referring*: Referrals to agencies established to help older people should be made whenever appropriate and possible. These resources will vary from neighborhood to neighborhood and knowledge of them on the part of the client cannot be assumed. The process of referral can be lengthy and always must be one in which the basic relationship is not threatened; that is, the client must never feel he's just being "palmed off" on someone else.

5. *Initiating Services*: Many needs will show themselves which cannot be met by referral to another agency or by the volunteer himself. An important function of the volunteer is to convey these needs to the PRC staff. Many unmet needs can be filled through the imagination and energy of the church cluster whose commitment to the healing mission is strong. Initiating a response among the secular community is usually the most appropriate reaction to these needs. However, the cluster's responsibility to aid the individual in the meantime must be kept. Programs to fill the gap may have to be undertaken by the cluster itself: e.g., a meals program.

6. *Continuing Relationhsips*: An individual's situation changes by the very nature of the aging process. A volunteer should be given a specific assignment of, for example, a geographic area, apartment house, list of individuals for which he assumes a continuing responsibility.

B. Recruitment

Volunteer recruitment will be through the church cluster and should be continuous among the separate congregations. Although, of course, volunteers need not be church members, motivation toward this kind of service may come out of a religious commitment. Increased participation will strengthen the local congregation as well as provide the cluster with an effective single thrust showing the church's concern for the community.

C. Training

Volunteers will be in continuous training at monthly meetings. Training aims are three:

1. To acquaint the volunteer with community referral resources.
2. To help the volunteer develop the techniques necessary to carry out his tasks.
3. To help the volunteer develop the personal resources necessary to the tasks and to provide the sense of community and support needed to maintain the emotional stamina required.

FERNANDO LOPEZ, COMPTON, CALIF.

That I am 75 years old I am under doctor's care at present I am praying that you will really do something about our health problems. Please help us elderly people.

1. Give us better health care
2. Adequate supply of medical and para-medical personnel
3. Stop these high costs of health care which we poor elderly citizens are not able to pay. If we do we can only half way live with the high cost of living.

BERTHA L. JOHNSON, LOS ANGELES, CALIF.

Won't all of you who have the power to make things happen please do not cut back Medicare or Medi-Cal. Our people need help and a program for survival, not a paper program. We are not poor by choice, but by virtue of everything being taken from us. We pay Social Security, we pay withholding tax, we pay insurance, etc. On a small salary we support our government. We carry the bulk of the load. Please—action is what we want. We don't want to die when

we could be saved. Don't you care? Do you? Then bring these things to pass. We trust you and ask for your support.

Please! We need Medicare and Medi-Cal.

MARY M. THOMPKINS, LOS ANGELES, CALIF.

I agree with the one said we do not need no cutback because it is hard to get doctor care with what we get now. I hope we can get more and instead of a cutback in Medicare and Medi-Cal.

IRENE SALCIDO, WILMINGTON, CALIF.

Please hear, listen to these people. Don't just sit back and make a few choice remarks. May be we the people should make our public official accountable. Some happen to forget the promises they made while seeking to be elected. It is a dirty shame when old people are treated dirt. I know what I am talking about my mother is a widow living on social security and O.A.S. but is living with me because she could not make ends meet. She has also had to wait at Harbor General Hospital from 5 p.m. all through the night until the next day to be taken care of.

MRS. BESSIE BELINSKY, LOS ANGELES, CALIF.

How there will be something done good about Medicare and the cost of medication, prices of doctors and drugs continue to rise in price!! What about the cost of housing? Prices are much too exorbitant.

CECIL S. GOLDBERG, LOS ANGELES, CALIF.

What are old folks to do. First we are raised on our initial cost and then they want to take it back one way or another. There should definitely something to be done on medicine every time you go to the druggist the prices are raised 30 to 60 cents per prescription.

MRS. VIRGINIA GRAY, LOS ANGELES, CALIF.

I, Mrs. Virgina Gray, the age of 77 years old, born in America. I am American I am poor I have worked here all these years suffering with little pay now since I have got old too old to work I am on pension and that's not enough to live on and pay doctor bills too, the food and everything is going up, up. I am not able to keep up with it I live alone I am a widow, I don't think it is right for we older one to be pushed aside like this.

BEN ROSS, LOS ANGELES, CALIF.

What I totally agree with the statements made by all the witnesses, only no comment was made on sickness prevention, as I am a layman I dont' know how to phrase it.

MR. AND MRS. SHAIN, SANTA MONICA, CALIF.

I am 73 years old and my husband is 83 years old. Medicare and Medi-Cal are very necessary for us as we don't known how we would pay our extensive medical bills otherwise.

JOSEPH J. HAGLER, JR., DOWNEY, CALIF.

In many ways life has been very good to me. However, twice I have been at death's door and was almost financially ruined by medical bills, even though I

carry medical insurance. In one illness alone, the laboratory fees ran over $5,000 in a thirty day period while the medication cost an additional $157 a day while in the hospital and $63 a day while at home. If I had not learned how to give myself injections, the cost would have been higher for a 4 cc injection had to be adminsitered every six hours.

From personal and family experience, I have witnessed people refused treatment in emergencies because medical coverage or financial ability could not be established at that moment. In one case, my cousin died of burns while he waited two hours for clearance and then rushed to another hospital. A friend lost the use of three fingers because he did not have $500 in cash to give the attending physician at 2:00 AM on a Christmas morning and I had to rush him to another hospital twenty miles away.

As a management consultant and advisor on health programs, it is my opinion that cutbacks would be a penalty imposed on people who by circumstance are poor and elderly. The truth of the matter, however, is not really if there should be cutbacks or even increments for these are immaterial when the delivery system, the root of the problem, is left unchanged. Our current systems for the delivery of health care are failures with cost rising daily without any comparable nor appreciable increase in benefits. As long as we continue to use outmoded systems, no one, regardless of age or economic condition, will be able to afford health coverage in the next five to ten years.

