COSTS AND DELIVERY OF HEALTH SERVICES TO OLDER AMERICANS

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH OF THE ELDERLY

OF THE

SPECIAL COMMITTEE ON AGING UNITED STATES SENATE

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

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COSTS AND DELIVERY OF HEALTH SERVICES TO OLDER AMERICANS

THURSDAY, OCTOBER 19, 1967

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE ELDERLY
OF THE SPECIAL COMMITTEE ON AGING,
New York, N.Y.

The subcommittee met at 10 a.m., pursuant to call, in the auditorium of the William Hodson Community Center, 1320 Webster Avenue, New York, N.Y., Senator George A. Smathers (chairman of the subcommittee) presiding.

Present: Senators Smathers and Robert F. Kennedy.

Also present: William E. Oriol, staff director; John Guy Miller, minority staff director; J. William Norman, professional staff member; Patricia G. Slinkard, chief clerk; and Carolyn Hyder, clerk.

OPENING STATEMENT BY SENATOR GEORGE A. SMATHERS, CHAIRMAN, SUBCOMMITTEE ON HEALTH OF THE ELDERLY

Senator SMATHERS. The meeting will come to order.

First I want to say that I am very pleased to be here. This is the Subcommittee on Health of the Elderly of the Special Committee on Aging.

I am particularly delighted to be here in this Hodson Center,[1] which itself bespeaks of the concern and interest of the people of New York and the State and the Nation of the problem of the elderly.

Senator Kennedy, I think, will be here shortly; he is delayed. He has already issued a statement to the press, and every indication is that he will be here.

I have a short statement which I would like to read before we proceed with our first witness.

This is the first field hearing to be conducted in our study of the costs and delivery of health services to older Americans, and it will give us on-the-spot information about several disquieting points made by expert witnesses at our opening hearing in Washington, D.C., on June 22 and 23.

The story told at that time can be summarized in three sentences:

Aging and aged Americans, those most in need of high-quality health services, often pay the heaviest price for deficiencies in those services.

Medicare and medicaid—although in need of several major changes that will make them more directly responsive to individual needs—are

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[1] Hodson Center, at its opening in 1943, was the first Day Care Center for the elderly in the world. For its history and description of present activities, see p. 608.

bestowing much-needed benefits; and they are performing another service by making longstanding health problems more visible.

Any discussion of costcutting in health services will be fruitless unless it also calls for major reorganization in the delivery of such services.

The Washington hearing also gave us some insights into the special problems of the elderly in metropolitan areas. Your former city health commissioner, Dr. George James, gave us much to think about when he said that New York City is "aging" by about 20,000 persons per year, that by 1970 you will have 1 million persons over age 65, making New York's aged the sixth-largest city in the United States, and that—with a few impressive exceptions—most health treatment for the elderly is geared to treat the illness rather than the person.

In clinics of this city, said Dr. James, an elderly individual may often spend his time in a futile round robin of visits to various specialty services, draining his energies and not really receiving the kind of care he needs.

I must admit that the thought of spending hours in a clinic is bad enough for a young person in fairly good health. What is it like for an older person? I have a letter here from a woman who tells what it is like. Her statement—sent to me by a member of the Hudson Guild-Fulton Senior Association in Manhattan as a result of subcommittee staff inquiries—is called "A Day in the Clinic." I will read it to you:

> You have a pain, and don't know a doctor, you believe the hospital clinic may have more facilities to handle your case.
>
> You come at 9 a.m. and wait for the clerk who takes your name and tells you you have to be screened as to your payments.
>
> You see several more clerks, each time you take a number and wait. By this time the last person to see is a doctor who asks you what is wrong and tells you to go to another clerk for an appointment for a doctor who will treat you. When you get to this clerk he gives you an appointment in 2 weeks time. You still have the pain.
>
> By this time it is 1 p.m. and you have not had any lunch.
>
> Somebody suggested that you go to emergency department. This you do and all they do is give you some painkiller pills after waiting again—2 or 3 hours and you spend a whole day.

Medicaid, of course, is intended to relieve the problems encountered in clinics, but this program is still in its very early stages; it can't change old patterns overnight or even in a year or two. As the ranking majority member of the Senate Finance Committee—which recently concluded extensive hearings on this year's Social Security amendments—I am especially interested in proposals for constructive change in medicare and medicaid. I believe we will hear several such suggestions today.

We will also receive, I am sure, very helpful testimony on major innovations that will improve health care here. If this city has its share of problems, it also has a rich share of enlightened experimenters whose work may yield important lessons for the entire Nation.

Just a few blocks away, for example, is the Bathgate Center of the neighborhood medical care demonstration project. I understand that this center is providing much-needed services in an area that has fewer doctors than it did 25 years ago, even though population has dramatically increased. We hope to see the center later today, and I am sure that we will be impressed by the good it is doing.

At the same time, however, I must confess to a few qualms about its future. It is now funded through the Office of Economic Opportunity, and it was created only because of the determination, medical know-how, and the grantsmanship of men associated with a well-established hospital.

Can we expect the development of such services in cities which may lack such sophisticated leadership? Do we need a new kind of Federal program to encourage establishment of such projects on a more widespread basis, perhaps not tied directly to antipoverty funds?

We have many more questions, but we will save them to ask during the course of this hearing. I will conclude this opening statement by thanking many individuals who have given help and guidance in the preparations for this hearing. We have received cooperation from the office of the health services administration, the State department of health, directors of hospitals, and many others. Particularly we are grateful to the persons at the Hodson Center.

I would also like to say that Mayor Lindsay has informed us that he would have been with us today if he had not set aside a brief time for well-earned vacation in the Virgin Islands along with 46 Governors of States. I hope that does not addle his judgment in this matter.

Gentlemen, we are now ready to go. Our first witness, Congressman James Scheuer, intended to be here and wanted to be here. He has long been concerned about the problems of the elderly, and in his absence I would like to say he has done very excellent work in this field and will continue to do so. I will also read into the record a telegram from him at this point. It reads as follows:

> My regrets to you and other members of the subcommittee being unable to attend your hearing today. The House Committee on Education and Labor has been holding double sessions daily on economic opportunity. In absentia I welcome you and the committee to the Bronx and look forward to reading your hearings at Hodson Center on services to older Americans. James H. Scheuer, Member of Congress.

We also have a statement from Representative Seymour Halpern.

(The complete statement of Congressman Halpern follows:)

Statement of Seymour Halpern, a Representative in Congress From the State of New York

This inquiry into the costs and delivery of health services to older Americans is an exceptionally valuable contribution to the well-being of older people not only in New York, but throughout the Nation. I commend the members of the Subcommittee on Health of the Elderly for their diligence in seeking to illumine the health problems of the elderly, and to search out the answers on the community level. Congress has passed legislation creating massive health programs. It must be encouraging to the people of New York to know that their advice is being sought to assist the Congress in improving these programs.

We in New York have serious problems in providing older people with adequate health care. We have more older people than any other State—about 1,900,000 who are age 65 or more. They represent 10.4 percent of our population, and this percentage is growing. These people are clearly not getting the health and medical care which they need. For a New Yorker who is now age 65, the average life expectancy is 13.77 years, which is lower than the national average. New York ranks 45th in the country in the number of years which an older man can expect to live.

New York is attacking the problem with a strong combination of Federal and State programs. About 1,900,000 people have hospital insurance under the Social Security Medicare program. Nearly all of these older people also have medical insurance coverage under Medicare.

However, Medicare covers only about 40 percent of the aggregate medical costs of the aged. New York's Medicaid program, therefore, is crucial in enabling older people to acquire needed health services without cost barriers. For the six month period from July 1966 to December 1966, the most recent period for which we have figures, 106,600 older people in New York were covered under the Medicaid program, at a cost of $68.5 million. The per capita figure for that period was $682. These figures are a measure both of our problem and of our success.

Traditionally, when we have thought of the problems of health care costs, we have thought of them in terms of the cost to the individual. Now, with the Federal and State governments so heavily involved, the rapid increases in the cost of medical care are a major concern for legislators. In 1966 the Bureau of Labor Statistics index of medical care prices rose 6.6 percent. The index of hospital daily room rates went up 16.5 percent. These increases are naturally reflected in the increasing costs of the Medicare and Medicaid programs. None of us, either in Congress or out, want to see these programs subverted by rising medical costs.

We in Congress will do what we can to forestall this possibility. We are working conscientiously to improve the legislative framework of these programs, to eliminate possibilities for waste and excessive costs. We are also approaching the problem from other directions. We are trying to ameliorate the current shortage of medical personnel. This country does not have enough doctors. It has been estimated that in hospitals the number of unfilled internships and residencies currently numbers approximately 10,000. A recent study by the Public Health Service revealed a need for 62,000 nurses, or an increase of 15 percent. This shortage of personnel will inevitably increase the pressure for rising medical costs. It will also make it increasingly difficult to acquire adequate medical care even in cases where cost is no factor. It is important, therefore, that we continue our efforts in Congress to encourage an expansion of medical education facilities and of scholarship and other financial aid.

I have been impressed by the testimony that has been given throughout this inquiry on the need to improve the efficiency of our medical establishments, and to experiment with such methods of delivery as the formation of groups of doctors into local clinics which can offer an older person total health care. The Social Security legislation which is now pending would provide for funds for experiments in delivery of high quality medical care at moderate cost. There is also a provision for experimentation with developing new types of medical personnel, who would be able to perform medical functions which do not require the very high degree of specialization which a doctor needs today. I hope the Congress will act to provide encouragement for this kind of experimentation.

The nature of the problem is clear: older people in New York and throughout the Nation need better medical and health care than they are getting. I believe that Congress must and will act when it can usefully do so. But the solution of the problem lies also in the hands of the public and of the medical professions, who must combine their efforts to serve the best interests of our older Americans.

Our first witness today, then, is going to be Dr. Howard J. Brown, administrator of the New York Health Services Administration, who will be accompanied by Albert F. Moncur, deputy commissioner of the New York Department of Social Services.

Dr. Brown and Mr. Moncur, we are delighted to have you.

STATEMENT OF HOWARD J. BROWN, M.D., ADMINISTRATOR, NEW YORK HEALTH SERVICES ADMINISTRATION; ACCOMPANIED BY ALBERT F. MONCUR, DEPUTY COMMISSIONER, NEW YORK DEPARTMENT OF SOCIAL SERVICES

Dr. BROWN. Thank you Senator Smathers.

We in New York City are very glad that you are concerning yourselves with the problem of health care for the aged. As you mentioned

from Dr. James' testimony, this is a major problem to us now in New York City because we now have 775,000 people over 65 and by 1970 we will have more than a million over 65.

Now, in testifying today I am really speaking from two viewpoints: one as the health services administrator for the city of New York, but also as the recent director of a medical care program that took care of a low-income neighborhood of over 100,000 people.

This was the Gouverneur medical care program, which was a demonstration experimental program and was designed to use the resources of the city's health services so that it would focus on the problems of people in their own community.

Now, while the health problems of the aged are by no means confined to our low-income areas in the city, they are accentuated there.

In the past in New York, and particularly in other parts of the country—and I come from the Middle West—larger homes plus close relationships with the family doctor often provided what seemed to be a workable pattern of care for older people. [Applause.]

(At this point Senator Robert F. Kennedy entered the auditorium.)

Senator SMATHERS. Excuse us a minute, Doctor.

I had stated to the group here, Senator Kennedy, that you would be here and I felt sure you were on your way, so we are glad to welcome you here at these hearings. Do you have anything at this time to say?

Senator KENNEDY. It is just one page. Shall we put it in the record?

Senator SMATHERS. Yes.

Senator KENNEDY. I will just place it in the record.

(The statement by Senator Kennedy follows:)

STATEMENT OF ROBERT F. KENNEDY, A U.S. SENATOR FROM THE STATE OF NEW YORK

I am pleased to join Senator Smathers at this, the first field hearing of his subcommittee investigating the costs and delivery of health services to older Americans. New York City is an appropriate place for this inquiry to begin. For we have in abundance both the problems that beset health services in our Nation today and many constructive experiments in developing new solutions to these problems.

For example, we have the most liberal and extensive medicaid program in the Nation, which insures the availability of medical care to hundreds of thousands of New Yorkers for whom regular medical attention was previously an unattainable luxury and catastrophic illness a bankrupting disaster. But, if we have shown great promise in Medicaid, we have also exposed its weaknesses. For here in New York—as elsewhere in the country—medical costs have skyrocketed in the last year and a half. Some individual physicians have taken undue advantage of the new bonanza and enriched themselves at the expense of the taxpayer. And the fees for all physicians under the program have more than doubled in many categories of care. Hospital costs have soared, in many cases without justification—for reimbursement is available almost regardless of the levels of costs and there are insufficient incentives to make hospital management more efficient and less costly to the taxpayer.[2]

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[2] Additional statement by Senator Kennedy on Medicaid appears on p. 497, Appendix 1.

New York is also a typical example of the dilemma which medicare and medicaid have exposed: we have pumped millions of additional dollars into the system but we have not fundamentally reorganized the delivery of health services. People still go to the emergency rooms and clinics of our huge, impersonal municipal hospitals and wait for hours to see a doctor they have never seen before and are likely to never see again.

The hearings today will air many of these problems in the costs and delivery of health services. The task ahead is to shape our responses to the questions that will be posed today. In simple monetary terms, we cannot afford not to begin decentralizing health care into facilities less costly than hospitals, facilities which coincidentally are more accessible to the patient. We cannot afford not to begin using our health manpower more efficiently through group practice, and through the development of less costly forms of subprofessional manpower, both of which coincidentally will allow the development of new family-based practices that are more responsive to the needs of the patient. We cannot afford not to replace our present piecemeal financing of health care with a national system of health insurance which makes adequate health care a right for every American of every age. That is why these hearings are so important. That is why I am especially pleased to be here.

Senator KENNEDY. Thank you, Mr. Chairman. Let me state I am delighted to be here.

Senator SMATHERS. All right, Dr. Brown, you may proceed.

Senator KENNEDY. Excuse me, Dr. Brown.

Dr. BROWN. You are welcome, Senator Kennedy.

I was just making the point that in the past in other areas of the country as well as New York City, larger homes plus the close relationship with the family doctor often provided what seemed to be a workable pattern of care. People didn't live as long as they do now and therefore this was relatively effective. It provided what are the essential components of health care; that is, a basic living arrangement which ties an older person to a community and its associations and to a family as giving him the personal continuity of care which you describe so graphically, Senator Smathers, as lacking in our clinics and I agree with that.

However, in the past when the old system broke down, we moved our aged to either mental hospitals or public-home infirmaries and these were always conveniently located outside of the city so as not to trouble our conscience by the visibility of the misery of the aged. We continued to build in New York City these kinds of facilities through the fifties.

But the past is no longer working. In our vast urban areas, we now have a substantial number of aged who live alone. Where they have children with families, often these apartments are not large enough to allow these people to live with their families.

DECLINE OF FAMILY DOCTORING

Furthermore, family doctoring has completely broken down in the low-income areas of this city, and I speak of areas with at least 40 percent of the city's population. This is simply because private physi-

cians are no longer settling or practicing in these areas. So the old pattern is really no longer a workable reality, and as a partial result of the breakdown in this old pattern, we have the following situation here in New York City:

Our city hospitals at any given time have at least 5 to 10 percent of their acute-care, general-care beds occupied by older people who are there because there is no other resource in the community. One could estimate the cost of this at $15 million to $25 million a year in the city hospitals alone.

We have in New York City a shortage of nursing-home beds, which we are in the process of correcting by construction planning largely under State loans. There is, however, increasing evidence that we will have a problem of older people remaining in nursing homes simply because again there is no other appropriate place for them to go and live.

Preliminary studies at our chronic-care facilities on Staten Island's Seaview Hospital indicate a substantial percentage of the population there. This is a chronic-care facility with nursing-home and public-home infirmary, a substantial percentage of the patients who would be better cared for at lower cost in the community. Our State mental institutions are crowded with older people who are not mentally ill in the ordinary sense, rather they are there largely because they are difficult to handle in any other facility.

What I really fear is that if the present trend continues where there are increasing numbers of aged where families are unable to care for their older members in their small apartments, where there are older people without families, and finally with the increasing shortage of neighborhood family doctors, that we shall have an immense institutional population of older people.

I fear this because while at times these institutions are necessary, most frequently they are the enemy of the older person and they, of course, will also represent a tremendous unnecessary drain on our tax dollar and our professional resources.

Now, given this formulation of the problem, let us turn to what we are trying to do about it in New York City and then what help we feel you can give us at the Federal level. The whole basis for our programing in New York City by the health services administration is the community, and this is because only in the community can health care be related to the real needs of older people, their need to continue to function, to relate to their cause, such as the churches, their synagogues, and if they have families, their families and friends.

Neighborhood Health Centers

To replace the missing family doctor in low-income areas and to replace partially the crowded clinics of our hospitals in New York City, we are instituting a massive program of neighborhood health centers. I understand you will see the project today headed by Dr. Harold Wise, which is nearby, and in many ways will show you specifically what I am talking about.[3] Without going into the details, you will see basically what it does; it brings to people group practice connected with the hospital.

[3] Description of project on p. 421–423.

Also this group practice is in the community and related to the community and its social institutions and its needs. It simplifies complex modern scientific care so that an older person can have the feeling of relying on a health unit and a health profession with which they can feel this personal tie, and I may tell you this personal relationship is essential in health care in the aged based on my own experience.

Now, connected with these neighborhood health centers, there must be home-care programs, special arrangements for the care of patients living in housing projects for the aged and social and physical rehabilitation projects. We did this kind of programing at Gouverneur and I can tell you it can be done and that it works.

In our planning for the health services administration in New York City, we have a goal: that there shall be no more chronic-care facilities, whether in hospitals or in mental institutions, that are isolated from the community; rather, all of these will be a part of a medical complex which consists of the neighborhood health center which you will see today and a hospital with extended-care facilities and mental-health facilities in the community.

We have talked a great deal about the need for home-care and other programs to keep people out of hospitals and get them out as soon as possible. I want to make it quite clear that we need similar programs to keep people out of mental-health and chronic hospitals and also to get them out once they are in.

The essence of this program is to provide alternate domiciliary facilities and a community-based medical care program which has ties to the various resources needed, whether it be community neighborhood care such as you will see, special shelter homes for the aged, a home-care program or a nursing-home program.

Now in our plan in this city we are continuing this neighborhood theme by the development, and a large development, of community mental health centers. These, as you know, are partially financed by Federal money. Here we will have day or night care, emergency care and ambulatory care for patients living at home.

Isolated Chronic Care Facilities

In New York City we are reversing the policy that caused us to build, even as late as the 1940's and 1950's, chronic-care facilities in isolated areas. This important role, then, of living in the community, whether it be with the family or with old friends, must be restored and maintained.

The enemy of older people is social isolation and inactivity. Let me give you a few examples of this. While at Gouverneur, we organized a special program in which older people visited older people in nursing homes, providing activity for both. Let me give you another kind of example: We had a number of older people on home-care programs. We were able to keep them in the home because from time to time we would move the older person into a nursing home and give the family a vacation. This at the same time enables the more thorough evaluation of the patient's medical-care program.