Since World War II, there have been major advances in the development and control and cure of disease. All fields of health care have shown great increases in their ability to control human suffering and to increase human life span. In spite of the achievements in health care, the system by which care is made available to people failed to change and has not kept pace with this expanding capacity to prevent and treat illness.

In my opinion, the answer is multifold. First, the concept of group practice would not only tend to raise the quality of medicine practiced, but also cut down on the over utilization of hospitals for people could be treated by a physician within the medical group. Unnecessary and over-utilization of hospital beds is one of the major causes for the continual rise in medical coverage. Group practice would also solve much of the transportation problems for people would not have to travel for special treatment or examination by a specific specialist.

Under most indemnity programs, diagnostic work must be performed in a hospital before the insurance carrier will reimburse. Under the group practice concept many tests could be performed at the medical center. As for reimbursement for services rendered, here too the structure must be overhauled. As long as economics is a major factor in care and treatment, then we witness countless stories similar to those I previously outlined. Indemnity programs perpetuate a system where people are treated on their ability to pay rather than on the basis of their medical needs. A per capitation program would remove economics from the office visit and all the physician would know that he has a patient to treat.

Under a per capitation program, doctors would be paid to keep people well and would be able to spot problems before they become serious and require hospitalization, and perhaps an operation. Not only, in the long run, would the cost for medical care reduce, but for the first time in this country, doctors would be able to practice preventative medicine and not just curative.

Unemployment is of major concern to the elderly as well as the young. How many people could be put to work within the para-medical profession. We are losing a resource by not using the skills of all age groups in the para-medical fields. Over the long run, many things currently done by medical professionals could be done as well by a para-medical person thereby not only reducing the costs of care and treatment, but also freeing the medical person for the professional skills that only he can perform.

In conclusion, I thank you for the opportunity to place these few ideas before you and offer myself to you for the development of the concepts outlined here.

WILLIAM R. KISSINGER, DOWNEY, CALIF.

Let me begin with a few simple facts. At the present, there are approximately 20 million senior citizens (age 65 or over) in the United States. By the year 2000, there will be 65 million. This portion of our population is increasing at the astounding rate of 900 per day.

Thus, it is a necessity that we establish an effective program for the health care of this approximate 10% of the total population. This should be a *TOTAL* care system which would also include dental as well as optical provisions. At the present, eyeglasses and dentures are almost classified as a luxury item, while in actuality, they are utmost necessities. Lack of proper dental care is a major factor for the high rate of malnutrition among low-income senior citizens. It may seem funny that dental service provided by health care could sharply lower the hunger rate, but it is very true.

Allow me to point out a few other facts, Mr. Senator. A certain government document, which is also inscribed in certain government facilities, states that "all men are created equal." Does that not mean that a man who is 65 or older is equal to a man of 20 or 30? This same document also states that man has certain inalienable rights. Do you not agree that one of these rights should be equal support of the aged as they have supported the government most of their lives?

Yet, the one that strikes me the hardest is the statement I am about to quote: "That government *of* the people, *by* the people, and *for* the people shall not perish from this earth."

This is a very fine piece of material, true to American Heritage, but we do not seem to be upholding it. You will notice that I strongly emphasized *of*, *by* and *for*. The reason for this is that health is going to make the people perish, and then there will *be* no government (and that includes Ronald Reagan).

Thank you for your most valuable time and attention, Senator.

MRS. ARTHUR DANEMAN, NORTH HOLLYWOOD, CALIF.

It is about time something will be done about the older Americans in the way of helping them to retain their dignity and independence.

We certainly do NOT want handouts or charity as such but indeed we cannot pay the present cost of staying well. The hospital and doctors' cost is way out of reason. We want and need some one to step in and investigate what is going on in this area.

I am not familiar with Medicaid, but am sure that Medicare is not fulfilling its promise to help pay necessary doctor's and hospital costs. In your opening statement, you stated that only 43% is being paid by Medicare. We seem to be in the middle of the scramble—Medicare cuts us down and the doctor boosts his price. We are somewhere between the two trying to make ends meet.

As President of a Senior Citizen Group in North Hollywood, I deliver your message and the information we heard as given by the various speakers. All members—150 strong—agreed that some measure should be taken to remedy the present situation.

For many years I have served as Chairman of the Medicare Committee of the Mayors Advisory Committee for Senior Citizens in the City of Los Angeles and realize that the criticism expressed against Medicaid and Medicare has been justified.

Recently I attended a meeting on Health in preparation for the White House Conference to be held in Washington on November 28th. Forty or more persons participated in this Workshop and the consensus of opinion was there is a great need for a National Health Program for all Americans. Need also for Free Clinics for the older persons would save taxpayers' money in the long run. Thank you for this opportunity to write you.

EVELYN LESLIE ENCHES, ALTADENA, CALIF.

In relation to the costs and benefits of Medicare, careful attention should be given to *supplementary insurance plans;* this study should include:

1. *Methods and media used for promotion* (misrepresentation and high pressure tactics are frequently present).
2. *Policies should be clearly worded* and *in large print.* They should be as brief as is feasible with the terms of the policy.
3. *Claims should require the minimum of clerical work on the part of the insured.* It would be helpful if these forms could also have large print.

Perhaps a *special grace period* could be granted to a person who had had a policy for five years, for instance. (Could the typical 30-day period be extended to 60- or 90-days?) Many elderly people have had little clerical or legal experience, and they find every aspect of insurance puzzling, annoying, or frustrating. Filing claims is the most exasperating part of it all, and often comes when the person is still convalescent and not his best, either physically or mentally.

MRS. HARRY MAISEL, N. HOLLYWOOD, CALIF.

That I was greatly impressed by your deep feeling toward senior citizens. The overlapping and wasteful spending of moneys that should go to the people who desperately need it is a national disgrace. I'm not sure that one man, great human being that you are can accomplish this tremendous job but do the best you can to help us. I hope you will be our next President but more than this I pray you have good health and the strength to combat the selfish, greedy forces that seem to have our country in a deathgrip. Good luck.

MRS. IRENE BOWSER, LOS ANGELES, CALIF.

The Medicare and Medi-Cal has been a blessing to me. As I am a widow 84 years old. I wouldn't be able to pay doctor's bills, and take care of other expenses. So I am very grateful for your help. I pray you will continue as it is. I enjoyed the meeting last week, sorry to be late writing to you but I just haven't been able too well to write. Again I thank you hope there will be no cut backs.

MARTHA WALKER, LOS ANGELES, CALIF.

It's easy for you so called "upper-middle class" bastards to pick on the old and the poor, but remember you never know what tomorrow holds for you! Your mother might suffer behind the cut backs!

Stop sending money to the moon to bring back rocks, and keep it here to help the old, sick and the poor!

ELAINE GEALER, LOS ANGELES, CALIF.

"The poorer you are, the poorer you're treated." Aside from the obvious moral implications of mistreating the poor there are incredible financial implications too.

What we avoid paying for now healthwise is later *more expensive.* Preventative medicine is well known to be less expensive in the long run.

We also embitter the poor towards society's positive goals and give those who advocate violent revolution a legitimate weapon for their arsenals.

Being poor dosen't equate with being inadequate or bad. People are people—everyone is somebody's son or brother or mother—and they are loved as you love your own family. If you run for President please do not run on the backs of those who are poor.

SAMUEL A. BROWN, LOS ANGELES, CALIF.

The cost of living keeps going up. Also other commodities keep going up.

Taxes keep going up and it is a struggle to keep one's head above the water.

CECIL O. MCCAFFERTY, LOS ANGELES, CALIF.

I do not favor any more cut backs in Medicare or Medi-Cal. When you are old enough to retire and cannot work any more, we have so little to get along on that it's to decide whether to cut back on the eating or do without other necessities.

We went through the depression in the 1930's and many of us lost jobs, our equity in homes and at the time were raising our children and were never able to catch up on the losses of the depression.

It seems now and has been the last 2 or 3 years when a raise in social security benefits were given to us in the next few months came a raise in our social security medicare insurance. There seems to be so many programs in our government where many times there is great waste in manpower and materials.

Please try to keep the Medicare and Medi-Cal at the level it was as of January 1, 1971. We can not afford to be sick and hospitalized even at the above date.

KAISER GORDON, LOS ANGELES, CALIF.

It is time the elderly who, as you say, helped build this country, asserted themselves to demand as their due and just rights the services for which they have paid (Social Security, Medicare, Medi-Cal) rather than having them considered "a gift" conferred by a beneficent government. The majority of Senior Citizens bought and paid for a form of annuity insurance and medical insurance (for which they are still paying monthly premiums). We have a bona fide contract with the government as the insurer, and we have every right to expect and demand that it fulfill its obligations, like any commerical insurer, under that contract.

In the light of the appalling escalation of the cost of medical and hospital care, no one in the Administration, the Congress, or the HEW, has had the courage to face up to the problem of putting the onus where it belongs—on the medical profession which has fought Medicare from its inception and has done everything possible to discourage and discredit it—and to call a halt to the exploitation of the poor, the low- and low-middle income recipient who is forced to utilize the services of that group through Medicare. Instead of properly administering and supervising the program and demanding that the medical profession keep their fees within reasonable bounds, the Congress and H E W have taken the easiest way out by demanding from the recipients larger contributions which many, if not most, of them can ill afford to pay. As I see it, the Administration and the Congress have thus abdicated their responsibility.

H E W is particularly culpable. It was, as I understand it, created primarily to serve the poor, the low, and the low-middle income citizen and the aged and, through Social Security and Medicare, to promote their Health, Education and Welfare. With regard to health, this can only be accomplished vis-a-vis the medical profession. However, instead of carrying out its designated function and discharging its responsibility in this area, it has abandoned them to the "tender mercies' 'of the A M A. In support of this, let me point out, first, that when Robert Finch was Secretary of H E W, he abandoned the aged when he established his position and philosophy by stating categorically "We are spending too much on the old and not enough on the youth." I can, if necessary document this charge. Second, instead of calling a halt to the unconscionable fee increase demanded by health practitioners and institutions, HEW demanded increased Medicare "B" contributions from recipients. Congress, which concurred and enacted the necessary legislation, must also share this onus.

In further support of my contention that we, the aged, have been exploited, a survey of B L S reports on the increasing cost of living over the past several years will show that practically every periodic report mentions prominently among the factors responsible "increased medical costs." H E W certainly must be aware, though it sems to ignore the fact, that many senior citizens are forced to exercise a devastating choice between medical care and essential and adequate food. The matter of food stamps and the regulations and restrictions surrounding their acquisition is another harrowing story with which I cannot deal because of space limitation. I will merely say that a hearing here in California a few years ago disclosed the fact that an estimated 25% of animal food sales were made to no- or low-income people for human consumption in lieu of proper food which they could not afford to purchase. This was confirmed later by a Department of Agriculture report.

To further illustrate the ineptitude (euphemistically speaking) of H E W, the Agency, charged with safeguarding the health of Senior Citizens among others, bowed to the pressure of the medical profession when it ignored and

made no effort to explore the demonstrated success of prepaid and group medical plans like Kaiser-Permanente in California and H I P (Health Insurance Plan to which I was a happy and well-served subscriber from its inception about 1946 until my retirement in 1965) in New York City. Only now, when we have been forced into a critical and desperate situation in health care for the elderly and the poor, are we beginning to explore the matter of restructuring the program and beginning to explore the matter of a bona fide National Health Service. This was most ably discussed by the Rev. John G. Simmons, who was particularly effective in his indictment and exposure of the selfish, unconscionable restrictive licensing procedures sponsored by the powerful and autocratic A M A and which were enacted by most State legislatures. The establishment of a national code would, as he stressed it, facilitate and expedite the movement of needed medical services to areas of critical need. H E W should have been a pioneer in advocating national legislation of this nature instead of seeking refuge in the excuse that "we are suffering from a shortage of medical personnel."