Now, the problems that we have in New York City are really not that different from the other large urban areas, so I think I need to turn now to what I think you should do.

We need much more money for pilot neighborhood medical-care programs similar to the neighborhood health center of the Office of Economic Opportunity. I do not believe there should be specific funding for health projects for the aged but rather that the family programs such as those of the neighborhood health center should be strengthened and perhaps special provisions for the aged written in.[4]

These kinds of grants will be absolutely essential if you are going to secure the best results for medicare and medicaid. It would be unconscionable for Congress to cut back on title 19 financing.[5] This financing is absolutely essential to maintain the ongoing programs of health care for the aged which might be set up under the neighborhood program grants. If Congress must be concerned about the cost of these programs, they should then write in provisions strengthening the need for organized programs such as the neighborhood health center.

I would urge that title 18 financing be made more comprehensive so that it could be used more readily for the funding of the kinds of programs that I am talking about. Additional money is necessary for the construction of extended-care and nursing-home facilities adjacent to the hospital and located in the community.

Now, these facilities need not be the unpleasant end of the road that we so often see in New York City, but they can be something quite different, as has well been demonstrated by Switzerland in its magnificent combination of residential facilities and extended-care facilities which are both pleasant and preserve life.

Finally, increased funding of the Community Mental Health Centers Act is essential to strengthen return of mental health care as far as possible into the community.

Hospital Costs Up to $100 a Day

Now, this kind of funding that I am talking about for neighborhood health centers, increased construction money for extended-care and psychiatric facilities, and special housing for the aged is expensive, but I think the alternative is perhaps more expensive. Hospital costs are now reaching $100 a day in New York City, and you may be interested in knowing that in at least one of our city hospitals, the charges to private patients are now $100 a day.

A Cornell University study of care given to a welfare population indicated that of the total costs of care, 32 percent of it went for chronic-institutional care. In our city facilities it costs us $10,000 to $12,000 a year to keep patients in these facilities. The costs of the individual solo care by physicians are soaring. You may have read in the New York Times this morning preliminary results of a study of one of our institutions where physicians provide care on salaries in which the costs are at least 20 percent below those beneath the surface.

Now, unless the Congress moves decisively in the areas that I have mentioned, we face the danger that the money necessary to provide the kind of program I am talking about will be lost. Financing an unnecessary number of in-hospital days, unnecessary nursing-home days, unnecessary mental-hospital days will lose this money. The payment of

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[4] Additional discussion of this point at p. 375.

[5] Medicaid amendments in the Social Security Amendments of 1967 (Public Law 90–248), resulted in reducing Federal medicaid funds to the States by an estimated $125,000,000 for fiscal year 1969; $60,000,000 of this amount represents the estimated reduction in medicaid funds to New York State for the year.

fees to private practitioners in urban areas will not only fail to produce results but will be inflationary.

So both courageous social vision and prudent fiscal consideration lead to the necessity of organized programs of community health care for the aged of our large cities.

Senator SMATHERS. All right, sir. Thank you very much, Dr. Brown.

Let me, if I may, ask a few questions and then Senator Kennedy may ask questions he wants to ask.

On the last page, you say: "Financing an unnecessary number of in-hospital days, unnecessary nursing-home days, and unnecessary mental-hospital days will destroy it."

In other words, what you are saying is, when there are unnecessary days you need the hospital, the nursing homes, or mental hospitals and we destroy the purpose of the program, which is to take care of those who need it.

Dr. BROWN. Destroy it in two ways. First of all, older institutions may not need it and are the enemy of older people. Let me give you several examples. It is not uncommon for an older person when hospitalized—and I am referring now to an acute procedure—to become disoriented. He was able to function at home around sights that were familiar, but once in a hospital, unfamiliar, he loses contact with reality.

It is not an uncommon experience, I am ashamed to say, that in some of our present chronic-care facilities, at the end of 2 or 3 months, patients lose all track of time. Their clothes are taken away, there is no relationship to the things that kept them in touch with life, they are moved out of the community and away from their friends. Now, this need not be, incidentally.

Now, both of the kinds of cares that I just mentioned are expensive; our hospital costs are approaching $100 a day in a few institutions. Our present inadequate city facilities are running close to $30 a day for chronic care of the type that I mentioned. Now, you can keep people out of these and get them out sooner if we have the kind of organized programs I am talking about, and that is what I mean about the money being lost.

Senator SMATHERS. I wanted to ask you how you were going to eliminate these people who are staying unnecessarily long in these institutions if we have no place to put them.

Dr. BROWN. Well, no; I think there are solutions. First of all, a substantial number of the older people in chronic-care facilities could be cared for in foster homes, provided it was continuing medical care; in homes with their families, provided there were home-care programs and the possibility of some relief from the family when needed.

It is also possible to maintain people in special projects or the housing projects for the aged, provided there is, on the site, health care and nursing and the possibility of bringing in meals.

Senator SMATHERS. You said that hospital costs are going up to as much as $100 a day. I don't know whether it has achieved that high altitude all over the country, but I do think that is almost nationwide.

Now, what, in your judgment, are the reasons that hospital costs are rising?

Reasons for Increased Costs

Dr. Brown. Well, the reasons are complex. The cost of medical care for the highly technical resources we need in hospitals for the acute care of certain problems are, of course, increasing. Secondly, historically nonprofessional and certain professional classes such as nursing in hospitals has been underpaid and there has been a catching up.

Finally I will have to say I think we will not solve the problem, however, by concentrating on the costs per day; rather we need to concentrate on the total number of days and develop an organized program which will use hospitals only when it is appropriate. I am referring to the general-care hospital.

You will not solve this problem of either care for the aged, care for the poor, or cutting costs until we develop organization and client for our programs to care.

Senator Smathers. Do you find that increased doctors' fees have any relationship with the increased cost of hospitals?

Dr. Brown. Well, doctors' fees, of course, by Washington studies and our own, are going up. The problem is basically fee-for-service payment in urban areas will not solve the problems of care of the aged or for the poor, and the reason for this is, there are not enough doctors in low-income areas.

Secondly, it is no longer possible to provide the kind of care people need by a solo doctor unconnected with the hospital in a low-income or perhaps middle-income area; he must be part of an organized program.

Now, the inflationary part of paying doctors' fees has been well known for years; it has been well demonstrated in insurance programs.

Senator Smathers. Do you think that if we had more doctors, that that would, in any fashion, solve the problem? If we had more nurses, would that help alleviate the problem?

Dr. Brown. More doctors alone will not solve the problem.

Senator Smathers. Well, there is nothing alone that will solve the problem, isn't that true?

Dr. Brown. We certainly need more doctors and more nurses, but first of all we need to organize the framework which will bring them into the areas of need. Whether that be our low-income ghetto areas or it be Mississippi, they are both deprived in terms of doctors.

Senator Smathers. All right, sir.

Senator Kennedy.

Senator Kennedy. Following up on that, who has the responsibility for organizing such a program or such a plan?

Dr. Brown. I believe quite strongly the government will have to take the lead, working, however, in close partnership with the voluntary, but government must have the lead.

Senator Kennedy. How would you do that? Should the Federal Government accept this responsibility, the State government or the city, or who?

Dr. Brown. No; I think it exists at three levels. We certainly feel here in New York City a sense of responsibility. I am referring to local government to actively organize the delivery of services to accomplish this goal. I feel quite strongly that the impetus will have to

come from the government. Now, that is the local level; local organization is important.

At the Federal level I think you need to learn from the experience that we have had with financing under social security, and begin to write in programs or put together programs which will restructure the delivery of services; in other words, more neighborhood health center programs similar to the comprehensive grants of the Children's Bureau rather than isolated payment for services.

Senator KENNEDY. I think that that, of course, would be satisfactory, worthwhile, but it still seems to me that you are going to have the problem of increased cost, increased doctors' cost, and there will still be a shortage of doctors despite the fact that the Government might provide more of these facilities. And it is going to be much more difficult as the war goes on and its demands increase.

Dr. BROWN. Let me speak first to that point. You should look at New York City, where we have more doctors in relationship to the population than anywhere in the country. Our present supply in New York City would be a goal far beyond the reach of the whole country, yet we don't have doctors in our low-income areas.

Senator KENNEDY. I know that.

Dr. BROWN. This, therefore, indicates that the solution is not that: it is setting up the kinds of programs that will enable them to practice in the low-income areas.

Senator KENNEDY. How are you going to get the doctors who have a rather profitable practice in the wealthy areas of the city to suddenly move into the low-income areas as they don't do now?

Dr. BROWN. Let me give you some facts on this. First of all we are staffing the neighborhood programs in New York City. We are setting up in our city hospitals, of course, our 21 city hospitals, we have ours completely staffed by salaried doctors and we have had no difficulty, and these are often in low-income areas, staffing them with very low qualified young physicians as well as older ones.

The reason for this is, while money is indeed a motivation to all of us, doctors also have a motivation to practice good medicine, which they cannot do in solo practice.

Senator KENNEDY. How much have costs risen in New York City and in New York State over the past year?

Dr. BROWN. We don't have figures on this yet for the last year. Our health services budget,[6] you may be interested, which is this year somewhat over $800 million, is up 20 percent over last year, and the previous year was up 20-some percent over that year. Now, some of this represented previous underfinancing.

Senator KENNEDY. Do you think that the increase in medical costs, doctors' costs, is due to medicare?

Dr. BROWN. Yes, provided you, however, understand what I am saying. Some of it represented needed catching up in hospital salaries and also beginning to pay for services that were previously given free. However, I hope the Congress will not take that statement to mean that I think you should cut back. Rather the point is, I think the salary situation, you should go ahead with much greater planning, much greater organization, financing of organized programs.

[6] Mayor's budget statement on health services, see p. 546.

Senator KENNEDY. Are there adequate regulations at the present time for dealing with reimbursement under the law for medicaid and medicare?

Dr. BROWN. I don't think there is enough attention paid in this legislation to the need for standards of quality and of organization of delivering.

Senator KENNEDY. Do you have some specific suggestions on that?

Dr. BROWN. We would be very glad to submit such suggestions.

FEES FOR DOCTORS UNDER MEDICAID

Senator KENNEDY. What about in the State of New York here and in the city of New York; have doctors' fees risen since the passage of medicaid?

Dr. BROWN. There is evidence that that has occurred. We don't have final evidence of this.

Now I want to make an interesting point. A substantial amount of our medicaid money is not going to private doctors in New York City, and this is simply because the people that are eligible for medicaid basically do not live in areas where there are private doctors. Most of our money payments under medicaid—and I do have figures on this—are going for institutional or clinic care.

Senator KENNEDY. I have seen the California report showing that $83 million has been paid to 1,200 physicians, which work out to an average of $70,000 per physician.

Dr. BROWN. We have had, of course, some striking examples, which I quote to you, excessive sums paid to private doctors. However, let me give you a bit of perspective.

Senator KENNEDY. Just tell me what you have found on that.

Dr. BROWN. I think the worst example is $7,000 a month in billings. We are, incidentally, collecting these.

Senator KENNEDY. $7,000 a month——

Dr. BROWN. In billings by one physician.

Senator KENNEDY. Under medicaid?

Dr. BROWN. Yes.

Senator KENNEDY. What kind of a study have you made? Have you made an extensive study?

Dr. BROWN. Oh, yes. We are beginning to segregate these out and we certainly will take action on these.

Senator KENNEDY. I want to stay with this for just a moment. How widespread has the practice of raising fees been?

Dr. BROWN. That has not been extensive, and here is where we are going to stop it.

Senator KENNEDY. Let me ask, have you made a study of it to find out how much of this is going on?

Dr. BROWN. Yes; we have monthly figures on the payments, and we can submit these to you.

Senator KENNEDY. But I would like to have them now if I may.

Dr. BROWN. I don't have them in front of me. We have monthly reports on this kind of thing. I want to make one point and we will submit it to you in detailed form.

Senator KENNEDY. Is it at all comparable to what they have found in California?

Dr. BROWN. It is not as great.

Here is the point I want to make: Our medicaid reimbursement payments to private doctors are only running at the rate of slightly over $10 million a year for the city. In contrast to this, payments to dentists are running at about $40 million, and the cost of the total program is $600 million this year in New York City. So the payment to private physicians is not a substantial part of our medicaid expenditures in New York City.

Senator KENNEDY. You mention the dentists. Have there been abuses by dentists under the law? If so, it is very possible that we would want to suggest legislation to tighten the law up. That is why I ask.

DENTISTRY NEEDS ARE GREAT

Dr. BROWN. Anyone who has worked in low-income neighborhoods knows that the greatest unmet need is dentistry. Prior to the beginning of medicaid, there was no way for the medical indigents in New York City to get their teeth fixed; it was just that simple. So certainly we are catching up on unmet need.

It is clear, however, and we have some preliminary studies which show that the cost of doing it on fees as compared to our organized health department programs is about threefold.

Senator KENNEDY. I think we are all interested in making sure that these kinds of medical and dental assistance and services are available to the poor; that was the purpose behind medicare and medicaid. But we are also concerned to know if the program is being abused—whether, because of improper administration or because of the misconduct of some doctors or dentists even though it might be a small minority, the program is resulting in tremendously increased cost to the Government.

The cost of medicare and medicaid is a matter of great concern, it is a matter of tremendous concern, here in the State of New York, as it is to the Congress of the United States, as it is across the rest of the country. We must be careful not to throw out the baby with the bathwater, but we should candidly examine the weaknesses of the program.

That is what I am trying to explore with you. If there are abuses, I think that we should bring them out at this hearing and then determine—Senator Smathers has had much more experience with this program than anybody in Congress—what to do about theirs. The State of New York is the focus of all of the attention in Congress about the abuses in medicaid and medicare, and I am trying to learn from you whether you think we can improve the bill—improve the legislation, and not merely the administration of it—so as to prevent abuses by individual physicians and individual dentists.

I don't think it is going to do anybody any good if we cover it up.

Dr. BROWN. I am not attempting to cover it up at all. I made the point in my presentation that I think the real solution for the business of medicaid and medicare for financing is only through organized programs connected with hospitals. I gave an example of our salaried physicians at Elmhurst, their cost being lower than fee for service. We also have information indicating the higher cost of dental care given under fees as opposed to our organized health department programs.

I would hate to see the dental expenses, however, solely focused on the question of abuse simply because the unmet needs in dentistry are so great among the poor people. Rather I think we should look at the comparable costs under organized programs and fees. Our evidence indicates that it will be too expensive under fees.

Senator KENNEDY. There have been some studies made in the State. I don't want to take too much time, we have a lot of witnesses, but here is an article from Watertown which shows that an office call before the passage of this legislation was $3; afterwards it was $6.50; a home call, $4; afterwards $8; special service, initial visit, $7.50; after the passage of the bill, it was $20.

So in some areas of the State all costs appear to be double what they were before passage.

Secondly, there are indications that the same thing is happening in California. They have made a detailed study of the problem there, for which they are to be commended, which shows that costs have gone up astronomically.

Now everybody is very concerned all over the United States as to what has happened here in the city of New York, and so I was grateful to Senator Smathers for the opportunity to appear at this hearing and to get on the record the problems that exist and the suggestions that might be made by city officials and by others who believe in the bill as I do and as Senator Smathers does. We must discover what we can do to reduce the tremendous cost to the Federal Government, the tremendous cost to the State, and the cost to the city, which will end up bankrupting us all, it seems to me, unless we do something about it.

We want to provide these services for those who have been deprived of them, for the elderly people, but we do not want to have people make a killing out of the program financially. That is what is of such concern to us. If we can't control this we are going to destroy the whole program in my judgment.

Dr. BROWN. I made strong statements opposing fee-for-service payment to doctors. The point I was making, however, is that as a component of spending in New York City $10 million a year out of roughly $600 million, this is a relatively small part, and I am not in that way suggesting there are not abuses. The larger increases in cost in New York City have been in the costs of institutional and hospital-connected care.

Senator SMATHERS. All right. Let me just ask two questions of Commissioner Moncur. Commissioner, what percentage of the doctors registered here in the city of New York participate in the medicaid program?

Mr. MONCUR. I would say that slightly over half of the doctors are actually participating in the program.

Senator SMATHERS. What percentage of dentists are participating in the program?

Mr. MONCUR. That is a somewhat higher figure. I don't have a precise figure on that.

Senator SMATHERS. I gather the reason that the other doctors don't participate and the dentists don't participate, they make more money by not participating; is that a fair statement or not?

Mr. MONCUR. I just would like to say one thing about that. I have heard several statements as to why doctors don't participate. One state-

ment, for example, I have heard over and over again has been about the payments question. I personally don't think that that is a significant reason why they don't participate.

Senator SMATHERS. Why don't they participate?

Mr. MONCUR. It has been said that they are concerned about the fees, but I will let Dr. Brown speak to that.

Senator SMATHERS. All right.

Dr. BROWN. I think some feel the fees are not adequate. I don't think, however, that that is basically the problem if you know the city and its ghetto areas as I do. First of all, there are not private doctors in low-income areas—there are only a handful. We have them on a map downtown; you would be astonished. The doctors who practice in the middle- and upper-income areas don't want to take care of the medically indigent in their offices.

Senator SMATHERS. I agree with your long-range program that you say is the solution and Senator Kennedy questioned you about so well; that is, the solution if you can get it staffed, if you can get the doctors to go there and take these jobs.

Now, what reason do you have to believe that a doctor who can make $100,000 downtown is going to take a salary at some neighborhood health center at $20,000 a year?

Dr. BROWN. Well, first of all, the median income of physicians in New York City is not $100,000; it is actually much lower than that.

Senator SMATHERS. All right. If it is $50,000.

Dr. BROWN. It is not $50,000.

Senator SMATHERS. What is it?

Dr. BROWN. The median income of physicians in New York City, it is lower in New York City than in the rest of the country, and the reason for that, of course, is our larger supply of physicians.

Senator KENNEDY. Well, what is it?

Dr. BROWN. The latest figure, as I recall—and I wish I had all my information—is around $30,000, $35,000.

INCENTIVES FOR GROUP PRACTICE

Now, based on my own experience—I have spent my life working in group-practice units—a lot of physicians in addition to income also value practicing good medicine. This is a very powerful drive on the part of doctors. Now, we have been able to staff our salaried posts in the city hospitals and we have thousands of doctors, you see, on salary—young, well-qualified, board-trained doctors. We have been able to staff our new neighborhood health programs as we set them up, again because of this motivation of practicing good medicine.

I think there is also an element of service that is in all of our lives.

Senator SMATHERS. All right, sir. Thank you. We certainly don't want to cast any aspersions to the effect that the doctors do not share an equal amount of responsibility. Those who are in public service, we think they do also generally a great good.

Our problem is the question that I come back to and you have not answered; I don't know if there is an answer: How do we get more doctors and more nurses? If we are not going to get more doctors or more nurses in the foreseeable future, then what are the alternatives? Now, your alternative is community neighborhood health centers.