Another area in which the Administration and Congress are particularly remiss is the unconscionable and inequitable tax structure which affords tax loopholes to particularly favored individuals (246 who earned over a million dollars last year reportedly paid no tax at all), to foundations which are tax-exempt, and in depletion allowances which, analysis discloses, are larger than they seem because they allow a double benefit—first the depletion allowance itself, and, secondly, providing that the taxpayer may (and does) also deduct from income and profits the cost of exploration and test drilling, etc. as a business expense. Oil companies in particular enjoy this tax windfall. As a further illustration, the 1969 tax law stipulated a minimum tax payment on all large incomes regardless of source. The present Administration and Congress removed this stipulation in the 1970 tax law.

Though much more could be offered in criticism, let me now turn to what I believe could be done to remedy the situation. It is easily recognized from the foregoing that I feel H E W has failed to adequately serve the aged. It has been suggested, and I heartily agree, that we must demand a restructuring and reorganization of all agencies concerned with the problems of the aging, particularly H E W. It is imperative that a SEPARATE and DISTINCT agency be established, independent of H E W, and enjoying Cabinet status. Only in this way can we be free from the erroneous philisophy that Social Security, Medicare, Medi-Cal, etc., are government gifts. (In fact, I have read that the I R S considers Social Security in just that category.)

Under such an independent agency, with a change in philosophy, there should be no conflict regarding "priorities" and the problems created in H E W and which led to former H E W Secretary Robert Finch's classic statement of the aged vs the youth which I previously quoted.

In this connection, I am appalled by the failure of the no- the low- the low-middle and the middle-income citizens of this country to establish a program of cooperation rather than engaging in the conflict and competition for priorities as it exists today. My observation (objective, I hope) and reflection have led me to the following distressing conclusion:—"The privileged do not exploit the privileged but help each other to assure and enhance their position at the expense of the (by contrast) underprivileged. On the other hand, the underprivileged exploit each other, scrambling for priorities and advantages and a larger "piece of the pie."

I regret the length of this presentation, but I am sure you want a full and explicit (though it is by no means exhaustive) statement, and I hope it will serve to let you know how some of us feel. I trust it will help and influence you in your consideration of the problems of the aging.

Thank you again for this opportunity.

Respectfully submitted

MRS. MINNE ROBISON, LOS ANGELES, CALIF.

To the people here that will show us their least concern. We of the older citizens here in California are in sincere need of our medical benefits as they are presently.

I myself like many other mothers of the children of this and other communities are without ample funds to really provide medical care for ourselves.

These expenses being greater at times than one can really imagine, for such expenses as heart care in my case. I ask of you sir please do not cut these present benefits.

SEBASTIAN F. DI BELLA, LOS ANGELES, CALIF.

How can we exist if we didn't have a dollar saved up. Social Security, the predicaments old folks face with the outrageous office medical and hospital charges. Help clean up the welfare mess and abuses. Introduce a bill to punish welfare chiselers (and investigators).

How about taxing the extensive holdings of real estate of banks and insurance companies? You'll have my vote. May God bless you.

LILLIE B. STEWARD, MONTEBELLO, CALIF.

Dear Sir I think. We are been cut enough already. We sure barely exist on what we are getting now about little to get by on. If some of you people would have to live on what we old people live on would find out.

VIOLA J. GLUE, MONTEBELLO, CALIF.

That I don't think it is right to take away what we already had that is removing the 60 day Medi-Cal or Medicare and reducing the time to 30 days. Please do what you can to have the time extended to the 60 days again as the senior citizen really need this care.

FRANK N. GALBRAITH, MONTBELLO, CALIF.

This letter is uncalled for to a man that voted himself a double wage hike and now wants to be President of the U.S.A.

GEORGE BOWMAN, LOS ANGELES, CALIF.

Because of the extra charge and the high cost of medicine I think we ought to hold up any further changes now until year 1972.

MRS. MARGETTE BARBER, MONTBELLO, CALIF.

1. Restore the 70 million cuts in Medicare and Medi-Cal.
2. Restore aid to elderely for dentist work as present time can only get a tooth pulled.
3. Restore hearing aids for elderly, also eye glasses. In hispital longer period and rest homes with a doctor care.
4. The 10 percent increase on social security for June 1st, 1971 ask that the increase would not be deducted from state grants. The present administration now deduct any increase we get on our social security from state grants. This is wrong. We do not get raise.
5. Present high prices, we are unable to compete on our low incomes to even think of paying out money to doctor, dentist, hospital. We don't have the money for items as these.
6. Create separate category for sensior citizen so they would be "pensioners" and not classed as welfare.

I am a widow, 77 years, and from past on our low incomes we are not covered enough to meet up with present day high prices in hospital or doctor bill, eyes and hearing. I have a hearing aid. Rents are sailing up so unreasonable. However; I am a good democrat and hope to see them soon return to power.

MRS. ROSA E. TAFAYA, LOS ANGELES, CALIF.

That the cost of prescribed drugs is way too expensive for senior citizens on a low social security benefit. Even with Medicare and Medi-Cal the individual needs more income or assistance on property tax. The senior citizens has to save from the low social security benefit to pay 3 or 400 dollar property tax.

I work with senior citizens as director of a senior citizen information center for Mexican-American aged. (3864 Whittier Blvd., Los Angeles.)

MRS. OLLIE YOKUM, LOS ANGELES, CALIF.

I been a working woman all my days but work for a small salary please please please don't stop our medicine or our food stamp or our checks please help us to live. I am sick but please please please help us to live and God will keep you all we needs a doctor in our community, a church, a schools, hospitals from yours as ever.

LUPE SOTELO, LOS ANGELES, CALIF.

Please, if it is not asking too much, I would like to get enough money to buy some medicine that I need. I don't have enough money to pay for it. I get Medi-Cal, but it doesn't cover some of the medicine in the program.

LEANNA J. BROWN, LOS ANGELES, CALIF.

I am writing this letter for myself and for my community. I live in the City Terrace section of Los Angeles. My name is Leanna J. Brown and I am 83 years old. When someone is sick here in my community, it is hard for them to get to a hospital or to a doctor. Carfare and ambulance costs are very high. We need your help so badly. Is there nothing that you can do to help us Senior Citizens in our time of need?

FRANCES M. ARMSTRONG, LOS ANGELES, CALIF.

Please help us I am almost blind I need Medi-Cal and Medicare so please help us. We need it so bad I need glasses and eye care.

I would like to see the doctor more than twice a month. I have ulcers for more than 9 years. I am a widower and I am 70 years old. I do need Medi-Cal and Medicare. I would sure be glad if I could see the doctor at least once a week when I am sick. Please have some pity on the poor people. I live alone and some time I do need someone here with me to take me to the doctor.

CLARA BROWN, LOS ANGELES, CALIF.

Thank you for everything you has done for me, the doctors has been nice to me, ever since I started. Thank all of you please help others. I am happy with Medi-Cal and Medicare. May God bless and keep you all. I am mental ill. I am much better, but need medicine to keep me up and out. I cannot print so I paste my name here.

SAM G. HERRERA, LOS ANGELES, CALIF.

On the contrary as to my knowledge I have visited house to house at east Los Angeles area and I know that I have not visited all of them. Yet, but I have already visited, it gives me the impression of the necessity that there is in the rest of the houses that I have not come to maybe because they think that if they try to talk they will be turn by someone that can help them or they think it too impossible however a good many people is afraid to talk that's what I myself, have learned. By facing my problems with them that's

why I have offered by service to a good many people by taking them to clinics or hospitals and to welfare offices and to legal aid offices, even serving for or in funerals when a good many are short of transportation. Transporting Elderly to the Foods for the Elderly Programs taking them back home so I faces hundreds of elderly every week of the year day in and day out. I am a staff of the Hot Meals for the Elderly program under the direction of the Senior Citizens Organization, so I visit house to house so I really know that there are hundreds of needed elderly in east Los Angeles, California, I, presume that if this Medicare and Medi-cal are cut off then it'll be worst that it is now so please help America as always I will keep on doing and helping the very same way that I have been doing and organizing like I have since 1964 and 1963 and on since in 1965 I started organizing through Mr. Larry Chrisco for the Allied Senior Citizens Corporation and I have been there yet retired and busy. Doing my part in cooperating with everyone.

Dear Sr and Brother shall we keep this elderly happy? For our return? . . .

I am as always sincerely yours,

MRS. ESTHER SANFORD, LOS ANGELES, CALIF.

First Senator we appreciate you coming all the way to L.A. to represent us. It nice to know we seniors have you on our side. I hope you be our next President. I belong Ted Walkins Club, WLCAC. He been taking the senior citizens shopping but I think his grant run out the 31 of this month. So that will be hardship for us seniors. The cuts in Medi-Cal—Medicare has put hardship on all the senior. That was cover by that program. I think Dr. Hensley express our need beautifully.

VELMA LEWIS, LOS ANGELES, CALIF.

I need Medi-Cal and all so I need Medicare because I can't pay for no doctor bill out of what I get, the Medicare keep me to live the doctor fee is $10 at the door.

DAVID A. MONTAGUE, LOS ANGELES, CALIF.

I for one just can't believe that we Americans would allow anyone in our great country to cut off the lives of those elderly peoples, it just don't seem human. We have every materials needed to relieve humane want or need. I would asked to be present at the Hearing May 10/71. I was there with other oldsters. I was happy to meet Mr. David Affeldt and Mr. Don Lewis. Reprint of your office I feel we are not wanted. You as ever for the needy.

TOMÀS SANCHEZ, SANTA MONICA, CALIF.

One finds that Medicare and Medi-Cal programs are being cut back. Why? Is someone making a profit? Are funds being diverted? Is the state of the economy that bad to cut back programs for the ailing sick? Why are the old and the sick the first ones to be cut back?

Today, there are approximately 885,000 Spanish surnamed individuals in Los Angeles county. Out of this total a large percentage are sick, blind, crippled, or deformed. Consequently, to the extent the Spanish surnamed individuals are deprived of Medicare and Medi-Cal. the government is indirectly contributing to their ailments and eventual death.

It seems to me to be a deprivation of the pursuit of happiness which is the right of not only the Americans, but the Spanish surnamed people as well.

Thus my recommendation is that priorities have to be re-ordered. Namely, space programs should be cut back so that we can take care of the people here on earth. If the people are sick and dying on earth, it's not much to travel to the moon.

So let's please not cut back Medi-Cal or Medicare, but let us re-establish the goals of these programs.

Your assistance in this matter is appreciated.

EMMA WALLS, COMPTON, CALIF.

Why do we need so much study and so many hearings about the aging? So many reports and inquiries? Can't we have some action and money for our needs?

Our people are blind from lack of glasses, hungry from lack of food (can't eat anyway; no teeth) and lonely from lack of funds to attend church etc. Please no more talk, Action!

HOLLICE ALLEN, LOS ANGELES, CALIF.

I have high blood pressure, heart trouble and a noise in my head. I need a washing machine and money for insurance.

LENA CAMARILLO, LOS ANGELES, CALIF.