Dr. BROWN. One doctor per thousand can provide good care for the population, particularly with the use of other, nonprofessionals. This is well documented in the work of the prepaid insurance plans such as HIP and Kaiser.

Senator SMATHERS. Would you not also agree that we need more doctors?

Dr. BROWN. Yes, I do. I am being stubborn on this problem of organization because we cannot solve the problem unless we organize care and you will not solve it in the rest of the country simply by more doctors.

Senator SMATHERS. All right, sir. Thank you very much, Dr. Brown and Commissioner Moncur.

(The chairman addressed the following questions to Dr. Brown in a letter written after the hearings:)

1. Your statement said that family doctoring has completely broken down in the vast low-income areas in New York City, roughly in areas with at least 40 per cent of the city's population. May we have statistical information on density of private physicians in selected low-income areas of the city?

2. You also reported that the city is instituting "a massive program of neighborhood health centers." May we have details on:

a. The number of such centers now established or contemplated and the number of individuals in the service areas.

b. Whether such centers are financed wholly or partially with O.E.O. funds.

c. Information on sources of funds for other centers, both short-term and long-term. (Dr. Haughton's statement has some information on the above points but we would like additional data.)

d. You mentioned Title 18 financing as a potential source of funds for neighborhood health centers and, I presume, associated health services. May I have more details on your suggestion? Do you see other potential sources of funds for neighborhood health centers?

3. As the transcript shows on page 18, I asked how you would eliminate unnecessarily long stays in hospitals or chronic care institutions if you have no place to put the elderly individuals. You said that home care programs would be of help, but a later witness—Mrs. Susan Kinoy—described what appear to be serious limitations in such programs. What efforts are now under way to make such services more available in New York City, and what more can be done at the federal level to help provide them?

4. On page 23, you indicated that you would submit suggestions in response to Senator Kennedy's question about methods for establishing standards of quality and organization of delivering services under Medicare and Medicaid. I would appreciate your giving me a copy of your reply as part of this supplementary statement. On page 25 you also indicated that you would provide details on billings submitted by doctors under Medicaid, and I would like a copy of that report, too. I would also like additional information on the median income of physicians in New York City, as we discussed.

5. You made the following comment: (p. 14, transcript) "I do not believe there should be specific funding for health projects for the aged but rather that the family programs such as those of the neighborhood health center should be strengthened and perhaps special provisions for the aged written in."

I would like additional commentary from you on how such "special provisions could be written in." One reason for my inquiry is that the Subcommittee has received information indicating that the elderly served by the Hudson Guild-Fulton Center apparently received major benefits from a health maintenance project maintained for the elderly until approximately 1 year ago. The Subcommittee has been informed that the project gave on-site attention to illnesses or complaints for residents there. With the suspension of the project, many elderly now apparently spend many hours waiting for treatment at clinics, and in some cases they merely need periodic examination of chronic conditions. The Subcommittee is also informed that the Queensbridge Health Maintenance Service for the Elderly at Queensbridge Houses is still in operation, but that the home services component of the program may be suspended in November and that the future of the overall project may be in doubt.

Do you believe that such health maintenance projects for the elderly have considerable value in neighborhoods with a high-density population of the elderly, as so often occurs in low-income public housing projects? I would appreciate some discussion by you of the desirability of continuing such projects. Much as I sympathize with the concept of family treatment in neighborhood health centers, could it be that the elderly—particularly those who live alone in public housing—may require special services and sustained attention of the kind provided at Queensbridge and formerly provided in the Hudson Guild-Fulton area?[1]

6. Miss Helen M. Harris, Executive Director of the United Neighborhood Houses of New York, told the Subcommittee that the $11 clinic fee imposed in New York City municipal hospitals is causing hardships for many elderly individuals who had previously been charged nothing. May we have some commentary from you on this point?

7. Mrs. Harris also said that many elderly persons not on welfare are in desperate need of Medicaid, but they have a little more savings than Medicaid allows and are reluctant to declare those savings. Have you any suggestions on possible changes in law or policy that would be of help to such individuals.

8. The hearing record will include Dr. Cherkasky's article of October 8 from the New York Times Magazine about New York City Municipal Hospitals and several other articles dealing with the city hospitals. May we have your comments, in addition to those given by Dr. Haughton in his Exhibit A, on:

a. Your views on alternatives to present administrative policy.

b. Any suggestions you may wish to offer on federal action that would be of help to New York City and other cities with large municipal hospital responsibilities.

9. In my letter of September 27 to you, I put several questions to you and Dr. Haughton. A copy is enclosed. We would appreciate your responding on matters not discussed during the hearing.

(The following replies were received:)

THE CITY OF NEW YORK,
HEALTH SERVICES ADMINISTRATION,
November 10, 1967.

DEAR SENATOR SMATHERS: Thank you very much for asking me for additional information.

I have enclosed material on our neighborhood health centers, which I think is self explanatory. In addition, I have enclosed a statement on details on billings by doctors under Medicaid. I will now comment on the additional questions that you asked.

We have evidence that from our health officers surveys of the great shortage in family doctors in lower income areas. We also have such evidence from the recruiting effort of the Health Insurance of Greater New York in these areas. We have, at present, underway, a specific study which will give us the number of family doctors by low income areas in this city. One figure, however, worth noting prior to that is, in the low income part of Brownsville there is one private physician to 4,000 people.

In regard to question three, about home care programs, I feel that these programs are indeed helpful provided they are tied both to neighborhood health centers, nursing homes and hospitals. We are expanding home care programs in our city hospitals and as we develop neighborhood health centers, home care programs will be included.

Question four asked about suggestions for establishing standards of quality in organization under Medicare and Medicaid. I would suggest the following: Employment of physicians on salary by hospitals should be encouraged rather than discouraged by the legislation as it now exists. Special provisions should be made which encourage the formation of group practice units connected with hospitals. This could include elimination of the deductibles when patients use such facilities. Another possibility would be increasing reimbursement to hospitals with a special incentive factor that set up group practice units connected with them which treated all income levels. Amendments which mandated states to encourage development of systems of one level of care connected with hospitals, whether these be in-patients or out-patients, would also be helpful in attaining this goal.

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[1] Additional discussion on this point on p. 543.

In regard to question five, I am very glad to comment on this. The Hudson-Guild Fulton Center served less than a hundred older adults. And the Queensbridge Health Maintenance, about 600 older adults. These by no means gave comprehensive service, and the services that were provided were at such high cost in terms of money and professional resources that they could not conceivably be duplicated. There has been considerable loose thinking about both Queensbridge and the Hudson Guild-Fulton Program. The loose thinking has arisen from the need of people connected with these projects to have an interesting project to talk about. They have consistently ignored the impossibility of replicating these procedures. They have also ignored the fact that they by no means provide comprehensive care. In each situation, I would far prefer having a single doctor and nurse providing their kind of care. However, in New York City, we have dense enough population that we could easily do this with our neighborhood health center.

In regard to question six, there is no doubt in my mind that the eleven dollar fee has caused us some difficulty as to older people. This is largely because of the savings requirement under Medicaid. I favor removal of consideration of savings for eligibility for Medicaid. I do not have specific figures to bear this out, but I have a strong hunch that it costs us more to enforce this than we save.

In regard to question eight, the problem of the city hospitals is indeed a complicated one and probably has to be solved in an individual manner by each city.

The restrictions such as civil service complicated procedures of fiscal accountability and other such things called "red tape" make the operation of city hospitals particularly difficult. On the other hand, it is my impression that people are reluctant to give up city hospitals because of their historic role in caring for those unwanted by the voluntary hospitals. A federal program of help to city hospitals which included massive sums for renovation in reconstruction would obviously be of great help. This money should be geared to converting these into hospitals which physically can serve all income areas. If the amount of money needed to rebuild all of the city hospitals in the country could not be raised, an alternative suggestion would be a program of grants for the emergency rooms and/or the clinics of these city hospitals.

Sincerely yours,

HOWARD J. BROWN, M.D.,
Health Services Administrator.

EXHIBIT A. Information on Medicaid in New York City

Our projections are based on 4,000,000 New Yorkers being Medicaid eligible. While projections indicate no increase in New York City's population over the next 15 or 20 years, these same projections indicate a continuance of trends prominent between 1950 and 1960, to wit: an increase in the population of individuals over 65 by 35%, an increase in the population under 15 by 13%, a decrease in the white population by 12%, an increase in the Puerto Rican population by 149% and an increase in the non-white population by 48%. While continued increases in these statistics might not be as great as in the previous decade, it seems fair to assume that New York City will have enough of a shift in these population groups to offset any changes in Medicaid eligibility which may be passed by the Congress.

Based on approximately 9,000,000 combined out-patient and emergency room visits to voluntary hospitals in 1966 and 5,000,000 like visits to municipal hospitals, we are projecting a capacity of approximately 3,000,000 patients for the hospital system as a whole. If we divide the remaining 1,000,000 eligible patients into 30,000 units—since this is the optimum size presently recommended—we would need in addition to old funded projects, about 30 neighborhood centers or approximately 20 over and above those already approved in our 1967–68 Capital Budget. Since we do not anticipate that all eligible patients will avail themselves of the services to which they are entitled at the same rate of speed, we are projecting a phasing in of four additional units each year for the next five years. It is also assumed that during this period the out-patient departments of the various hospitals will themselves reorganize to provide comprehensive care to conform to Medicaid standards. Any decrease in the potential number of patients who can be seen as a result of the change to more comprehensive care should be offset by reorganization of the clinics to provide for more efficient scheduling and evening operation.

In projecting future needs and locations, we have had each health officer inventory his district for services presently available, the numbers of patients those services can treat, those patients theoretically going without adequate services at the present time and dividing that number by 30,000 to arrive at the number of centers needed in any given health district. The locations of such centers are based on the health characteristics and indices of the community, socio-economic characteristics of the neighborhood, lack of availability or accessibility to other health resources, availability of sites, transportation, the amount of time required for acquisition of sites, relocation problems, etc.

Each of these facilities will provide medical care for adults and children, prenatal services, dental services and mental health services. We are presently exploring the possibility of providing more complete mental health services in selected centers as a means of reducing costs for land acquisition, planning and construction. At the same time we are concerned lest there be a tendency to allow such centers to become too large and resemble the kinds of facilities from which we are trying to move.

In making these projections we have also been most aware of one very significant variable whose impact cannot, at this time be measured, i.e., that demand, especially for services, is frequently a product of supply. If there is any merit to this hypothesis there is a good possibility that we may be under-projecting our needs.

Health Services has also prepared a bill which it hopes to have submitted in the New York State Legislature which will provide for New York State reimbursing localities for 50% of the cost of constructing such neighborhood family care centers. At the present time, however, support of the construction costs of these centers will come from tax levy monies and operating costs will be borne by title XIX.

EXHIBIT B

THE CITY OF NEW YORK,
DEPARTMENT OF HEALTH,
November 21, 1967.

To: Dr. Howard Brown, Health Services Administrator
From: Mr. Raymond S. Alexander, Assistant Commissioner
Subject: Medicaid Payments

Based on limited data, we can make the following projections on payments under Medicaid to physicians and dentists. These projections are based upon the rate of professional participation to date and current utilization data. If more professionals participate, which will be the case, the lower the figures listed below will be:

Physicians

1. About 3,000 physicians in private practice are participating. The average yearly income from Medicaid will be around $9,000 to $10,000—for over 90% of the physicians.
2. About 5% of the physicians with heavy Medicaid practices, some 150 to 200 doctors, will make $35,000 to $60,000/year.
3. About 1% of the doctors, 30 to 40 will earn in excess of $60,000/year.
4. In these figures, a 40 to 50% overhead figure must be considered to calculate net income.

Dentists

1. About 2500 dentists are actively participating. The yearly average income will be around $14,000 to $15,000.
2. About 5% of the dentists, some 100 to 120, will earn between $60,000 to $100,000 a year.
3. About 1% or 20 to 25, will earn in excess of $100,000/year.
4. The large amounts go to dentists with multiple chair offices, who usually have other dentists working for them.

RAYMOND S. ALEXANDER,
Assistant Commissioner.

Senator SMATHERS. We have a statement from Dr. James Haughton, deputy to Dr. Brown. We will insert it here.

(The complete statement of Dr. Haughton follows:)

PREPARED STATEMENT OF JAMES G. HAUGHTON, M.D., M.P.H., FAPHA, FIRST DEPUTY ADMINISTRATOR, HEALTH SERVICES ADMINISTRATION, CITY OF NEW YORK

The Irony

It is indeed ironic that the major problems which we face in addressing ourselves to the health needs of our over 65 population have been created by the major public health victories of the last hundred years. At the turn of the century the leading causes of death were infectious diseases: influenza-pneumonia, diarrhea and enteritis, diphtheria and tuberculosis. At that time 4 out of 10 deaths (40%) were caused by infectious diseases.[1] In addition to the leading causes of death there were such scourges as smallpox, typhoid, malaria, and venereal diseases.

Major Public Health Victories

But by the early 1950's vaccines had been developed and major eradication programs had been mounted; penicillin, sulfa and other antibiotics had been discovered and deaths from infectious diseases had been reduced to 1 out of 13 (7.7%). Even in the area of chronic disease there have been some break-throughs which have reduced mortality and disability. Examples of these are the discovery of insulin for diabetes and cortisone for arthritis and other disabling collogen diseases.

Positive Results

These victories have indeed had many positive results for our populace particularly when one looks at our generally accepted measures of the health status of the nation. In 1915, 100 of every 1000 children born alive in the United States died before their first birthday; in 1965 the rate was 24/1000.[2] In 1900 the death rate from all causes was 17.2 per 1000 population while in 1965 it was 9.4—almost a 50% improvement.[3] As a result of all this, while the life span has not changed, the life expectancy has improved so that, whereas in 1900 the average American born could expect to live 47 years, the American born in 1964 can expect to reach 70 years of age.

The Price of Progress

But as always we have paid a price for this progress, and what is the price? Our birth rate is twice our death rate; therefore, there is rapid population growth placing considerable strain on our resources especially in the crowded Metropolitan complexes where housing, water pollution and air pollution are among our major problems.

In addition we have a rapidly growing aging population now estimated at 19 million and projected to reach 24.5 million before the end of this century.

With the burgeoning of this segment of the population has come a shift in the major causes of death. Instead of the acute infectious diseases previously mentioned, the major killers are now heart disease, cancer, stroke and diabetes. But what is perhaps worse is that these killers do not act quickly; instead they are a major drain upon the economy because of the prolonged disability which they cause.

Our public health progress has also brought us face to face with some of the social problems of the aging. The American worker who retires at age 65 can reasonably look forward to about 20 years of retired life. He is therefore faced with the need to fill 20 years of leisure time.

He must also learn to cope with the need to be a contributing, useful member of society at a time when his usefulness seems to have come to an end. He must adjust to the isolation resulting from the maturing and scattering of his family. He must adapt to his diminishing physical capabilities even if he is not disabled by a chronic disease.

Health Needs

Having pointed out the irony in our unprecedented public health progress, let us look at the challenges it presents us. Because the major causes of morbidity

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[1] Encyclopaedia Britannica, Vol. 18, p. 739 "Public Health in the U.S."
[2] Encyclopaedia Britannica, Book of the Year—1966, p. 802.
[3] Encyclopaedia Britannica, Book of the Year—1966, p. 803.

in this population are the chronic diseases which we have not yet learned to prevent, we must make major efforts to detect them as early as possible so that we can hopefully delay or limit the disability they cause. Fortunately the means for early detection are at our command.

For more than a decade we have been investing major portions of our effort into the early detection of chronic diseases, but we have been doing it in a vacuum because we have persisted in defining public health in its narrowest terms. As a result we have reached only a fraction of those who need our services.

The mental health of this population should be one of our major concerns. Here again prevention is of major significance, and again the means are at our disposal. I read recently that David Dubinsky, retired president of the International Ladies Garment Workers Union would devote his retirement years to a program for preparing prospective retirees of his industry for retirement. Other unions have also taken steps in that direction. Public Health agencies must also address themselves to this problem for this is an important part of preventive medicine.

There are approximately 50,000 persons in New York City over the age of 80. Many of them are isolated because of disability and become disoriented and senile because of their isolation. Public Health programs must also address themselves to this aspect of preventive care either by direct intervention by official health agencies or by the stimulation and leadership which such agencies can provide to the private and voluntary sectors.

One of the major causes of death which merits mention is accidents. Many of these accidents occur in the over 65 population because they live in inadequate housing. Hardly a week passes without local press reports of deaths of elderly persons from fires in New York City. I wonder how many of these deaths could have been prevented. I wonder how many hip fractures could be prevented by housing designed specifically for the aged with all the known safety features. I suspect that in terms of cost benefit the investment would be well worthwhile in pure dollars and cents without even considering the saving in human suffering.

Treatment Services

Treatment services are, of course, an important part of planning for any segment of the population, but it may well have less significance for this population than for a younger one. Obviously, early detection is useless unless it is followed up by immediate and vigorous treatment. But in the later phases of the natural history of these chronic ailments it has become increasingly clear to me that some of the social considerations are of much greater import than the actual medical services.

Five years ago we began an experiment to provide private group practice medical care to a dependent over 65 population. We assumed that these persons would welcome the opportunity to leave what we considered the impersonal, demeaning atmosphere of hospital out-patient clinics and have access to a private physician by appointment in comfortable surroundings. Instead we found to our surprise that many of them refused to leave the familiarity of the clinics, not only because the surroundings were familiar but also because the visit to the clinic was a social affair—a chance to visit with friends, to get away from the isolation of a small apartment or a small room, a chance to be the center of attraction while an interesting disease was being described to a group of residents by the head of the department. We further found that of those who did accept care from the group practice program we received fewer complaints from those who were enrolled in a group whose physicians were older and therefore apparently more in empathy with this elderly population even though this medical group was not considered one of the medically strong groups in the program. We are convinced that these patients were more impressed with the social aspects of the care received than with the efficacy of the medication prescribed.

The Future

Much has been learned about the care of the aged from our own experience in New York City [4] and the experience of others in other parts of the country.

[4] Haughton, J. G.—"The Organization of Medical Services in a Private Nursing Home: Three New Approaches". New England Journal of Medicine, May 13, 1965, p. 996–1003.

We must take advantage of this experience and enlarge upon it. We must redefine Public Health in much broader terms and address ourselves not only to the control of disease but to the physical, mental and social well being of this population.

Health Care cannot exist in a vaccum. A dollar spent in better and safer housing for the elderly may well be more productive in terms of cost effectiveness than the same dollar spent in health services for the same population and may well have greater impact upon the health status of the elderly.

I believe that this may well be true because during the period July 1959 to June 1961, 66.8% of all persons 65 and over who were injured in their homes in the United States received medical attention for the injury and 72.4% of these had one or more days of restricted activity as a result. In addition, fractures and dislocations in persons 65 and over accounted for 4,228,000 hospital days during the period 1963–1965 for an average length of stay of 24.2 days.[5] The annual cost of accidents in the home for all ages is estimated at $1,300,000,000,[6] and since we know that the accident rate per 100 population for those 65 and over is higher than for every other age group except children under 10 we can readily judge the cost to the economy.