The cutbacks have as we all heard worked a severe hardship on all our senior citizens. The majority are poor people that cannot afford the rising cost of medical care and medicine. The cost is ridiculous to expect most wage earners to pay.

Attendants for handicapped persons are gravely needed. The cut is doing a terrible injustice to all these people. I am sure Governor Reagan knows all this. Why is he so insensitive about it? I can't understand.

VELMA SNEAD, LOS ANGELES, CALIF.

Please help the elderly to keep Medicare and Medi-Cal. So many of us don't have nothing to live on so please help us. I don't know what the poor will do without your help, don't take buses away, we can't get around. Please don't cut Medi-Cal and Medicare coverage.

LESLIE FOUSE, LOS ANGELES, CALIF.

I am denied Medicare because I worked and did not apply for it while I was working. My job closed last October 9th, I applied for Social Security, Medicare or Medi-Cal and the reply was from the Social Security. It was too late to apply for it.

Why should I be denied this service?

JEANETTE CLEAGE, LOS ANGELES, CALIF.

I need dental treatment, I cannot use my plates, must eat without teeth, cannot chew my food. Also, treatment of eyes. I need public transportation for shopping and meetings. I am under the doctors care due to arthritis, must have foot care. I have a heart condition.

MARIE B. SORENSEN, LOS ANGELES, CALIF.

Establish a diagnostic center where a person can go without being hospitalized.
More preventive measures.
Reduction of our older persons in care and nutrition.
Not institutions but personal care and services.

YGNACIA P. GONZALES, PASADENA, CALIF.

I am 53 years old. I live with my children. I am on Welfare. The cutbacks has affected my family greatly. We have diabetes throughout the family. Our vision requires lenses changed very often due to the diabetes. We at the present

can not get lens or much help getting medicine because of the cutback. I am not too old yet. I am unable to work because of my illness. I am without dentures because of the cutback. If I could get the aid medically for my family and self, I would be able to get off Welfare. I could seek employment and help myself. Maybe this isn't much asked but get us the help we need back. Thank you.

MRS. GLADYS C. JOHUS, GLENDALE, CALIF.

I wish to report a problem which involves my 94 year old sister-in-law Mrs. Grace Correll who lives in a residential care home for the aged. Because of her lack of hearing ability she was unable to communicate properly with other residents and therefore did not adjust or assimilate into the activities or make friends as she should in order to have a satisfactory social life. As a result she became almost a recluse going to meals but returning to her room and not participating in the social life of the home.

In order to overcome this problem she was examined at an Otological Clinic and was found that she could probably benefit from a hearing aid. It was suggested she try this out for a month before the physician would request authorization for Medical to approve payment (Mrs. Correll receives OAS from LA County). At the expiration of the trial month, Mrs. Correll was ill and could not return to the clinic for a check-up. This caused further delay so that she did not see the clinic doctor until Dec. 8, 1970. The doctor found sufficient improvement in her hearing to justify continuance of its use. However, we later learned he was not able to refer her case to the LA County for authorization of payment (due to illness of his secretary—birth of a child) until after Dec. 15th—the date the Medical program cut back occurred Authorization was denied. The hearing aid man from whom the purchase had been made agreed to let her keep the hearing aid pending renewal of the Medical program. He is still not paid for a bill amounting to about $25 since no restoration of cutbacks for hearing aids has been allowed. Mrs. Correll is greatly concerned about her inability to make payments herself as her OAS and Social Security do not leave her with sufficient funds to more than meet her expenses at the home and her personal needs. Had it not been for the unfortunate delay in events out of premeditation the authorization would probably have been given. This may be only one of many similar instances depriving persons of needed appliances by which their physical and social adjustment would be improved.

ROSIE PATTERSON, LOS ANGELES, CALIF.

Please don't take Medicare and Medi-Cal coverage from the poor. If you do I don't know what we will do so please help us. May God bless you. My husband needs medical care and we have been unable to get help, he has been sick for a year.

YVONNE NEALY, LOS ANGELES, CALIF.

The medical cutback is inhuman.

I have a slip disc that is pressing against my spine. I can only see the doctor twice a month. Since I can't afford the medicine that will help me, and the doctor can't give it to me, what sense does it make to go to the doctor.

My eyes are so bad I can't see with glasses and can't see without them. But the eye doctor said he can't help because of Medi-Cal changes so please do something to help us. May God bless you.

DOLORES A. TUCKER, LOS ANGELES, CALIF.

The cutbacks of Medicare is inhuman, you're telling us, if an elderly person is or sick and have a heart condition, you'll just let them go ahead and die, because they can only go to the doctor once or twice a month.

Dogs have better care than humans. We want Medicare back more strong than ever now for the people. Right on.

EUNICE JACKSON, LOS ANGELES, CALIF.

In am in favor of going to the doctor when needed. There are some Medicare and Medi-Cal needs. Why not get the medicine when needed?

MRS. SAMUEL I. RAPAPORT, PASADENA, CALIF.

If, as you stated, the witnesses have a wealth of knowledge, how can you in Washington help us to utilize some of this talent? Can't a "task force" both national and local of competent, qualified people be structured to move *more rapidly* and efficiently on both the National, State and local health programs?

Can Congressional hearings accomplish much when, as I understand, there are only two doctors (who have not practiced recently) in Congress? Why not use some of the medical and administrative talent which is available to help revise and plan with and for the nation *effective medical help?*

EUGENE L. JUDD, GARDEN GROVE, CALIF.

Having last year spent 73 days in a hospital for hip surgery, followed in 10 days by a ruptured diverticula I feel that it is brutal to limit Senior Citizens to 14 days hospital care, or worse, to the 9 days recommended by the President.

If I had been under Medicare at that time, instead of being covered by Kaiser Hospital Insurance, I coould not have paid the bill in the balance of my life.