Activities in concert with social service and other service agencies aimed at ameliorating the isolation, depression and disorientation of the aged may well do more to promote the mental health of this group than all our mental health facilities and treatment modalities.

Recent health legislation creating the Medicare and Medicaid programs is providing new health funds and thereby relieving some of the demand for local funding of treatment services. This should make it possible to address ourselves to some of the socio-medical aspects of the problem. Whether this happens will depend upon the leadership Public Health and Social Service professionals provide.

Public Health officials must take their places among those who plan for our communities. They must show them that they do not wear blinders and that they are not health chauvinists who ignore other needs of the community in their quest for health dollars. They must convince them that they see health within the broader context of the total well-being of the community and that they recognize the impact of other services upon the total health of the community. Then and only then will they become effective members of the political structure of our society.

Comprehensive Health Planning

This approach to health planning may seem like rank heresy to some, but I submit that this must be the approach if P.L. 89–749 is to be effective as an instrument for rational comprehensive health planning. Planning which addresses itself to the real health needs of a community cannot be carried out in splendid isolation. Urban Renewal, Model Cities, OEO programs, all these must include health concerns and Public Health officials must therefore take an active part in these developments. It is because of our commitment to this point of view that the New York City Health Services Administration has developed and maintains a close working relationship with the City Planning Commission and Human Resources Association.

The fact is that some of the emerging nations which we like to call the underdeveloped nations have already been forced to do that kind of planning. When resources are limited, rationality demands that planning be carried out in terms of what is in the broadest public interest and how the greatest cost benefit can be derived. It is in this context that health and welfare services tend to be funded in terms of their contribution to the total well-being of the community rather than because health is presumably intrinsically good.

Some nations have for example had to decide to reduce a malaria eradication program to a malaria control program in order to expend more funds for agricultural development because it didn't make sense to save people from malaria so they could die of malnutrition. The funds spent in agricultural development contributed more to the growth of the economy and hence to the total well-being

[5] U.S. National Health Survey (Injured Persons)—Series B–16 (1960), B–37 (1962), B–39 (1963).

[6] Accident Facts—1966 Edition, National Safety Council, Chicago.

of the nation. The net-cost benefit was therefore greater and more in the public interest.

We may perhaps never be forced to make such choices, but we must certainly be prepared to justify our health activities on better grounds than the intrinsic goodness of health services both for our aged population and those who are younger.

In a city as large as New York it will not be a simple matter to provide health services to the aging with all the social concerns which we all agree are necessary. But I believe that this goal can at least be approached if we abandon the rigidities of the past and become more flexible about the way in which services are provided. There is a growing literature on the use of subprofessional personnel with appropriate training and supervision. This literature seems to indicate that we have been caught in a trap based upon a confusion of objectives.[7]

Let me give an example. There are in the United States approximately 400 public health educators at the Master's degree level. Even with the most optimistic statistical projection is it conceivable that we could even produce enough health educators at that level to make them the only source of health education to the public? Obviously this is not feasible. Should our objective therefore be to alleviate the shortage of public health educators or rather to attack the inadequacy of community health education? If the latter is our objective, we can begin rationally to explore other more realistic means of solving the problem. We can draw the same analogies in public health nursing and in social work.

This approach has already begun to bear fruit in New York City. Public Health Assistants are already expanding the productivity of the public health nurse, dental hygienists are already expanding the capabilities of the dentists and in addition providing more dental health education than public health educators.

More recently social health technicians and social work case aides have begun through some of our antipoverty and manpower development programs to provide some of the social service outreach and supportive services which are expanding the capabilities of the limited number of professional social workers available to us. It is only through such innovation that large Metropolitan enclaves will be able to effectively combine health and social services for large numbers of people.

OEO Neighborhood Family Care Centers

Recently we have received 5 grants from OEO for the establishment of Neighborhood Family Care Centers where we will not only deliver comprehensive health care but will also train subprofessional workers to perform relevant health and social service functions as part of the socio-medical team. In addition there are currently in our capital budget funds for 17 New Neighborhood Family Care Centers and funds for the renovation and conversion of several existing Public Health centers to family health care. All of these resources will be equally available to the elderly among us.

The effects of Medicare and Medicaid upon health care of the aging is a subject about which we have great concern. Attached to this statement is a paper which I have prepared for delivery at a session of the 95th annual meeting of the APHA in Miami Beach Fla. on October 26, 1967. I have labeled it Appendix A. It deals with some of the issues related to the effects of this legislation on health care for the elderly.[8]

Domiciliary facilities for the aging who cannot live alone but who do not require institutionalization is another matter to which we have given some attention. Appendix B attached is a report of our findings in a study made in 1964 and our resulting recommendations.[9] These have been submitted to the New York State Department of Social Services which has jurisdiction over such facilities and some of our recommendations have recently been implemented.

With a rapidly growing aging population we will be continually faced with the need to anticipate and deal with new problems. The extent to which we deal successfully with these problems will be determined by our ability to be innovative and flexible in the application of our resources to the problems. This committee

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[7] Bellin, L. E.; Killeen, Mary; Mazerka, J. J.—"Preparing Public Health Subprofessionals Recruited From the Poverty Group—Lessons From an OEO Work Study Program." American Journal of P.H. Vol 57, No. 2, February, 1967.

[8] See p. 506.

[9] In subcommittee files.

can play an important role in creating a public awareness of the problems and in providing the leadership in the Congress which will be necessary to generate the resources required for the accomplishment of our tasks.

(The chairman addressed the following questions to Dr. Haughton in a letter written after the hearings:)

1. Your statement (p. 7) says that P.L. 89–749, if it is to be effective, must be implemented in conjunction with other federal programs. We would appreciate additional discussion of this point, with any suggestions you may wish to give on possible changes in federal law or policy in order to facilitate such a broad-based approach.

2. On page 5, you described the reluctance of many elderly individuals to leave their familiar clinics when you implemented a group practice medical care program for them. Was this a serious problem that should be considered in plans for establishment of such group health practice programs in the future?

3. Your address on the future of public general hospitals makes the case for transforming such hospitals into centers of high-quality care for all income groups. Have you any suggestions for federal action that would accelerate this process?

4. Your working paper on medicare and medicaid protests against the "prohibition of routine physical examinations under medicare". How would you implement such checkups? Do you now have the screening facilities that would be required?

(The following reply was received:)

* * * * * * *

Question 1, with regard to Public Law 89–749, is a most important one. If comprehensive health planning is to be meaningful and really comprehensive it must be responsible for all health planning in a region, in this case the region being New York City. In the past, urban renewal programs, slum clearance programs, and even OEO programs have been planned without any real concern for the health facilities which must accompany such planning. As a matter of fact, members of the health agencies have not been involved in this community planning. In some instances, OEO programs are planned for health services without involving local health authorities. This has not happened in New York City simply because we have taken a very firm position against it and, in some instances, have even threatened not to accept any OEO funds if the priorities and concerns of the local health authorities were not taken into consideration. The time has long passed when health planners can isolate themselves from the agencies who plan for the total community. Health planning must of necessity become a part of total community planning, and this is possible and should be vigorously implemented under Public Law 89–749.

As I read the present law, it is clear the intent is that the comprehensive health planning agency at the State level be a public or governmental agency. At the local level, however, it apparently provides that the agency may be a voluntary agency. This is, to my mind, a weakness, since a voluntary agency can never be as publicly accountable as is a public agency. While it is true that in some localities the local health authority may not have the competence or expertise to carry out such planning, I believe that these agencies should be encouraged to develop such expertise and that, in the interim, a State planning agency carry out the functions for those localities which do not have the talent. Because of this permissiveness in the law with regard to what agency may do the planning at the local community level, we are now faced in New York City with a rivalry between the local regional health and hospital planning council and a proposed public agency. This kind of rivalry can be eliminated or avoided if an amendment to the law should provide that, clearly, the planning agency must be based in government.

Question 2 is a sociological one, and one that is difficult to deal with, since there is no way to create an aura of familiarity in a new setting. Those persons over 65 who have been going to out-patient clinics for many years will want to continue to attend them in some cases. Our aim, therefore, should be to up-grade the out-patient clinics and to convert them to group practice organizations so that we may improve the quality of the services and the amenities related to them while, at the same time, maintaining these older persons in the familiar surroundings to which they are accustomed. Our aim in New York City is to reorganize the

services in our out-patient clinics so that they function as group practice organizations in lieu of the presently over-specialized, fragmented services which are provided in these clinics.

Question 3 could be dealt with through an amendment to the Hill-Burton Law. As I understand it, the present law provides funds for the building of hospitals in areas where the number of beds available are deficient. It takes no account of the fact that in many areas, while the bed complement is sufficient, the physical quality of those beds is such that they all require replacement. An amendment which would provide Federal funds for the replacement of obsolete public general hospital beds would be a big help in speeding up the process of converting these general hospitals into physical facilities which would be acceptable to all income levels.

Question 4 may be answered by pointing out that it does not require screening facilities to provide routine physical examinations. Under Medicare it should be possible for a patient to visit a physician for a routine physical check-up at least once in each twelve-month period. The law might stipulate the minimum services that should be performed at such an annual check-up.

I regret that I was unable to appear personally at the hearing but I was busy chairing a session at the Surgeon General's Group Practice Conference in Chicago. I hope that I have answered your questions adequately.

Senator SMATHERS. Now our next group of doctors includes Dr. Martin Cherkasky, director of the Montefiore Hospital & Medical Center, and he is accompanied by Dr. Cecil G. Sheps, general director of Beth Israel Medical Center; Dr. George R. Reader, director of the comprehensive care and teaching program, Cornell Medical College; and Dr. David D. Thompson, director of New York Hospital.

Dr. Cherkasky will be the first witness to testify, and each of the other doctors has a statement.

All right, Dr. Cherkasky, we are very pleased to have you, sir.

STATEMENTS OF MARTIN CHERKASKY, M.D., DIRECTOR, MONTEFIORE HOSPITAL & MEDICAL CENTER; CECIL G. SHEPS, M.D., GENERAL DIRECTOR, BETH ISRAEL MEDICAL CENTER; GEORGE G. READER, M.D., DIRECTOR, COMPREHENSIVE CARE AND TEACHING PROGRAM, CORNELL MEDICAL COLLEGE; AND DAVID D. THOMPSON, M.D., DIRECTOR, NEW YORK HOSPITAL

Dr. CHERKASKY. Senator Smathers and Senator Kennedy, we are delighted to have you here. Some of the solutions we hope lie in your hands.

Before I get on with my brief prepared statement, I must continue on where you left off with Dr. Brown. First of all, Senator Kennedy, I think that in response to your question about the doctors of New York compared with the doctors of California, I want to assure you that our physicians will be as aggressive and effective in pursuing fees under medicaid and medicare as the people in California; you will not have to bow your head in shame in that regard.

One of the problems that we have in New York City is that there has been a great deal of foul-up in payment of doctors, and for that reason the evidence is not all in but I would point out to you that if someone wanted to devise a program to encourage a doctor to delinquency, to encourage him to think more about fees than about care, then medicaid and medicare were almost created with that view in mind.

As a matter of fact, the position of organized medicine in the State of New York, in my view, has been disastrously antisocial.

Every attempt which has been made to link standards of quality to fees, has run into organized medicine's resistance.

The medicaid funds are spent on behalf of the most needy part of our population. They are the ones who have the greatest difficulty in finding thier own way through this complex business of getting medical care. Is it not reasonable that those who are responsible for these funds ought to see to it that the money is spent for appropriate kinds and quality of service?

Senator SMATHERS. Doctor, may I interrupt you right there because I am naive about a lot of this business.

Dr. CHERKASKY. I doubt that, Senator.

Senator SMATHERS. I am. I would like to have you explain to me a little bit further why it is that you think that this program that we had hoped would be at least part of the answer to the problem of lack of medical care for the aged has not worked. In other words, you said if you could think of anything that had worked the wrong way, it was this program of medicare and medicaid.

Dr. CHERKASKY. I am talking primarily about the payment for doctors' services. I think the part such as the hospital part is excellent. I think the breadth of the medicaid program is superb, but I think that when we get to dealing with the payment of the doctors we don't do what is in the public interest; we respond to the enormously effective pressure of the medical lobbies.

We know from previous experience, Senator, that fee-for-service produces unnecessary utilization. The woods are full of figures and facts from the United Mine Workers program, from all kinds of studies, that the fee-for-service arrangement produces unnecessary services and surgical procedures.

Senator SMATHERS. I can ask you right there: Then as far as I gather from what you are saying, your criticism is not directed at the program per se of medicare or medicaid; you narrow your criticism down to the fee-for-service, to that particular section of it?

Dr. CHERKASKY. That is one of my criticisms with regard to that program, but of course you know——

Senator SMATHERS. Can I just stay on that a moment because Senator Kennedy said we might be able to do something about that particular facet of the medicaid program. What is it right in that field that you object to so much?

Dr. CHERKASKY. I think that when we set up money arrangements, we have to examine what direction that money leads to, and I think we have got to be very hard and tough about it and not depend upon the so-called ideals of any profession or any group.

FEE-FOR-SERVICE MECHANISM

I used to believe, once upon a time, that everybody did right because it was right, but you and I know it does not always work out that way. When you set up a fee-for-service mechanism, you are encouraging the practioner to provide more services and to collect more and higher fees, and I would say to you the fact that in the last 2 years doctors' fees have gone up more than in many years before, about 15 percent is a very simple response to the fact that there is medicare legislation

and medicaid legislation which means that while they knew before these people could not pay those fees, now there is somebody who can pay these fees so you are going to have higher fees and you are going to have more fees.

I would not mind that so much but I don't think we are getting our money's worth.

Senator SMATHERS. In other words, you are saying that there was a catchup feature as Dr. Brown testified that was needed originally, or are you saying, and as you suggested, that because somebody could pay, it was possible for them to get a maximum amount of money even though they were not deserving of that high a fee?

Dr. CHERKASKY. You know, Senator Smathers, the American Medical Association told its physicians under medicare not to accept assignments. By an assignment the doctor would then agree to accept what is the reasonable fee in his area. Say it is a $10 fee, the Government would pay $8 and the patient would pay $2. By not accepting an assignment, and they say they don't accept assignment because of some so-called hallowed relationship between patient and doctor, how that is favorably affected by squeezing a fee out of a patient I have never understood; but by not accepting an assignment, they can charge the patient anything—$20. The patient will only recover $8 and have to pay the difference.

In addition, we are talking about older people. One of the reasons we have medicare is because they don't have the money with which to buy these services. By refusing assignments the older patient's limited income is required to pay the doctor and then recover from the Government; this is a severe burden.

Senator SMATHERS. Now then, my final question on that point would be: Does the fault lie with the legislation or does it lie with the doctors?

Dr. CHERKASKY. I think it lies with the legislation. I think we have to take into account some of the realities of life, and I think we have to set up our money to produce the kinds of qualities and the kinds of relationships between patients and doctors that we want to foster.

You know, in response to the question that you ask and that Senator Kennedy asked, too, I would like to say a further word about the doctors. I agree with Dr. Brown that one of the fundamental things that we have not done is reorganize and restructure our medical care services in some logical fashion so that we then could pour money into a reasonable structure.

What we have really done is taken a structure in medicine in this city and in this country so chaotic that in my view it is almost hard to believe that it happened accidentally, and all we have done is to pour huge additional amounts of money into this chaotic structure.

In my view, the key to this is still the physician. I think we need a new structure, but I would also tell you I think we need huge additional numbers of doctors. I think we need more doctors because I don't think there are enough doctors to go around and do the job. I also think that we need enough doctors so that we are going to be able to deal with them in some kind of a reasonable fashion.

I might say to you that I had not intended to do this but I have a quite specific proposal for you. We have about 100 medical schools in

this country turning out about 9,000 doctors or a few less than that annually. As you probably know, to fill out our inadequate number of doctors in this country, to keep the present adequate ratio of doctors to a growing population, 20 percent foreign-trained physicians are licensed every year. In other words, the United States is a debtor nation with regard to physicians.

Senator SMATHERS. Do you think that doctors of the Medical Association of New York would allow these foreign doctors to come in and practice?

Dr. CHERKASKY. Well, they do in the State of New York because if we didn't we would be in real bad shape.

Senator SMATHERS. I regret to say that in my State of Florida——

Dr. CHERKASKY. Well, they are tougher.

Senator SMATHERS. They just won't let them come in. We need them badly. They are Cubans who have been run out of Cuba by Castro and are very well qualified doctors, but the medical profession just adamantly stands there and says, "You cannot practice here."

100 ADDITIONAL MEDICAL SCHOOLS PROPOSED

Dr. CHERKASKY. I think, Senator, that obviously qualified people ought to be encouraged to come here from any place. We think we have the best medical education in the world and for us to be a debtor nation and to be short of doctors is, in my view, a national disgrace.

We have heard about various solutions. First of all, some people don't want to face up to it and they talk about training subprofessionals and about all other ways of doing it except adding more doctors and more nurses. I believe we need subprofessionals. I believe we need to use doctors and nurses much more effectively, but I also believe we need huge additional numbers of doctors and nurses.

My own thought is that we ought to, in the next 10 to 15 years, create 100 additional medical schools, increase the numbers of physicians that we turn out from 9,000 to 20,000. We need to subsidize those people who go into medicine, because, as you know, one of the reasons for the characteristics of medicine is, 50 percent of all the physicians come from the upper 12 percent of the economic population, which means that this profession is really not representative of the society as a whole.

We have magnificent talent in the underprivileged areas of this country who could make a contribution to medicine if medicine was a profession which they could even hope to enter, but you know what an obstacle course it is educationally and financially. I believe that everybody who goes to medical school ought to be fully subsidized.

Senator SMATHERS. Do you mean fully subsidized while he is in medical school?

Dr. CHERKASKY. Yes.

Senator SMATHERS. And while training?

Dr. CHERKASKY. Yes.

Senator SMATHERS. The subsidy stops once he finally finishes his training?

Dr. CHERKASKY. Right.

Senator SMATHERS. All right.

Dr. CHERKASKY. I have done some very crude figuring on this. It is my estimate that if we were, when the program is in full swing, to spend a billion dollars a year, with that billion dollars we would create medical schools, create the teaching staffs that are necessary for those medical schools, subsidize every single student in medical school in the United States, change the character of medical education to produce physicians more in keeping with the social goals of the society and really solve this problem.

I must say to you we have a lot of other things that we need to do—legislative changes and so forth. In my view, if we don't get to that core problem, I don't think we are going to have the medical care not only for older people but there is much to be desired in the care that is given to people who pay their own way.

Senator SMATHERS. You go ahead with your statement. We have some other questions I want to ask you but we also want to get that in because it is an actual statement.

Dr. CHERKASKY. It is brief.

I appear before you today as a long-time proponent of the financing of health care for the aged through the social security system. What I say here should in no way imply that I do not consider this legislation seminal and revolutionary. At long last we have a commitment of social policy on the part of the Congress that at least for the aged, the Federal Government has a crucial role, to play in the financing of health care services. This achievement is not to be underestimated. This is not to say, however, that all is going well with this program; this is not the case.