F. KORY, SANTA MONICA, CALIF.

I need medicines and it is hard for me to purchase it, due to the fact, that we live on a limited budget and medicine is very expensive almost 5 times what it used to be. I feel that something has to be done too to make possible to control prices of medicines.

LAURINE NEVELS, LOS ANGELES, CALIF.

Since cutback one instance a patient in a convalescent hospital had the choice of paying $18.00 a day or going home. Unable to do anything for herself but not sick enough to be confined to bed.

Not enough therapy given in nursing homes to stroke patients. Many in wheel chairs not encouraged to try to walk or given exercises to prevent loss of use.

Senile patients just given food, tranquilizers, etc. No one takes the time to try to keep the brain from deteriorating.

LOU RABIN, LOS ANGELES, CALIF.

As a community aid what you have heard this morning will give you a lot of information among Senior Citizens.

LUKE ESTRELLA, LOS ANGELES, CALIF.

The Medicare cutback is inhuman indecent. Could also be *Murder*. I have a heart condition and arthritis and the doctor won't see me but twice a month. There are times when I am so sick I don't know what to do. I can't afford to pay the ten ($10) dollars for the Medicine because I am living on a fix salary.

So please may the Good Lord Guide you so you can help *us* poor people.

J. KORITNY, SANTA MONICA, CALIF.

I need a check up annually, as I'm 80 years old. My Social Security is $122.90. To see a Doctor I have to pay in deductables $50 from the check is taken of

$5.30 a month=$63.60 per year+20% of Dr. charges. In the 1970 I did pay out $145.40. I also had seen a Doctor for varicous vein, who send me bill for $65. Where shall I take money to pay as I my income is so limited. Another problem, when I get an increase in Social Security the landlord takes it away by raising the rent. I need to see a eye Dr. but I have not money for it.

ZELMEN KNIGHT, LOS ANGELES, CALIF.

Please Lord get in the heart of every one in this building and on this program Medical. I been disabled for 16 years am on Medicare 4 or 5 years. I been sick with high blood and arthritis in knees and shoulders. Disabled to work just do my housework some time that what I would say about Medical. I don't know what I would do so I say Lord let us all get into this program and vote on this Medicare and Medical Coverage.

LILLIE MAE KENNEDY, LOS ANGELES, CALIF.

Please Oh! God get into the hearts of every one in charge guide and direct our minds and less don't let us vote this program out. Because if we do, I wonder what will the poor do. Well, I will say the rich would live and the poor would die. Because I get Medicare and sure have helped me because at no time I have money for these treatments and Medicare I receive. So I feel that this coverage is the most important step in the lives of the Senior Citizens of the U.S. of America. Do lets not do the worst, lets keep this program in action. Very truly, Lets not talk, Lets do something now.

MRS. CORDIA M. ADAMS, LOS ANGELES, CALIF.

I support you, Mr. Senator for going to bat for me a Watts citizen. 20 years ago it simply was an impossibility for me and other Senior Citizens to be present at your meeting, mush less to support you with our heart felt interest. You only have to add 20 years to your present age to know that you will be sitting here in our shoes and seats or beds, if it be so some are bedridden.

May I thank you sir, Mr. Muskie.

ELSIE WRIGHT, LOS ANGELES, CALIF.

Certainly, the remedy will necessitate drastic measures, to be sure after hearing various speakers, must be taken in behalf of Senior Citizens. Whereas while you are working in behalf of myself and others, at this time, surely you must know that you are performing a long range program, which you certainly will be a beneficiary of the same, when you are a Senior Citizen yourself.

The National Preservation of the Nation thru the care of the Aged is just as important as for the care of the young. The Heritage for antiquity of any Nation is as always and ever will be is passed down thru the minds and spirits of the *Honorable* and *respectably Aged.*

Thank you so much Mr. Senator.

GLADYS BAILEY, LOS ANGELES, CALIF.

Medicare and Medi-Cal coverage should be increased instead of cutback. The elderly population in the nation has helped to make America the rich nation it is today and deserve all the consideration possible, to be given to them *now.* Lord! Send us *men,* who can right the injustices of the present system of financing of the Medi-Cal and Medicare program. Help us, I pray thee!

MRS. WILLIE KIMBROUGH, COMPTON, CALIF.

Sir I feel privileged to have the opportunity of attending this meeting and was very much impressed with the presentation submitted by Mrs. Lilla Keiser,

Mr. Juan, Hubert L. Hemsley M.D., Rev. John G. Simons. To me, I feel that there are much too much of the grant money for the elderly program is spent for paper work and employment of uninterested people; who care nothing for the well-being of the elderly. There are qualified elderly people who would be be more considerate with the need of the elderly because of their years of experiences working with people. The waiting on the phone at the agency is time consuming imposed on the elderly because the employee is not interested in this elderly person on the other end of the line. Sometime they forget to come back to answer so you just have to hang up. Please investigate.

MAURICE WEIROMAKER, LOS ANGELES, CALIF.

Cutting back Medicare and Medi-Cal Coverage is the worst our government has done, it puts a great hardship on elderly citizens in our city, county and State. I protest very much on the action of our Governor against our Elderly Sick Americans. We demand that our health Laws Should be improved for the Senior Citizens in our State, County and City and to Return the Citizens of health Care for Elderly retired Americans.

DAVID SITREN, HOLLYWOOD, CALIF.

Roll back *all prices 10 years* and *hold* them down by *law* . . .

PEARL FELPER, LOS ANGELES, CALIF.

Please let Medicare and Medi-Cal stay for the Lord Sake, for I am not able to take care of my self because of my age. I am Praying to God to get in Ronald Reagan Heart to change him so we can get more treatment from Medicare and Medi-Cal. I am Praying to the Lord for Medicare to stand.

MATTIE WASHINGTON, PASADENA, CALIF.