I might say initially that part A of title 18 has been the most successful component of this multifacted program. Hospital care is being rendered to the aged of our community as a right and has relieved those persons from a terrifying burden. On the whole, hospitals are now on a firm, viable financial footing for the first time in their history.

The program has had a salutary effect on standards of hospital care, especially in its insistence on utilization committees and review. In our own institution, we are expanding the function of the Utilization Review Committee to encompass the whole area of medical audit and quality control—something we have long wished to do.

INADEQUACIES OF PART B—MEDICINE

I would be less than honest—which I never am—if I did not indicate that my early uneasiness about part B of title 18 unfortunately has been confirmed by experience with it. I am convinced that in the vital areas of quality, utilization, and costs, this aspect of the medicare program has significant inadequacies.

Members of this subcommittee, I am sure, realize that this is an open-ended program with no quality controls.

By the way, Senators Smathers and Kennedy, it is interesting that Senators fought tooth and nail; we finally did something about laboratories but only with great difficulties, Senator Kennedy.

There is very little control of utilization and, as it has developed, insignificant control over charges and costs. You know the figures on increased physician charges as well as I do. The program is fragmented,

covering many services, it is true, but not covering others. The increased physician charges plus lack of comprehensiveness, capped by deductibles and coinsurance, have vitiated the impact of this program for the aged patient.

A recent report from the Social Security Administration indicates that in a random sample, only 52 percent of the costs incurred for medical services covered under part B is potentially reimbursable to the aged.

You know, all of us, and you talk to the older people, thought that part B was going to pay for medical costs, for doctors' costs. When one considers the hospital benefit deductible and coinsurance, the lack of coverage for drugs and dental care, it is safe to say, I believe, that less than 50 percent of the total medical-care costs incurred by the aged are being covered by title 18, parts A and B. This is a far cry from what we thought we were doing with this legislation.

The main message, however, that I wish to bring to your attention this morning is one of principle and concept. Structurally, the fundamental defect in title 18 is the separation of part A and part B. This separation is unfortunate not only because of its administrative difficulties which have turned out to be legion but because it has tended to freeze existing modes of medical practice and prevented major innovative developments in the delivery of health services.

We at Montefiore Hospital believe that medical care is a continuum; that the hospital should be the core facility for the delivery of health services to the community—preventive, treatment, rehabilitative, for both the vertical and the horizontal patient. Ambulatory services should be physically or functionally related to the hospital on the basis of prepaid group practice.

Dr. Brown said something that was so true: The cost of hospital care is escalating and is going to soar even more. Our costs at Montefiore will be higher in 1967 than they were in 1966, and in 1966 they were 15 percent higher than they were in 1965. One of the reasons they are higher is because medicare and medicaid have poured huge new amounts of money into a medical establishment with the same number of personnel. We had a radiologist who in January 1965, 20 months ago, was receiving $14,000. I now pay him $29,000 because I have to pay him that or I can't keep him.

Senator SMATHERS. Does that not result from the shortage of radiologists?

Dr. CHERKASKY. A lot of money and not enough people. That does it in every economic area.

Ambulatory service should be prepaid group practice. That is one method we know cuts down on hospital cost because it cuts down on hospital groups. We have a medical group that provides care for 20,000 people. Those people use 20 percent less hospital days than if those same people are cared for in this town by doctors who are on fee-for-service.

We have $350 million Blue Cross in this town. One-fifth of that, $70 million, is not hay, and that is the kind of reward that we could expect of all practice in New York City on an organized basis. That is the only way for modern medical care to deliver.

Senator SMATHERS. May I ask you a question there, and I agree with that. How do you get these doctors to participate in this? That is what I don't understand.

Dr. CHERKASKY. This is one of the things I am talking about when I talk about doctors in sufficient supply so we can deal with them. I say to you, when you have a profession that is in such enormous demand and where the supply is short, they are not very susceptible to the needs and desires of the society. I don't think we can afford that any longer.

A SPECTRUM OF FACILITIES

We also need, as a part of this whole spectrum, extended-care facilities, nursing-care, home-care programs; all should be coordinated and integrated in the hospital. We don't just talk about this in philosophical terms. The Montefiore Hospital, while we have not gone as far as we would like, has a group-practice unit, has a home-care program which it pioneered over 20 years ago; it has a nursing home, it has a recreational facility, it has relationships with nursing homes around us where we provide medical supervision. We are the institution that you refer to that created the OEO program that you are going to be seeing this afternoon.

So the things we are talking about, coordinated medical care centered around the hospital, is not a figment of the imagination despite the fact that we have had to piece the moneys together from a thousand different sources we have it in operation. It can be done. If we set up our money in a way to encourage this, I think you could have this all over the country.

It is our firm conviction that this concept of hospital care is the best method of insuring high-quality, comprehensive service to the aged and to the population as a whole, while at the same time it shows the most promise for moderating or controlling medical-care costs.

The separation of doctors' services from hospital services, the support which part B—by the way, the way it is set up, our group practice is in jeopardy. I won't go into that with you now. Our group-practice activities are being menaced by this particular undertaking because it is set up in such a way that it is going to pay us to go to fee for service.

Senator SMATHERS. This would be radical if we ever did this and I am just merely throwing it out to get your thinking: Should we—Senator Kennedy and I and other legislators—change the law to say that there would be no doctor who would be eligible to receive a fee unless he participated in group practice?

Dr. CHERKASKY. I would say to you, if you do that at the moment—you would not have any care. There are realities we must face. I would say to you, while I think it is possible with ingenuity to reward the kind of practice which is going to accomplish our goals, we are not doing that.

Senator SMATHERS. Can you tell us what that ingenuity would be? We are looking for that.

Dr. CHERKASKY. I will tell you, for example, that we now have in our group something like 4,000 people over 65. If the mechanisms were worked out whereby we would be able to receive what we need for the care of those patients by an overall payment rather than by a fee-for-service arrangement, we would jump at it and it would, in my view,

still be less money than you would pay us for the care of these 4,000 patients if we go on fee for service.

We can get the money we require and more for fee for service, but we cannot get the money by capitation, which means, in fact, you are going to drive people who want to be in prepaid group practice out of it.

I would say to you that I think that every place where you could provide payment on an annual-premium basis, the Government would get more care for less money without any question.

The lack of comprehensive care under part B, the difficulties which group practices like ours have in maintaining the capitation system of payment for doctors—all have the effect of preventing the movement toward the creation of the hospital as the central resource for the delivery of health services in the community and hold back the development of group practice.

Difficulties in Experimentation

It would be wrong to assert that it is impossible to develop such a program under the existing legislation. My point, however, is that the existing legislation makes it extremely difficult to experiment with new methods of delivery of health services.

We went to Social Security before the medicare law was in effect and said, "Why don't you provide for overall payment to provide for home care, doctors' care, diagnostic care, nursing-home care, and let us experiment and see how, by using these various interrelated facilities, we can come up with the best package of care at the least possible cost?" They were unable to do this.

I understand that now hopefully some of the changes which are being contemplated will not force us to do what we have been doing so long so wrong but will enable us to begin to experiment in these new ways of bringing services together.

Just a word about medicaid. Ironically this program has the potential to provide significantly more comprehensive service to the aged than title 18, as you know, with general care and drug coverage and things of that sort. Practically speaking, however, our experience in New York City with this program up to now has not been a happy one.

First and foremost, there have been no quality standards for doctors. Every time we wanted to talk about that, the doctors wanted to talk about fees. Secondly, there has been little control, if any, over doctors' fees and services under the program. And as yet, we have not seen any significant improvement in ambulatory services of hospitals, both municipal and voluntary, as a result of a vast infusion of new moneys.

I do not presume to say that this improvement will not come. However, at the present time my impression is that medicaid has meant more money for doctors and more money for hospitals without any significant improvement in the quality of service to the public.

Senator Smathers. All right, sir. That was a strong, hard-hitting statement.

(The chairman addressed the following questions to Dr. Cherkasky in a letter written after the hearing:)

1. On page 39 of the transcript you said that Medicare should help "produce the kinds of qualities and the kinds of relationships between patients and doctors that we want to foster." Later you and Dr. Sheps touched upon the need for quality controls under Medicaid. I would appreciate your giving me an additional statement on: (a) your suggestions for legislative changes that would improve the quality of care and (b) specific information on the way in which quality standards could be imposed.

2. Your proposal for 100 additional medical schools for fully subsidized students also calls for additional discussion. Would you care to give a supplementary statement on the need for such action and on the details of your proposal?

3. You say on page 1 of your statement that Part A of Title 18 has helped put hospitals "on a firm, viable financial footing for the first time in their history." Are you in agreement, then, with current reimbursement policies to hospitals under Part A?

4. Your comment about the need for "coordinated medical care centered around the hospital" leads me to ask for your suggestions on Federal action intended to encourage development of such coordinated services. Your complaint about having "to piece the monies together from a thousand different sources suggests that you now encounter grave difficulties. Will the "Partnership for Health" legislation be of help in this area?

5. May we have additional discussion of your proposal (p. 49 of transcript) for payment on an annual premium basis, and the likely effect such an arrangement would have in helping you to experiment with new methods of delivery of healthy services?

(The following reply was received:)

In response to your letter of October 27, I am pleased to provide further amplification of my views on certain matters which I brought up in my testimony before the hearing of the Subcommittee held in the Bronx on October 19, 1967.

Question 1: You asked for suggestions concerning legislative changes that would improve the quality of care to patients through Medicare or Medicaid and also, specific information as to the way in which quality standards could be imposed.

The main thrust of my testimony I believe was that it is difficult to deal with the problems of quality care in the community with the existing open ended fee-for-service system under Part B, and for the most part under Medicaid.

As I see it, in New York City and New York State, legislation and regulations as now exist provide absolutely no quality or utilization control that government can exercise under Part B of Medicare. The only requirement for rendering medical care is for a physician to be licensed.

Medicaid, or Title 19, gives the individual states considerable leeway in establishing the quality controls. In New York State there is apparently some control over specialty practice but at the present time there is very little or no control over the private practice of medicine on a general practice level. Some kind of continuing education for the physician will be required around the middle of next year.

The entire matter of quality of medical care especially in physicians' offices is an extremely complex one. In fact, one of our initial tasks should be to further study how we can check on the medical quality in doctors' offices.

Quality Evaluation Techniques Available

There are now at hand very adequate techniques to check on the quality in organized systems of care, i.e., in hospitals, nursing homes and other such institutions, in outpatient departments and in group practices. There is, however, no reasonable technique which would enable us to know of all that goes on within the doctor's office. Yet this is where the bulk of medical care services in this country takes place.

We do not, however, have to wait for the development of new techniques to bring institutional and organized medical care under appropriate continuous audit. As a matter of fact, since there is a great interplay between office and institutional practice, if we were to bring our institutional practice standards up to an acceptable level, we would have a greater impact on practice in the doctor's office. I will only touch on some of the steps that might be taken. To cover this adequately I would have to write a book.

The basis for quality care is related to the specialization which has occurred in medicine in the past 35 years. While specialization has created some problems of fragmentation of patient care, it has clearly enabled us to bring to bear on the patient a level of scientific skill of a very high order. If we were able to secure for every person in the United States the services of a Board qualified specialist to deal with the major medical events in the patient's life, we would have enormously improved the quality of medical care, at least with regard to serious illness.

How can this be reflected in legislation? Provisions for payment could require that major surgery only be paid for if carried out in an institution fully accredited by the Joint Commission on Accreditation and carried out by a surgeon who is either Board qualified or Board eligible. This should be a federal requirement with the provision that if local circumstances make it impossible to fulfill this provision in one specialty or another, the states would have the right to waive. There also should be quite different payments where waiver has been found necessary. In other words, a gall bladder removal by a qualified specialist should be paid for at a significantly higher rate than by a general practitioner.

That these standards have practical consequence can easily be demonstrated. It has been reported that not fully qualified people operating on cases of cervical cancer produce a 50% cure while such cases, operated on by fully qualified gynecologists, produce an 80% cure. Can we afford to allow for that 30% difference in life? Incentives could be further built in to help and encourage communities which now have surgery by not fully qualified surgeons to move in the proper direction.

Where a person whose medical care is paid for by federal funds, in whole or part, has a major diagnosis of heart disease or cancer or diabetes, or a whole host of other serious illnesses and where the physician who cares for this patient is not, by his training, fully qualified, a consultation with a qualified specialist should be required.

One of the serious problems we have in maintaining the quality of medical practice is that many physicians have either no hospital appointment or have appointments in institutions which, while they are called hospitals, do not have any of the hallmarks and the institutional regulations which would limit the doctor to doing those things of which he is capable and which would also act as a source of continuing education for the physician. In due course, federal funds should only be paid to those physicians who have active appointments at hospitals which have the hallmarks which I have noted above.

If you require any evidence that practicing physicians, both within their offices and within the institutions that many of them work, practice medicine unacceptable in the light of our present scientific knowledge and capacity, we can document this from our own experience at the Teamster Center at Montefiore Hospital and in the two surveys of Teamster quality medical care carried out by the Columbia School of Public Health and Preventive Medicine.

In the long run I believe that the solution to quality in medicine must be achieved in another way. We must have a network of interrelated community hospitals, teaching hospitals and medical schools. These hospitals must have community rather than institutional goals. The area of hospital responsibility would not be only to the inpatient but must also include broad responsibility within a geographic area for the medical care of the community. All doctors within this area should serve the community as part of the hospital staff. In this way, we would have a structured mechanism whereby the doctor, under supervision and with accountability, does only what he is fully qualified to do and the patient does not suffer because of the limitations of any single doctor since there is available for his immediate care all of the institutional and extramural resources he requires. I am attaching a copy of a paper I gave at the New York Academy of Medicine which provides a schematic proposal for organizing urban medical care.

Question 2: The overwhelming need for additional physician manpower is now generally recognized by all students of the problem. The American Medical Association until recently resisted this conclusion. Now even they are convinced that there is a serious shortage of physicians serving the community.

It is my conviction that we need double the number of physicians we now have. At the present time there are in the country roughly 300,000 physicians, or a ratio of 153 per 100,000 population. It should be noted, however, that roughly 50,000 of these physicians are inactive or in hospital administration, teaching and research. Moreover, almost 20% of the doctors we license each year are foreign trained. It has been estimated by the American Medical Association that 13%,

or 40,000, of the licensed physicians in this country are graduates of foreign medical schools.

I would think that public policy in this country should aim for 600,000 practicing physicians by 1985. The increased demand for health services, the serious unmet need for medical care which is becoming increasingly apparent each day, the increased cost of health services—all suggest tremendous shortage. Further, the development of new forms of medical practice and of innovative structuring of the health care system will become much more feasible and practical if physicians are not in such obviously short supply. Finally, it must be remembered that increased specialization of physicians has resulted in a marked decrease in the number of physicians available for primary family care. In this connection, a table from a recently published study of "The Doctor Shortage" by Rashi Fein is particularly revealing:

TABLE III-4.—FAMILY PHYSICIAN POTENTIAL (M.D.), SELECTED YEARS

Type of private practice	1931	1940	1949	1957	1965
Pediatrics	1,396	2,222	3,787	5,876	9,726
Internal medicine	3,567	5,892	10,923	14,654	22,432
General practice	112,116	109,272	95,526	81,443	65,951
Total	117,079	117,386	110,236	101,973	98,109
Total per 100,000 population	94	89	75	60	50

It has been said that we will never have enough physicians and therefore we must develop paramedical or ancillary personnel to do a variety of tasks that physicians now are doing. I believe that we should use other health professionals in the most creative way possible and that medical practice must be structured so that the physician's time and energy is most productively and effectively utilized. However, this should not be used as an excuse for the richest country in the world to shirk its responsibility to do what it certainly can do—and that is, to produce an appropriate number of physicians to serve the health needs of the population.

For the United States to have 600,000 practicing physicians by 1985 is a tremendous challenge but I believe that it can be done. Studies now suggest that by 1975 we will have about 365,000 physicians in this country. In order to have close to 600,000 practicing physicians by 1985, we will have to graduate roughly 20,000 doctors a year between 1975 and 1985. We now graduate about 7,900 physicians per year. This means then that we must increase the number of our graduates by two and a half times.

Based upon current figures, we calculate that it will take about $5,000 per year to educate a medical student. Therefore, it would cost $400,000,000 a year for the education of 80,000 medical students, i.e., 20,000 in each year of the four years of school. Further, subsistence of $4,000 for each student would cost an additional $320,000,000 per year—for a total of $720,000,000.

To do this job we would probably need 100 additional medical schools. (At the present time there are in this country a total of 102 schools in operation or in some stage of planning.) Construction of a medical school and teaching hospital is now estimated to be roughly $50,000,000. Therefore, the total needed for medical school construction would be Five Billion Dollars ($5,000,000,000.)—or Five Hundred Million Dollars ($500,000,000.) each year for a period of ten years.

Adding this $500,000,000 to the $720,000,000 necessary for the education and subsistence of the students, the total estimate for the cost of this program would be about One Billion Two Hundred Twenty Million Dollars ($1,220,000,000!) per year.

These calculations are rough and will undoubtedly require further refinement and study. Nevertheless, I believe they substantially reflect the magnitude and dimension of the need and the cost.

I am convinced that the financing of this program is a public and government responsibility. I believe that all qualified students of whatever social class or ethnic group, should be able to secure a medical education. There should be no financial barriers to such an education and as a matter of fact, we should follow the example of most western countries where medical education is totally financed by government.

Question 3: For many years hospitals were under-financed. Wages and salaries were unconscionably low. Many hospitals had insufficient funds to develop new and necessary programs. Hospital physical plants especially in urban areas, have been and are in a serious state of deterioration. Yet the explosion of medical science is continuing and in fact hospitals are able and required to do more and more for people with consequent increased costs and expenditures.

By paying hospitals reasonable costs, the federal government, through Medicare and Medicaid, has for the first time put the hospitals of this country on a firm and viable footing financially. This is to be applauded. There was, therefore, every reason to expect that due to this vast infusion of new money, hospital costs would rise. I am convinced that the rise is due substantially to the ability of the hospitals now to begin to pay adequate wages and develop programs and facilities long needed.

This is not to say, however, that all money in all hospitals is being expended responsibly and in the community's best interest. Under an open ended cost reimbursement formula, the certainty of inefficient use of funds clearly exists.

One of the things that must puzzle the layman is why one institution which calls itself a hospital has a $40 per diem cost while another institution has an $80 per diem cost. The same patient may by the choice of his physician, be in either one or the other hospital for his condition. What, in fact, does this difference in cost mean and indeed, should we not adopt the policies of the $40-per-day hospital for everyone?

Variations in Hospital Costs

It must be remembered that hospital care means very different things just as hotel care does. You can get a bed for $1 a night in urban slums or pay $25 or $30 for a luxury hotel. If both the $40 and $80 per day hospitals are operating equally efficiently, the $80 a day hospital then clearly must represent more services and programs than the less costly hospital. You will find that every illustrious institution in this country—illustrious because of its reputation for high quality care and for teaching—counts itself among the high cost hospitals. The hotel services which the hospital renders are the smallest part of the cost. There are marked differences between a top-notch x-ray department, staffed with superb physicians and modern complex equipment, than an x-ray department which does not have these characteristics. The same could be said for the laboratories, operating rooms, recovery suites and for the educational programs.

This does not mean that any hospital's per diem, whether it be $40 or $100 per day, should be accepted at face value as representing high quality care. However, before restrictive formulas are placed on the rapidly escalating hospital costs, very careful examination must be made of these different categories of hospitals to determine whether in the social interest these differences in costs are legitimate and desirable. Therefore, while I would certainly agree that open ended reimbursements are an invitation to inefficiency, I also believe that we need some hard data concerning the operations of various types of hospitals. The important overriding factor must be the quality of care and the program of the individual hospital. I am convinced that at the present time, in most instances, the community is getting more for its money from its high-cost hospitals than from its low-cost ones.

Question 4: In a sense the answer to this question is very much like my answer to question 1, concerning quality of medical care. Coordinated medical care centered around the hospital, it seems to me, should be the direction toward which all federal and local programs in health should be directed. Quality of care can best be achieved through this coordination. It will also result in increased efficient utilization of all services and this would surely lead to economic use of available resources.

In terms of the existing Medicare program, I might say that elimination of physician services in hospitals from Part A is a very serious defect. It makes the delivery of medical care services to the community, by and through the hospital, extremely difficult. Therefore, an initial, practical step would be to allow Part A to pay for physician services located at the hospital.

It seems to me that in any new programs for hospital construction which the Federal Government will undertake, there should be markedly increased funds for the development of coordinated health services, i.e., group practice and community health centers around the hospital. Standards developed at the federal and

state level for the recipients of federal funds for hospital construction should demand that such hospitals provide a broad spectrum of care including extramural services such as comprehensive ambulatory care services, extended care services and home care.

I believe that Partnership for Health legislation is a great step forward. If properly done, it will permit for the first time some kind of coordinated and integrated planning for health services on a regional and community basis. It will also provide some modest amount of funds for individual agencies to develop certain new service programs.

True, we have in the past encountered some grave difficulties in dealing with the multiplicity of federal funding programs. The multiplicity of agencies that fund for health at the federal level is overwhelming. This past year we attempted to get federal funds for the construction and operation of an ambulatory center in the South Bronx and we failed even though there was goodwill and cooperation on the part of all federal agencies involved.

It seems to me that major institutions embarking on significant health care programs on a community should be able to approach one agency in the federal government to receive an appropriate amount of money and support. It could be that the partnership for health legislation will eventually be able to provide such an opportunity. The major thrust of the program, however, is on coordinated planning. At the present time I believe it is questionable whether it will solve the problem of direct, single-door funding for a complete program, from a single federal department to a single provider of service.

Question 5: It is becoming increasingly obvious that the way services are paid for has direct and immediate implications on the way services are delivered and organized. There is really no such thing as just a program for financing health care. Part B of Medicare, although making specific allowances for prepaid group practice, really is a payment system designed to expand and enrich solo, fee-for-service practice. In one stroke it effectively sabotages the movement toward broad, comprehensive total coverage for the aged. Among its major defects is the lack of payment for preventive health examination. Further, it separates doctor services from hospital, from extended care and nursing home service. Payment is made to physicians on the basis of charges or fees, and to institutions on the basis of costs. The aged patient is confused and harassed my deductibles and co-insurance.

It is my thesis that if a hospital like Montefiore could be paid in annual capitation on the basis of actual costs incurred in rendering total comprehensive care services to a given population, the services would be of high quality and the cost to the patient and to the Social Security Administration would be measurably less than the exiting fragmented method.

Paradoxically, we who are committed to this type of program are being forced in the operation of our own Medical Group to the fee-for-service payment for those over 65. It is estimated that on the current capitation that we receive from the Health Insurance Plan for the aged, we lose $35–$40 per year per patient. Since we have approximately 4,000 patients over 65 in our group, this could come to $140,000 a year. It is possible to receive this income and more if we were to transfer these patients to fee-for-service under Part B. It would not only cover our costs but under the existing fee schedules, it would be possible to receive substantially more income for the care of these patients.

The point, I believe, is a simple one. Even agencies strongly committed to the capitation system in principle are being forced to consider fee-for-service system which will most certainly result in increased expenditures on the part of government. My plea here is that, at least for demonstration purposes, an institution like our own and others with similar capacities should receive a single overall payment for an identified population. We would then use the Hospital, our Loeb Extended Care Unit, our affiliated Beth Abraham Custodial Home, our Home Care Program, our Group Practice unit and the other ambulatory service facilities in the most efficient and economical manner designed to meet the patient's needs. I will state flatly that such flexibility will produce better medical care more economically than the care obstructed by the present restrictions in Part A and Part B. Indeed, it might be said that Parts A and B were set up to satisfy the providers of service rather than the patients.

Sincerely yours,

MARTIN CHERKASKY, M.D.,
Director.

Senator SMATHERS. Dr. Sheps will now be heard. We will be very pleased to hear from you, sir.

STATEMENT BY DR. SHEPS

Dr. SHEPS. Thank you very much, Senator Smathers. My comments are directed perhaps narrowly to the problem of health services to the aged in terms of their organization. Having been privileged to listen to the discussion up to this point, I would like to preface my remarks by saying that I believe, sir, that what we need to do, in addition to vastly increasing the supply of personnel, is to face the fact that the solutions lie in a series of confrontations—confrontations between methods of payment and confrontations between different methods of providing care. These two are closely related.

I would say that while there certainly is disturbing evidence that there are physicians who take advantage of the fee structure in the manner in which Dr. Cherkasky has described it, I think there is still another way to look at this fee-for-service method, and that is to evaluate what it means if the physician, under the present scale of fees, or the surgeon, spends a full day doing the things that ought to be done for his patients and to determine the annual income he will have under those circumstances, ruling out completely the possibility that he may be doing certain things because there is a fee in it.

Have him spend his whole day working as he should, doing what is needed, and see what income level he will be. Will he be equal to the captain of industry, will he be at the level of the President or a Senator of the United States, or will he be at the level of a college professor? I think this is a pertinent approach to this matter; and, as others have said, the evidence is in.

The second confrontation I would like to mention, sir, before I read my statement or answer your questions, is the confrontation in the organization of care, and it is to that point that I have some recommendations to make in my statement. Shall I proceed?

Senator SMATHERS. You go right ahead, sir.

Dr. SHEPS. My remarks will be based primarily upon the experience that I have had at the Beth Israel Medical Center in New York and also upon observations I have had the opportunity to make in other parts of the United States as an administrator, a consultant, and a researcher in the organization and administration of medical care.

In the various units of the Beth Israel Medical Center, we are now treating over 100,000 patients per year. A little more than two-thirds of these patients are being treated on an ambulatory basis.

Ambulatory care is of crucial importance in providing modern medical care for older people because their problems are predominantly those of chronic illness which needs to be forestalled, discovered early, treated effectively and followed consistently, all within the framework of a program that provides comprehensive care, with appropriate general hospital backup facilities, and continuity of responsibility for the total care of the patient.

GOUVERNEUR HEALTH SERVICES PROGRAM

In our Gouverneur health services program—to which Dr. Brown referred and in which he was the leader—in the lower East Side, where

we serve a large indigent population with a substantial proportion of old people, we are now treating a total of 40,000 people per year who make over a quarter of a million visits.

This program has been in operation for 6 years and has attracted a great deal of attention because it has demonstrated that modern care, incorporating the principles of group practice and the latest scientific methods, can indeed be provided to poor people in an atmosphere of warmth and friendliness with due attention to their dignity as human beings, and may I add, sir, at a reasonable and predictable cost.

In the Outpatient Department of the Beth Israel Hospital, we have completed a little more than 1 year's experience with a pilot program in comprehensive care which incorporates these same principles. These principles are now going to be implemented throughout the entire ambulatory care activities of this general hospital.

A number of conclusions emerge regarding the health needs of the aged:

1. The advent of medicare and medicaid has clearly been helpful. Even though there are still administrative problems to be ironed out in this payment program, there can be no question that this has and will facilitate care. The question that does arise, however, is the kind of care that will be provided. Now that we have taken a giant step in the organization of payment for care, this must be matched by appropriate changes in the organization of care itself. The fact the cost is being borne by Government agencies provides an opportunity that should not be missed in setting appropriate standards of performance and achievement.

Senator SMATHERS. May I interrupt you right there? I like what you said there so very much that I would like to ask you this question: Is it the responsibility of the Congress and the appropriate agencies of the State government and the city government to do anything other than the organization for payment for care, as you call it, and you say it must be matched by the organization of care. Now how far should we go, and what is it that we should do as Members of the Congress other than just make available the organization for payment? We can appropriate the money. Beyond that, what should we do?

Dr. SHEPS. Sir, I think you have a real and inescapable responsibility to concern yourself with the specifications of what you are paying for on behalf of the people of this country, and the specifications can be clearly delineated. It is not enough to say that people will meet certain qualifications of training and experience.

I suggest that methods of performance—we know a lot about this now—methods of performance can be delineated and measures of achievement can be implemented. I would say that it is no different than the specifications that the GSA puts out when they spend billions of dollars on hard goods that one buys.

Senator SMATHERS. Doctor, do you or Dr. Cherkasky, or any of these other eminent physicians here, have any list or set of specifications that, for example, we might use and deliver to the Department of Health, Education, and Welfare?

Dr. SHEPS. These are in the literature; this is not a vague, ectoplasmic area. There is literature in this field, there are departments in universities that work on this all the time, and there are programs of medical

care in this country that have adopted these standards of performance and achievement.

Senator SMATHERS. I want to ask you one other question in this connection. Do you think that what you are stating here this morning is the opinion and the judgment of most of the medical profession?

Dr. SHEPS. No, it is not. It is the opinion and the judgment of an informed minority of the medical profession. [Applause.]

May I say that it is interesting, however, to recognize that what I have reference to has been adopted in the best hospitals of this country. There is a precedent of longstanding progressive development in the general hospitals of this country that have adopted programs that require physicians to adhere to standards of performance and achievement. Also, they have methods of evaluating this and there is a long experience.

What we don't have as much experience with is the evaluation of ambulatory care, particularly in physicians' offices.

Senator SMATHERS. All right, sir. Thank you. Go ahead.

FRAGMENTATION OF SERVICES

Dr. SHEPS. The second point that emerges is that a major problem in health services for the aged is the fragmentation of services. The experience that we have accumulated with group-practice arrangements, organized home-care services, and the extension of services to our patients in nursing homes has clearly established, at least to our satisfaction, that the fragmentation characteristic of much of medical care in this country can indeed be overcome.

3. Many old people, particularly the poor, who live in the slums of our cities, are isolated from adequate medical care. This is so not only because of the fact that Dr. Brown mentioned, that generally the services of physicians and others are not as readily available as in the more well-to-do areas, but also because this important population group has not learned what good medical care means. Therefore they do not have adequate expectations and do not make sufficient demand for the care which they ought to have.

For example, in our Gouverneur health services program, which has a 6-year history, the proportion of visits by people 65 years and over is still significantly less than the proportion this group represents in the population we serve whereas it ought to be greater than others. This is despite the fact that our program has been a very popular one and is being used increasingly every year. We have established a health education program to help solve this problem in our area.

4. We have learned also that the auxiliary personnel, who have learned about the framework of medical care and who understand the social background of our patients, can be extremely helpful to physicians, nurses, and social workers in following through and seeing to it that the plan of medical and social management is implemented fully.

5. We have also learned that social problems have a profound effect upon the ability to implement health measures. Adequate housing and job opportunities are among the examples of this. Therefore, the most effective health program for the elderly should include close, effective, daily working relationships between health and social agencies.

I would suggest that the aim of health services for the elderly must be to maximize the potential of elderly people to live as human beings, as people who present both physical and social functions and needs. And we can do this, if the elderly get the care they need, when they need it, and where they need it—no more and no less.

I think we know a great deal about how to do this, and many elements that need to be put together can be found demonstrated quite effectively in different parts of this country. But it is rare, indeed, if ever, that you can see all of them put together into a meaningful and effective program. There are some good examples in New York, one of which you are going to be seeing today.

While there is clearly more that we can learn about these problems and their solution, I do not think that the implementation of programs should be delayed to await the results of further research. We already know a great deal which has been clearly established which is not yet being widely applied. And, I think it is the broad and full application of what we already know of the confrontations that I described at the beginning that I think needs attention.

Hence, I would respectfully recommend two measures to the committee which I believe would expedite the application of what we already know.

RECOMMENDATIONS FOR EDUCATION, DEMONSTRATIONS

1. Vigorous programs of special health education should be launched to help the elderly understand what they have to gain by obtaining appropriate health services and what these services are.

2. A special program of demonstrations should be launched in various parts of the country to establish clearly for the public, the professions, and institutions involved, what must be done to provide the full range of effective health and social services for the elderly. I would urge that these demonstrations should be carried out, not by grants, but through contracts that are made by appropriate Federal agencies. I make this suggestion because the contract mechanism is the one that has been demonstrated as providing the necessary opportunity for the agency which supplies the funds to see to it that the demonstration carries out the plan that has been developed fully, and therefore is more likely to reach its objective and, further, to insure that it is appropriately evaluated. This is to be distinguished from grants for research projects where this opportunity does not exist.

The lessons from these demonstrations should then be widely publicized to the public and to professional groups and implemented in legislation so that programs may then be launched to provide equal opportunity for modern health services for all the elderly of our country without further delays.[7]

Thank you.

Senator SMATHERS. Thank you, Doctor. [Applause.]

All right. Our next witness is Dr. George G. Reader, director of comprehensive care and teaching program of Cornell Medical College. Dr. Reader.

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[7] For discussion of geriatric clinic at Beth Israel Hospital, see p. 570, app. 3.

STATEMENT BY DR. READER

Dr. READER. Thank you, Senator Smathers, for this opportunity to testify today. I have been director of a comprehensive care program at The New York Hospital-Cornell Medical Center since 1952. This was designed to improve the care of ambulatory patients, children as well as adults, and to provide a basis for teaching medical students the principles of comprehensive health care.

As part of our endeavor, we have engaged in a number of studies and experiments and I want to tell you today about one of our experiments which I think bears on your discussion. This was an experiment conducted in collaboration with the city of New York, departments of health and welfare, and involved approximately 1,700 (1,681) welfare cases. We took people newly enrolled on welfare and divided them randomly into two groups. One group was offered a complete range of services by a group-practice organization within the comprehensive care program at the New York hospital; the other group was allowed to get their care in the usual way on their own.

We have a number of findings from this study that was carried on over a 2-year period of observation and I have broken out some of them that specifically relate to the elderly in that group for today's presentation. I want to make a point, however, about some of the other people as well because I think it bears on your general concern.

There were 2,500 people in the study group that were offered care. All of them did not respond to the invitation to come for care; some continued to go their own way, but they were still considered a part of that group.

There were almost 1,700 (1,685) people in the control group who got their care under the ordinary welfare system.

One of our early findings that we uncovered by analyzing the welfare records was that there was such a tremendous turnover of cases on welfare that over a 2-year period, people could be expected to be off welfare 50 percent of the time. This even included the old-age assistance category, although they were off welfare less than the average.

I think the implication of this is plain because the mechanisms for payment for medical care are only available during the periods when people are on welfare. Title 19 of the Social Security Act has served to attempt to correct this by creating a medically indigent program that will care for our people both on and off welfare.

Our welfare services—and I suspect this is true all over the country—spend 90 percent of their effort getting people off welfare, but this is mainly a bookkeeping operation because they are back on welfare in a few months, and people at this social level obviously do not improve in health during the period they are off; in fact they may often become worse because they are not getting needed services.

We find that many of our respondents, for example, told us when they were off welfare they thought they could not get medical care through the usual offices provided for them; they thought they could only get it if they went back on welfare. We also discovered that this group was an extremely ill group, they were much sicker than the rest of the population. The elderly, as you might expect, were even sicker than the others.

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I think the interesting feature about the finding in this regard was that those 65 and up actually were a little better than the people immediately younger than them. Beginning at about age 45 but particularly from age 50 to 60 people in over 50 percent of the instances complained of symptoms and these when examined turned out to be indicative of serious illness in many cases. So the elderly actually were not in as great need in our study as those who were younger.

Pre-65 Health Difficulties

We have reason to believe from other studies that possibly people in the decade just before 65 are actually going through a kind of crisis where they need help more and that after they reach the point of 65 they enter a more tranquil period. It would therefore seem reasonable that this group just under 65 should have care extended to them which might then make them better in the over-65 period of their lives.

We also found that when people go on welfare, just prior to enrolling they are often quite sick. There is a spike in their symptoms and in utilization of medical services at that point, which suggests that new enrollees on welfare should have a complete medical examination at that time.

We also found, as you might expect, that utilization of medical services was highest in the over-65 patients. Actually, although they were not quite as symptomatic as those a little younger, they made better use of the services. The over-65 people in our population gave us the best response to our invitation. Seventy-five percent of them came and they all were, on examination, quite ill but not as ill as those we examined in the age group just below.

Twenty percent, however, of the over-65 group required nursing-home care during the 2 years that we saw them, so this was a group who had illnesses that not only required admission to the hospital but beyond that really needed prolonged care as well.

Concerning the implications of our findings to the implementation of medicaid, I think the point that I made first that medicaid should solve the problem of welfare turnover is very important. Obviously the level of eligibility at which medicaid is set will make a difference. It should be above the level of eligibility for welfare and perhaps should be as high as in New York State.

I don't want to get into that argument today, but I think that, as has been said by my colleagues, the fee-for-service principle tends to make for more expensive service and essentially rewards the doctor for building up his practice as a piecework operation. It does not reward group practice; in fact it militates against an organized program of services and against preventive medicine.

We were able to give a comprehensive program of services to the people in our study because we had a grant from the Health Research Council of New York City and were able to work out a capitation arrangement with the department of welfare, so we had in a sense a prepaid group practice. It was only because of this feature, however, that we were able to give complete services effectively to the group that we studied.

I think that further experiment is still needed. Dr. Sheps is right when he says the principles of medical care are well understood. There

is a definite body of knowledge about medical services and hospital operations. However, I think the application of the principles is not as well understood and there is a great deal of need still for innovation. There must be some way of financing this that does not put the entire onus on someone's being able to write a proper grant proposal to get the funds, because the people who are innovators and program developers are not always the objective scientists who can write a proper grant proposal and justify their explorations in scientific terms.

Evaluation of Innovations

On the other hand, I think an evaluation of these innovations is essential and a body of methodological knowledge is needed in this area that is not yet available to us and is not available to those in the Department of Health, Education, and Welfare. For this reason the Department of Health, Education, and Welfare does need a health services research center to develop expertise in evaluation which could then be applied to the various attempts at innovation around the country and to the application of recognized medical care principles.