I coincide with all have been said. All of senior citizens have been disadvantaged with cutback in Medical and Medicare coverage. In November of 1970 I barely got in on dental work being paid by the State and county before it was cut off. After one month I went back for an adjustment of my teeth and was refused because of the cutback. Consequently my dentals are not fitting right. Therefore it makes it really difficult to eat properly. Lot more could be said which I don't have time to relay.

MARY JANE SANDS, PASADENA, CALIF.

Congratulations for taking the lid off a very necessary health crisis that confronts our older Americans—younger ones also. I speak to #2. . . . some rigid Medicaid (MediCal) regulations that frequently prevent medical care from being effective or efficient.

In correcting this health crisis please consider adequate skilled nursing care by registered nurses and for their assistants (vocational—practical nurse) in the care of the individual. Skilled nursing care as defined by Nursing to eliminate the confusion of what is skilled nursing care. Medicare and MediCal (Medicaid) policy does not cover nursing care. *The initial Medicare policy didn't include Nursing.* The revised policy must include skilled nursing care.

Have you ever thought of who cares for the sick and the ill in the country 24 days—yes—it is "The Nurse." The M.D. breezes in and out along with the other para-medical personnel, but the nurse has always cared for the sick. They care for people—even before they are ill. They are teachers of *health care* and *prevention of illness and accident.*

In my personal opinion what is needed:

1. Adequate skilled nursing care by RN and/or assistants as the patient needs indicate as determined by nursing.

2. Administration and supervision of this skilled nursing care should be recognized sources in the community who have knowledge and skills for the needs of their people. District and State nurses associations were one recognized reliable association never used in previous policy. Also there are studies published indicating their is an increased mortality in the elder in the first three months of admission to the Convalesance home. I think Levine from University of Chicago published such a study. I thank you and I'm willing to participate in solving this health crisis.

IRENE HESTON, PASADENA, CALIF.

Our commitment for health care was for *quality* health care. By cutting remuneration to providers of service we give substandard care which is damaging to patients and the professionals giving service. Why penalize the providers and expect this segment of the community to subsidize a good program that is the responsibility of all society. If government has not sufficient means for paying some, why has family supplementation not been made possible. Breakdown in family responsibility is not conducive to the well-being of sons, daughters and parents.

MABLE A. GAMES, SAN PEDRO, CALIF.

Change administrations in the forthcoming elections, and let everyone who is registered or who will register to vote, go to the polls on *"all"* voting days.

I am a polio victim, have a brace on my right leg, and severe kidney disease, I am asking for Social Security, I have a son exceptionally handicapped who is capable of learning and can get no help with schools. I am 56 years old and there are 7 other older children; they all have families.

FAY DOUGLAS, LOS ANGELES, CALIF.

Abolish Medicare for all except the needy. How dare you Congressmen provide Medicare for yourselves and the other wealthy while thousands are losing their homes in large part because of this.

JUANA D. SORIA, LOS ANGELES, CALIF.

It is imperative to do something to help our elderly who are suffering from the medical and Medicaid costs. They are suffering from lack of the right medicine they need because of the high price in drugs. Also a better Social Security service, housing and transportation are essential for better health for our elderly. I hope you will understand the real need there is for all services for senior citizens. We have been the forgotten group. Long enough.

MRS. MARION MARSHALL, LOS ANGELES, CALIF.

Proper health services should be available to *all* residents of the United States. Such services should include neighborhood and home repairs, safe streets, smog control. All of these things affect health and well-being, and these effects become more acute each year. A nation-wide program giving jobs to the unemployed in areas of health services could raise standards of living, life styles, of a large number of citizens. At the same time, older Americans would benefit thru lower-cost, more adequate health care. Certainly we have enough research, experience, reports from which to verify the validity of an intensive, wide-spread program of low-cost or free health services.

AGNES MSITREN, HOLLYWOOD, CALIF.

Roll back all Doctors Prices, Fees, Hospitals, Rent FOOD, all living Cost Everything.

Therefore there will *not be any excuses* to have higher prices, down at least 10 years back. *By Law.*

There should be more of these meetings and get the ideas of many people, suffering and dire needs and help. This meeting has been very instructive and thanks to:

Hon. Edmund S. Muskie
Mrs. Leila Keiser
Mr. Montano, Mr. Porter & Mr. Hunter
John Anthony Smith, M.D.
Hubert N. Hemsley, M.D.
The Reverend John G. Simmons
Robert Peck, M.D.
Mr. Thomas Moore

We all thank you for the clear happenings going on and the dire needs that the cutbacks in Medicare and Medical Coverage is doing to the Seniors and the Aging.

LILLIAN LA MANTIA, LOS ANGELES, CALIF.

SIRS: Very near Stovall Funtition Home for the aged, Mr. Montano who spoke in Spanish lives there—1-Block from said home is the Marivilla Clinic—it deals with immigration, Social Security, Youth Authority, rehabilitation job core, maternity service, dental clinic, all for youths only—not one doctor is available or do they have one day set aside for senior citizens. I asked the reason why and was told it would take away the services from the young. This place is located on the corner of Bonnie Beach Pl. & Faumont St. at Belvedere Gardens. Excuse my poor writing and spelling.

MRS. MARIE ROMITI, LOS ANGELES, CALIF.

Senator MUSKIE. There are many elderly people like me that would be in distress with the cut back on Medicare and Medi-Cal.

I am a widow since I was 35. I raised my children by doing domestic work. Was not able to save much. I am 81 years old now. Where do people like us stand if you cut back our medi-cal and Medicare. We all need aid now not later. Our days are short but there are many women in their 60 and 70 years that have the same problem. Please after all these years please help us. Thank you. God Bless.

GUY AND MARY GIORDANO, ALHAMBRA, CALIF.

The Medicare and Medi-Cal Coverage is a great need for the Senior Citizens as very little of us have been able to save for this wonderful care we are receiving by it now. We really need more. So many of us are getting so little to do with.

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