One of the questions that has come up in the past about the sick elderly is that they are isolated from health services. Did our experiment help that? Did we extend ourselves outside of a large medical center? I can say that we did not solve the problem of isolation.

One of the biggest problems we had in fact was that those who lived furthest away were least likely to come. I think the people who live in slum areas need services close to them, particularly old people who have difficulty traveling, and that we must reach out to them. I think neighborhood health projects are certainly one very rational way of reaching out. Other attempts at solving this problem must undoubtedly be made.

I have also been asked about the question of whether medicaid and medicare, because they pay for medical services for the old and indigent, would wipe away the charity image, as I had once hoped. I think that the answer is that it has not yet wiped away the charity image, because medicaid requires a means test and because of it has raised the argument as to whether people have a right to medical care.

The president of the American Medical Association recently stated that people don't have a right to medical care, it is a privilege, and only those who can afford it should have the privilege extended to them. I think this is still a terrible problem in our country of whether we can get rid of the charity image, but I think it comes down to the question of how physicians are paid.

Dr. Brown said that it is easy to get doctors to work in the slum areas. I think he has been lucky so far. I don't think it is easy to get doctors to work in the slum areas. It is not easy to offer them salaries to work when they can make more money in fee for service private practice.

In think the answer to it, though, may be that doctors should be paid in a variety of ways. If you can give them a useful experience, a feeling of satisfaction in their work, you don't have to pay them as much in salary. If we can relate the work they do in a slum area to a teaching hospital where they also get satisfactions from the work they

do there, they may then be willing to work for a salary rather than on a fee-for-service basis.

Fee-for-service medicine is bad for the doctor because it makes him a pieceworker and rewards him for increasing the number of services rather than their effectiveness. If the doctor wants to make more money, under fee for service he will work longer hours and will sacrifice the time available to put into study and the advancement of his profession. [Applause.]

Senator SMATHERS. All right. Thank you very much, Dr. Reader. I appreciate that statement.

(The following are questions submitted by Senator Smathers and replies supplied by Dr. Reader:)

Question #1

I am interested in your observation that "people in this decade just before 65 are actually going through a kind of crisis where they need help more and that after they reach the point of 65 they enter a more tranquil period and that it would therefore seem reasonable that this group would have some way of having care extended to them which might take them better in the over-65 era than they are before."

Are you calling for preventive care programs or health screening intended to deal with illness before it becomes chronic? Have you suggestions for implementing such programs?

Answer

The research has not yet been done to document my suggestion that health care for the symptomatic before 65 might make them better in the post-65 years; a longitudinal study is needed. We do not know that in general the pre-65 patients in the low-income categories are a high-risk group for illness, have many symptoms, and presumably ought to utilize services better than they do. Presumably, if we were more effective in reaching them with preventive and other services, they would be better off. What is needed then, aside from further careful research, is a program of case-finding in the high-risk group. Screening is one technique; another is development of ways to bring these people into contact effectively with the health care system by removing barriers such as payment. Extension of Medicare to cover the below 65 group, particularly the indigent would seem reasonable.

Question #2

On page 65 of the transcript, during your discussion of experimental programs you call for some form of financing "that does not put the entire onus on someone being able to write a proper proposal to get the funds." I would appreciate additional discussion of this point. If the Department of HEW does establish its health services research center, do you think that the center might provide trained manpower capable of giving assistance in grant preparation to doctors and others who have proposals for experimental projects?

Answer

What I had in mind in connection with my recommendations that other mechanisms are needed besides project grant proposals for experiments in medical care was a group of expert evaluators in HEW who could work with program directors rather than write proposals for them. Evaluation is essential, but many of the people skilled in managing programs and in innovating do not have the ability to evaluate them scientifically. Evaluation is also often done better by an outside group who can be more objective. I would visualize the health services research center providing this kind of expertise, and working closely from the beginning with program directors starting new medical care enterprises. The contract mechanism might be used for funding, or the evaluation might be a separate proposition funded by HEW.

Question #3

You and several other witnesses described the satisfaction experienced by physicians who practice high quality medicine even in poverty areas of cities.

Do you see any effective way of giving large numbers of physicians the opportunity to serve in this way as a normal and predictable part of their lifetime work career?

Answer

Physicians might be happy to work in poverty areas of cities if the working conditions were right for them but such conditions require a structured situation. The principles involved are: 1. that group practice is more conducive to satisfactory working conditions than solo practice; 2. that status in a teaching hospital or university faculty is likely to increase participation; 3. that active research opportunities (a spirit of inquiry) enhances interest. It is possible that young physicians could be induced to spend several years in this endeavor as part of their career development, if the opportunities offered were similar to others in the teaching hospital in academic medicine and specialty training. Vista program for physicians might also have appeal.

Now our last witness this morning, and not least of course, is Dr. David Thompson, the medical director of the New York Hospital.

STATEMENT BY DR. THOMPSON

Senator KENNEDY. I have some questions relative to hospital care. Would you rather I waited until you've made your statement? Could I take perhaps 5 minutes to raise some questions directed not to Dr. Sheps but to the others of you, and then you can give your statement, Dr. Thompson.

We have talked about the fact that the fees for doctors have increased and some of the problems connected with that. But it is also true, as Dr. Cherkasky has said, that hospital charges have also gone up. I wonder, first, if you would describe these increases in a little bit more detail.

Secondly, can you make some specific suggestions as to what could be done about them or indicate whether you think that we are moving in the right direction on this problem?

First if you could, give us any information about whether hospital costs to the patient have, in fact, increased over the period of the last 18 months, and whether the increases are due to medicare and medicaid.

Dr. THOMPSON. Perhaps, Senator Kennedy; each of us might wish to address ourselves to that question. I think we need to separate here the matter of the hospital cost from those of the physicians' fees. We spent a good deal of time this morning talking about the question whether physicians' fees have risen too rapidly and for what reasons and what can be done.

As far as hospital costs are concerned, they have indeed, as you know, gone up very rapidly. As others have pointed out before me this morning, I think that we did and still do have a lot of catching up. In other words, the personnel at our hospitals have been traditionally underpaid, and we are now, I think, getting to a point where we are much more competitive with the labor market; then in addition to this, your professionals, your nurses and the allied health personnel. The nurses have always been underpaid, so that the rise in hospital cost is not simply a matter of the introduction of medicare and medicaid; this has made it easier for us to catch up. We have a long way to go and we are now able to do it. I would say that medicare and medicaid have made it possible for us to bring the salaries up more competitively.

Perhaps the others would like to comment.

Senator KENNEDY. Well, it is true that the employees of hospitals have not been adequately paid and also that nurses have not been adequately paid. I am pleased that there is some progress being made in that field. But on the basis of information that I have received from around this State and from across the country, I wonder whether all of the increases in hospital charges are the result solely of efforts to rectify past injustices or whether there are some costs that have gone up rather considerably because of other facts.

Dr. CHERKASKY. I think when we talk about costs at hospitals, at Montefiore it is $90 a day, very close to $100, I think it would be foolish to say that our businesses are all run so well and so tightly that we could not do better. I think that there is much we need to do in the introduction of more automation. Our problem is that in a service industry like ours, most of our dollars go to payment of people and not supplies.

I would also point out that one of the problems that we have, Senator Kennedy, in this cost, is that a very large, significant part of that cost represents other than medical care for patients. It is the cost of education; we have a house debt of 300 at Montefiore Hospital; we pay them an average of $5,000 or $6,000 a year; it costs, in addition, at least $5,000 a year more because of the effort we have put into their education. Three million dollars of our costs annually is an educational cost.

In other words, the educational costs for doctors and for nurses and for other people are loaded into that patient-care bill and they don't belong there. This is the situation in our best and highest cost teaching hospitals.

I think Dr. Thompson is absolutely right: We have not paid nurses sufficiently; and our other workers are just beginning to catch up.

I would make an estimate at Montefiore Hospital, $10, $15 a day may be costs which are borne by the sick patient which are really educational costs which should be borne in some other manner.

Senator KENNEDY. You could stay at the best hotel in the United States for $100 a day.

Dr. CHERKASKY. In the best hotel in the United States, you don't get 60 percent special diets delivered to crotchety patients.

Senator KENNEDY. Maybe you could for $100 a day. I think for $50 and $60 a day you could make an arrangement down at the Waldorf-Astoria to get very lean hamburger and no butter with your bread. I think you could.

Dr. CHERKASKY. Senator, I think we need to pursue this business of internal hospital cost, but I want you to know you are not going to strike paydirt there. The paydirt is going to be in reexamining how the hospital is used. Everybody wants to find the answer within the hospital's costs. I think we should look at that very carefully, but that is not the solution to the problem.

Senator KENNEDY. Doctor, we've talked about other things for 2 hours; it is now 12 o'clock. But I think that this is a matter of legitimate concern.

Dr. CHERKASKY. Absolutely.

Senator KENNEDY. And I think we should at least discuss it so that we can learn about some of the problems you are facing. You know, I think it is generally accepted in the city of New York and

across the State and perhaps across the country that you are one of the great administrators of hospitals; so I am not speaking officially at all.

Dr. CHERKASKY. I understand.

Senator KENNEDY. Now, just what direction should we move in? It is simply impossible for a person to stay in a hospital when it costs $100 a day.

To Reduce Hospital Costs

Dr. CHERKASKY. Senator, I think we could help resolve the problem, if we could cut down the total community hospital bill by different kinds of practice; for example, in the city of New York, where we have something like 50,000 general hospital beds, if we could put that whole system together in an integrated fashion, I am willing to say to you that we could do it with 40,000 beds; but do you know what that would require?

It would be necessary for Montefiore not to be a separate hospital from Mount Sinai or Beth Israel. We would have to stop duplicating what we do, we would have to stop competing, which we do.

We have in the city of New York, for example, 15 cardiac surgery programs. Cardiac surgery is very expensive. Seven of those programs do 83 percent of the surgery; eight of them do 17 percent. A case a month some of these eight do. That means it costs them a fortune in equipment and personnel; they don't do it well because you cannot do it well if you do cardiac surgery infrequently.

These are the things we do. In other words, it is not by focusing on the individual hospital but by focusing on the communities total hospital program and methods of medical practice that we can solve the problem.

Senator KENNEDY. Is anything being done, for instance, in this community, in the city of New York, to coordinate services as you suggest? Everybody finds fault with the Federal Government, and I am sure that there are parts of the legislation that could be strengthened and changed, but should not a great deal more also be done here in the State?

Dr. CHERKASKY. Absolutely.

Senator KENNEDY. In all our States and local communities.

Dr. CHERKASKY. I agree it has to be done on some kind of a local level. As a matter of fact you know, one of the things the Federal Government could do is in some way tie its payments or it could tie its grants for construction to implement this kind of planning. In other words, Montefiore Hospital has to give up its autonomy in the community interest and I think what has to happen is that the hospital has to be pushed to do that. If we could integrate hospitals, I have no question that we could do the job with a much less hospital bill than we now spend.

Senator KENNEDY. I have introduced an amendment dealing generally with this subject which I would like to ask you about briefly to see if you have some thoughts on it.[8] In one part, it provides that payments to hospitals and nursing homes for in-patient care should be limited to the amount paid for comparable services by either the Blue

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[8] See p. 497 for explanation of proposed amendments

Cross plan or under title 18, whichever is less, while authorizing incentive payments to hospitals and nursing homes for efficient operation based upon their demonstrated ability to develop new management procedures and discharge patients promptly.

Secondly, for outpatient care, it directs that an outpatient visit must be defined and must include seeing a physician, and it puts a ceiling on payments for such visits of 18 percent of the per diem payment for inpatient care.

Third, as to payments for the services of physicians and other professionals, it directs that fee schedules shall be based upon the average level of fees charged in the area over the previous 10 years and it allows for the development of special reimbursement methods for group-practice plans.

I don't want to take the committee's time by going into this in great detail, but would you have some comment to make on it?

Dr. THOMPSON. Each of us may wish to comment on that, Senator Kennedy. I think one of the problems in terms of the ceiling arrangements or some sort of incentive plan in terms of more efficient care is that the end product of the hospital, which is the well patient, the quality of care is a very difficult think to judge. I know of no way as yet that one can really identify what is the best quality care in an institution when you compare institutions.

We have this problem. I think that you are going to run into this all the time when you try to consider whether or not you are getting your money's worth, whether one hospital is being paid too much versus the other. In the last analysis, what you want is the highest quality of care, and what is the evidence for that? I think that is a very difficult thing to judge.

Dr. SHEPS. Sir, I don't like to disagree with my colleague Dr. Thompson, but I must disagree. I think he has a point but I think it is not as difficult as he believes it is. In this matter of quality of care we are not dealing with the academic question of trying to decide how to measure the difference between 96.5 and 97 percent of their performance against a standard of perfection.

If we think of achievement and performance in terms of a spectrum with the very best at one end and the worst at the other, evaluation is easy and has been done many times; that is, to delineate that portion of care which is really quite unacceptable to any of our peers in medicine.

This can be done, and if we are thinking in terms of social policy performance on behalf of the public, then I am deeply convinced that we don't have an esoteric problem in delineating and finding poor care as distinguished from good care.

I would like to say that I thought I had something to add on this question of cost until Dr. Cherkasky made his final comment. I think that it is important to recognize that in genesis of hospitals, city hospitals, and other government hospitals were clearly developed to meet the medical care needs of a designated population.

The general voluntary hospitals of this country had a number of additional objectives; such as to provide a place where the private physician could get treatment for his patients. This does not do anything to provide treatment for those people who are not his patients or are not anybody's patients.

There is the objective of education which Dr. Cherkasky referred to. Education cannot take place without patient care, but if education is the end, then the patient care is the means, and what we need to do is to lift these individual hospitals out of the bounds of their complex history and the traditions that developed them and help them understand that they must relate more directly than they do now to the problems of the community, as a community, and not simply to the problems that happen to come to them for a variety of reasons, including the scientific interests of the individuals who are working there.

It is in this area that the areawide planning efforts of our cities have made only the most modest beginning. One of the reasons for this is, I believe, that their boards are generally dominated by the people who represent the hospital who would be affected by the determinations that are made.

I think the approach described by Cherkasky will not only contribute to making sure that we get value for our money, but it would hasten the confrontation that I mentioned in the organization of care in terms of the community as a community.

Senator SMATHERS. All right.

Dr. Thompson, you may make your statement, and then we have some other questions we want to ask.

Dr. THOMPSON. All right. I think, Senator Smathers and Senator Kennedy, that much of what has gone before really points up what I wish to talk about today; namely, the need for research, to study the problems that we have talked about this morning.

It is estimated that $50 billion is spent each year in the United States for health services. Despite the large expenditure of funds there are serious deficiencies in the delivery of health services which have been widely publicized. New programs such as medicare, medicaid, heart, stroke, and cancer have been superimposed on a system that has many inadequacies. These programs have focused attention on the need to develop a more efficient, effective, and economical approach to the delivery of health services and to some extent have accentuated preexisting deficiencies.

It is apparent that the many problems require thorough study and a large-scale research effort is needed if we are to develop new and better ways of meeting the health needs of our entire population.

As has been mentioned, there are critical shortages of personnel. Studies indicate that there are not enough physicians, nurses, and allied health personnel to meet today's needs. The research effort in biomedical sciences has resulted in better treatment, but at the same time has made the practice of medicine more complex and accentuated the need for more health personnel.

PHYSICIANS' ASSISTANTS BEING TRAINED

Programs have been initiated to train new members of the health-care team. One such program is in progress at Duke, where physicians' assistants are being trained. There is a great need to explore other training possibilities in order to add additional people to the health care professions and to relieve physicians and nurses of some of their traditional duties.

Many hospitals and other in-patient facilities such as nursing homes are obsolete. A study by the Hospital Review and Planning Council of Southern New York conducted in 1965 pointed up the needs of New York City hospitals. It is estimated today that $1.5 billion is needed for hospital construction in New York City.

At my own hospital, the New York Hospital, we have plans for renovation totaling $28 million. There is a serious question as to whether this investment is advisable in a 35-year-old plant. Indeed, architects have advised us that it would be more economical in the long run if a new in-patient facility were constructed. The source of such funds, which may total $100 million, is not apparent today, though legislation is pending in Congress which may provide a means for funding such large construction projects.

However, no major construction program for replacement of obsolete hospitals should move ahead without experimentation with new and better ways to care for sick people. There are research programs supported by a variety of local, State, and Federal agencies, but the efforts are not coordinated sufficiently nor are there adequate funds to mount a full-scale research endeavor.

The importance of coordination may be brought about by considering the individual patient. In his lifetime he is likely to need preventive measures; he will probably need ambulatory care for illness either at a doctor's office or ambulatory clinic; he will most likely need acute general hospital facilities and following this he may need convalescent care and home care. His needs require a continuity of effort in which many different health-care agencies and facilities are involved.

There has been a tendency to look at one or another aspect of this continuum without sufficient emphasis being placed on long-term needs of the patient. In designing new hospitals, for example, due consideration should be given to the progression of the patient's needs from the acute hospital to convalescent facilities and back into the home. It is wasteful of the resources of the acute hospital to provide care which can be given in a nursing or convalescent facility or in the home.

Changes in hospital structure and function will not come about unless well-designed experiments are carried out and the worthwhile new approaches are copied by others. I do not think there is adequate organization or funding of such research programs.

New Approaches to Patient Care

More important than the facilities themselves is the development of new approaches to patient care. We need to approach the problem of ambulatory care in our clinics with new perspectives. The traditional outpatient clinic should be replaced by one which provides more gracious and graceful patient care. I am convinced that this can and should be continued in large teaching hospitals such as the New York Hospital, but it will require revamping of current procedures. We should develop research projects and pilot programs to try out new ways of delivering ambulatory care.

Carefully designed and well-executed studies will be costly, but I know of no other way to assure improvement in patient care. The home care project which Dr. Reader has described, a 10-year study

carried out at the New York Hospital, is an example of the type of project for which research funds are needed.

The role of the nursing home should be studied more extensively. The traditional view of a nursing home as a long-term, terminal-care facility is outmoded. It should be looked upon as a way station between the hospital and the home. Continuity of care requires that a patient's course is planned through each step of the way to the hospital and back into the home.

Some patients may not require the elaborate resources of the acute hospital but could be admitted directly to an intermediate-care facility such as a nursing home. We do not have adequate studies of how nursing homes can mesh with other facilities to provide optimal patient care. I am confident that such studies would result in a new role for the nursing home, a more effective relationship between it, the hospitals, and home-care agencies.

It would also, I believe, be more economical if intermediate and extended care facilities took over some of the activities of the acute hospital.

In this regard, the problem of admissions to acute general hospitals has been a subject of such discussion. Long waiting lists are common, resulting in admission primarily of emergency problems. At the New York Hospital, for example, delays up to 4 weeks are common for less than emergency cases. One of the obvious solutions to the shortage of beds is a rapid turnover of patients. Better intermediate-care and home-care programs integrated closely with the general hospitals should help to correct the shortage.

I have proposed that a large-scale research effort be organized at a Federal level. I have compared this proposed undertaking to that of the National Institutes of Health, which have played a prominent role in the growth of biomedical research in this country. I believe a similar effort is needed in the field of health-care research.

In his statement to another committee, Under Secretary Wilbur Cohen outlined the needs for research and development in six major areas. He pointed out that currently only one-tenths of 1 percent of governmentwide investment in health services is invested in health services research. He stresses the need for a more vigorous effort and emphasizes the need to establish a National Health Center for Health Services Research and Development.

I agree with Mr. Cohen's analysis of the needs and with his proposal that this be organized on a national basis. Such an organization should be able to muster the topflight talent from the entire country to review and pass upon research proposals. It should also be able to coordinate research activities which are fragmented and inadequate to meet today's needs.

I have been quoted as stating that a billion dollars a year is needed for health-care research. This estimate is based on the conviction that funding comparable to that provided for biomedical research will be required to mount a vigorous, comprehensive research effort. It is unlikely that $1 billion could be spent wisely today. However, with the development of a national center or agency for health-care research, I would anticipate that a well-coordinated research program would grow rapidly.

I am pleased to have had the opportunity, Senator Smathers and Senator Kennedy, to address this committee and hope it will lend its support to the development of a large-scale research effort in health care.

Senator SMATHERS. All right, sir. Thank you very much, Dr. Thompson.

Senator Kennedy, do you have any questions?

Senator KENNEDY. No, I don't. Thank you.

Senator SMATHERS. I have one brief question. I am keenly interested in this question so you will excuse me if I take just 3 minutes.

In the service in World War II, I became accustomed to going down in the morning when we were overseas and here in the United States to a health call. There would be lined up there 25 or 35 or 40 marines in the outfit that I was in and they had anything from broken knees at that moment, skinned knees, head colds, a lot of other things.

We never got to see the doctor. We saw the corpsman but after a little while we became accustomed to seeing that fellow. When you went in to see the corpsman—he was a fairly well educated young man in medical ways; he did not have a medical degree but he had enough sense to know if a man came in there with a fever or something serious he would then set him aside and have him see the doctor.

But what happened was that these other 40 people did not have to see a doctor. We developed confidence in the corpsman. I have wondered why it would not be possible for the medical profession to develop some subassistants, have them meet these many, many people so that they would be smart enough to isolate the very serious cases and then the doctors would not have to spend their time on so many unimportant cases. Is it practical to assume that we could develop such a system, or should we develop a system like that in the medical profession?

Dr. THOMPSON. Indeed it is, Senator Smathers, and this is one of the points that I wanted to make; namely, that in addition to the fact that we need more personnel in their traditional roles—physicians and nurses—we do need to develop other health professionals.

This program I described at Duke is really a followup on the corpsman idea. The assistants are largely coming from the corpsman group. It is apparent in our hospitals today that nurses are taking on some of the traditional duties of physicians and then somebody will come along and take some of their traditional duties.

It is not only a matter of more personnel in their role but new personnel being fed into the health professions. I think you are quite correct that we have to develop new types of health personnel without question.

Senator SMATHERS. Thank you, Doctor.

Dr. SHEPS. I have something.

Senator SMATHERS. Yes.

Dr. SHEPS. I would like to add something to this. I think that the development of different types of personnel, which I believe is very sorely needed, will be inadequate if it takes place by itself and in a vacuum. This, it seems to me, sir, needs to be thought out in terms of the confrontation of different patterns of care.

The only way in which these new types of personnel can do the best job is if they are part of an organized program. In your Marine station the medical officer was indeed there, he was available and he was

supervising what these men were doing. This changes the whole structure of care and it also has implications for financing methods.

It is an interesting thing to contemplate. You graduate these assistants to the physician from Duke University. Who is going to pay them? The doctor will be paying them. He will then be having hired help who are part of his cost of operation. He will receive a fee for what? For what this assistant does or for what he does by way of supervision? This raises a lot of very interesting questions that go to the heart of how we provide and pay for medical care in this country.

Senator SMATHERS. All right, sir. Thank you very much.

(The chairman addressed the following questions to Dr. Thompson in a letter written after the hearings:)

1. Your case for an extensive research program is—as you pointed out—very similar to arguments raised in support of the National Health Center for Health Services Research now under study by the Department of Health, Education, and Welfare.

Do you envision the Center's being coordinated with action programs so that research can be put to immediate practical use. For example, if new techniques for ambulatory care of the elderly are developed in a promising demonstration program, could the Center in some way act to inform medical administrators throughout the nation as to the lessons learned from experimentation.

2. Have you any suggestions for research needed in health screening and preventive medicine in general?

(The following reply was received:)

Answer 1. You stress an important aspect of a research program in Patient Care; namely, the introduction of new ways of delivering health services to everyone. This will require that the promising results of research programs which have wide application be made known to appropriate groups who are in a position to implement them. This points up the importance of coordination of health care activities. The development of coordinating groups as a result of the Heart, Stroke and Cancer and Comprehensive Health Planning legislation should facilitate bringing the fruits of research more rapidly to the bedside.

You have asked whether a National Health Center for Health Services Research should act to inform medical administrators of new approaches generated by research. I think its most important function is the funding of promising new ventures. It could also help to designate the experimental results in a number of ways. These might include:

1. Publication of all ongoing research projects at regular intervals.
2. Publication of a bibliography including all published results stemming from research in health services.
3. Organization of symposia on research efforts which are receiving widespread attention.
4. Establishment of close liaison with governmental and voluntary agencies involved in health care research and delivery of health services.

Answer 2. These two areas are greatly in need of expanded research efforts. As you know, much has been written on these subjects; therefore, I shall only comment briefly.

Shortage of medical manpower has forced us to think of alternative methods of delivering health care. At the same time there is great demand for comprehensive care which includes a general examination at regular intervals. I think the goal is desirable, but its achievement should not accentuate shortage of health personnel in other health areas. It seems essential, therefore, to develop new methods of examination of patients requiring less time on the part of physicians and nurses. Screening procedures including history taking, laboratory examinations and certain aspects of physical examination can be carried out with a minimum number of professionals. Although the concept seems sound, there is need to examine the approach critically through well defined, well organized research projects. The role of the computer in history taking, the use of automated equipment for mass production of laboratory data, the development of health personnel to carry out most of these screening procedures should be studied carefully. Ultimately, I believe, the results of such studies will show that screening procedures will be beneficial to patients, will save time for doctors and nurses and will be more efficient and economical than the present system.

Research aimed at prevention is, of course, of vast importance. This consideration is related to the screening procedures since these should help in prevention of illness and early detection of medical problems. In addition, we are still woefully ignorant of causes and means of prevention of killer diseases and other less dramatic, but nonetheless serious illnesses. Certain known important factors in producing illness, e.g., cigarette smoking, air pollution, should be brought home more forcefully to the public. Experimentation is needed to develop more effective means of controlling known factors in disease.

In summary, it seems to me that the enormous sums of money spent on health care could be utilized more effectively. To develop better methods of health care we must invest in research. I know of no other way to develop new approaches which I am convinced are essential, if the delivery of health services to our people is to improve substantially.

Senator SMATHERS. I will insert into the record an article describing a recent Government action related to my comments about medical corpsmen, as well as later correspondence on the subject.

[From Today's Health magazine, November 1967]

GROUPS COOPERATE TO STEER VETS INTO HEALTH CAREERS

A program to attract into the health field some of the 65,000 to 70,000 medically trained veterans discharged annually from the armed forces was to begin in mid-October. So announced Edwin F. Rosinski, Ph.D., deputy assistant secretary for health manpower in the Department of Health, Education, and Welfare.

"We wish to tap this tremendous pool of trained personnel and encourage as many as possible to enter the allied health fields," said Doctor Rosinski.

The program will be conducted on a voluntary basis with several agencies cooperating at the local, state, and national level, and at no added tax cost, according to Doctor Rosinski.

The program has a two-fold purpose:

1. To steer those who are adequately trained into the health field immediately.
2. To encourage those who desire a higher occupational level to continue their education.

At the time of separation from the service, before discharge, veterans will be asked to fill out a questionnaire indicating the nature of their service-connected training. Within two to three days after returning home, the dischargee will again be sent a letter outlining this Health Manpower program. This will be followed up with a personal contact from the state employment office asking if the veteran would be interested in further counseling on opportunities in the health field.

The health-counseling officer in the state employment office will be provided with information from hospitals in the vicinity indicating the positions available and salary range and training required as well as training being offered in the hospital. The chief educational administration officer in the state will make available a list of educational institutions in the state offering further education in health sciences including vocational schools, community colleges, colleges, and postgraduate institutions.

For those veterans who are missed through the separation and state-employment channels, the Veterans Administration also will provide similar information.

Also cooperating in the voluntary effort are the American Hospital Association, which is alerting hospitals; the Department of Labor, which is making available the personnel of the state employment offices, and the Office of Education, which is working with the chief educational administrative officers in each state.

NOVEMBER 2, 1967.

Dr. EDWIN F. ROSINSKI,
Deputy Assistant Secretary for Health Manpower, Department of Health, Education, and Welfare, Washington, D.C.

DEAR DR. ROSINSKI: I was interested in the article on p. 15 of the November, 1967 issue of TODAY'S HEALTH concerning your program to attract into the health field some of the 65,000 to 70,000 medically trained veterans discharged annually from the armed forces. The Subcommittee on Health of the Elderly,

of which I am chairman, has been concerned over the shortages of trained health personnel which threaten to deny many elderly individuals—as well as individuals of all ages—medical services needed to maintain a high level of health. Your project impresses me as a sensible approach which gives great promise for improving health services in the United States at little or no public expense. Congratulations upon your imaginative work!

Our subcommittee is presently conducting a series of hearings on the subject, "Cost and Delivery of Health Services to Older Americans". Transmitted to you herewith is a copy of our first hearing in this series, to give you an idea of the scope of the hearings.

It would be a valuable addition to the record of these hearings to receive a statement from you describing your program, with particular reference to its anticipated effect upon cost and delivery of health services to the elderly. One aspect of this subject in which I am particularly interested is the development in civilian medical practice of subprofessionals of the type sometimes called "doctors' assistants" patterned after Navy medical corpsmen.

While serving as a Marine officer in the Pacific during World War II, I observed the efficient and effective use which was made of these personnel to perform many tasks which, while requiring a minimum of training, did not require the services of a Medical Doctor. Since returning to civilian life, I have been impressed with the need for a specialty of this type to help keep costs of medical treatment to a minimum and to relieve scarce physicians of tasks which could be performed by less highly trained personnel. Accordingly, I would be especially grateful for any advice you might be able to give us concerning the possibility that these former servicemen might continue in civilian life to carry out functions as "doctors' assistants" similar to those previously carried out as medical corpsmen.

You might also comment on the possibility that use of these trained, experienced former service personnel in this way might give impetus to the practice of using "doctors' assistants" in civilian life.

Thanking you, and with kind regards, I am

Sincerely yours,

GEORGE A. SMATHERS,
Chairman, Subcommittee on Health of the Elderly.

[From the New York Times, Oct. 17, 1967]

U.S. AIDS EX-MEDICS TO GET HEALTH JOBS

WASHINGTON, Oct. 16.—President Johnson announced today a plan called Project Remed to encourage discharged military medics to remain in the health field in civilian life.

The plan is part of a broader effort first announced last August to help smooth the transition of veterans to civilian life.

The new program will offer veterans either a job in the health field or training and education to improve the medical abilities obtained in the service.

The White House said about 60,000 men and women trained in the medical field were discharged from military service each year.

It said that about 300,000 more health workers were needed to give the nation the best possible medical care and that the rise in population alone would accentuate the shortage unless adequate steps were taken.

Officials said that no discharged medics could be employed as practical nurses, psychiatric aides and medical technicians, for example.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., November 15, 1967.

DEAR SENATOR SMATHERS: I should like to express my sincere appreciation for your most kind remarks about Project REMED in your letter of November 2, 1967.

The program was initiated for three major reasons: (1) To provide employment and educational opportunities for returning veterans; (2) To capitalize on the investment the Government made in training these men in the health occupations; and (3) To provide quality health care for all sectors of our society. Since the program has just begun, it is too early to predict, or to anticipate, what effect the program will have on the cost of delivery of health services to

the elderly. The Department of Labor is evaluating the program for us, and I shall provide you with data as soon as they are available.

I share your concern for the need to develop a new level of health personnel such as a "physician assistant." The enclosed article, which I wrote while still a professor of medical education at the Medical College of Virginia, might be of interest to you. While at the time I wrote the article I was still weighing the appropriateness of a "physician assistant" for this country, I am now convinced that such a medical auxiliary is indeed necessary if the health needs of our society are to be met. You might find the article of particular interest for it describes the efforts of the British and Australians in training and using "physician assistants" in the Fiji Island and Papua-New Guinea.

The Department of Health, Education, and Welfare strongly endorses the development and use of auxiliaries such as "physician assistants." A few significant starts have been made in this country. The University of North Carolina under Dr. Eugene Stead has such a program. Dr. Henry Silver at the University of Colorado is training "pediatric assistants." At Presbyterian Hospital Center in San Francisco, "orthopedic assistants" are being trained. As a matter of fact, one of the most imaginative proposals I have seen and discussed on this subject was prepared by the Department of Pediatrics at the University of Florida. They have a plan to develop an auxiliary that would be a physician assistant in the area of maternal and child health care.

As you can see, small inroads have been made. However, far more needs to be done. We need to develop and test a wide range of these "physician assistants" who can serve as an auxiliary to the physician. By using such auxiliaries, the physician's time could be put to more specialized use and health services could be extended.

We are deeply interested in the subject of physician assistant. I would welcome the opportunity to discuss it further with you.

Sincerely yours,

EDWIN F. ROSINSKI, Ed.D.,
Deputy Assistant Secretary for Health Manpower.

Senator SMATHERS. May I say let's give all these doctors, the four of them, a fine hand, because indeed they deserve it. [Applause.]

We will stand in recess until 2 o'clock.

(Whereupon, at 12:20 p.m. the subcommittee recessed, to reconvene at 2 p.m., the same day.)

AFTERNOON SESSION

(The subcommittee reconvened at 2:30 p.m., Senator Smathers presiding.)

Senator SMATHERS. The meeting will come to order.

First we would like to apologize for the fact we were late. We went out to the Montefiore Bathgate Health Center supported by the Office of Economic Opportunity to observe what they are doing. It is a remarkable and heartening sight to study the contributions they are making, although the neighborhood leaves a lot to be desired.

We left there and went to the Bronx State Hospital which is primarily a mental hospital, with Dr. Zwerling who was connected with Albert Einstein University, as their chief psychiatrist. He took us through these wards to look at some of the elderly in these wards who regrettably are—well, as he expressed it—they are stable emotionally but they really just don't have anywhere to go, they don't have any home to go to so they just stay on. It was a sad and yet warm experience.[9]

We left there and went viewing some of the other areas so I regret

[9] Statement by Dr. Zwerling appears on p. 582.

to say we are running late. We are here now and our first witness this afternoon is going to be the very able doctor who was with us all through the field trip, Dr. Wise. Harold B. Wise is the Project Director here.

I might further add so that there will be no disappointment and so that you will not wait and then be disappointed, Senator Kennedy was here this morning and with us during the lunch hour as we visited these various places but had some very important matters that he had to attend to this afternoon and doubts whether or not he will be able to get back before the hearing recesses at 5 o'clock. He regrets that he is not able to be here with you.

Dr. Wise, you may proceed any way you like.

STATEMENT OF HAROLD B. WISE, M.D., PROJECT DIRECTOR, MONTEFIORE HOSPITAL NEIGHBORHOOD MEDICAL CARE DEMONSTRATION, BRONX, NEW YORK; ACCOMPANIED BY MRS. DAVIS AND MRS. LOPEZ

Dr. WISE. Thank you, Senator.

I would like to introduce you to Mrs. Davis who is on my left and Mrs. Lopez will be up here momentarily. I have asked them to advise me if I get into difficulties.

Senator SMATHERS. All right, Doctor, you may proceed.

Dr. WISE. Senator, I would like to spend my time describing the problems from the viewpoint of a physician working in the community and rather leave the broad problems of medical care to the experts that spoke so ably this morning.

I would like to describe a patient who is under the care of a team consisting of a doctor and nurse and a family health worker. I included this in the testimony and I will summarize it. The only difference in the testimony is since Monday when we typed it up we have had to admit the patient into the hospital. Her problems I think represent many of the problems of an elderly person who is trying to maintain herself without going into the hospital or into a nursing home.

Mrs. O, and I am not giving you her full name for her protection, is a 72-year-old widow who lives alone on the fourth floor walk-up of a building not far from where we are now. She was born in the Carolinas and came to New York in 1950. She and her husband and three children were leading a productive life. He was manager of an apartment building and they belonged to a union health plan and things were not too bad, they were able to get their medical care from the union health service while he was alive.

About ten years ago things began to change and really from that point on Mrs. O's life has become a matter of just coping. Her husband was her entree to medical care. She had a couple of problems which were managed by her private family physicians at the union health plan. After that she had to get her medical care from a clinic in a city hospital, a free clinic, three-quarters of an hour here by public transportation. She went there for her heart disease and treatment of her diabetes and she went to another clinic in Manhattan because she had some tingling in her fingers and toes—a neurological problem. This was an hour and a half away by public transportation and your letter this morning really described a problem she had getting around.

She was unsteady on her feet and when she walked too quickly she got a pain in her chest, yet much of her time was spent going to clinics in various parts of the city and waiting many hours and often seeing a different doctor each time and trying to cope with her medical care. During an episode of unsteadiness she tripped. She fell and she broke her hip and was hospitalized and was in the hospital for many months because they could not find adequate housing for her on the outside.

Several years ago she had been living with her single daughter in her apartment. Her daughter got married and moved to Brooklyn so she lives alone now. Since that time her whole kind of robustness and happy attitude to life changed. She became lonely, she was afraid to go out. For shopping, she had to depend on a neighbor. She became gradually more and more reclusive. She didn't go to the doctors in the various clinics as they were hard to get to.

Her taking of medications was not reliable. This lady has gradually deteriorated so that her apartment which was very tidy and spic and span has gradually become run down. She has lost a lot of weight, she is not taking her insulin correctly. You have a person really who is both physically and psychologically run down because she has not really received comprehensive medical care and all the other things that go along with it that keep people healthy.

Consequences of Isolation

Now if this lady were left alone one of three things would happen. Her condition would become so bad that she might become forgetful and become unreasonable and she would be taken to a State mental hospital like the one we visited this morning.

She would slip and fall and break her hip again and be admitted into a general hospital where 10 percent of the patients in the general hospital units are just looking for homes on the outside to go and stay there as boarders in the kind of "hotel ward" very similar to the wards you have seen today.

Or the third and the most unfortunate failure of our system, she would not see anyone, her neighbors would not see her and one morning she would be found dead.

I see you are nodding. This is not an exaggerated story and I wanted to present one that was not too severe to focus on the kinds of problems we have in providing medical care for the elderly.

A major problem that has been discussed is the lack of medical manpower in this area. In these 55 blocks that we are in, there used to be 25 doctors practicing, now there are four. There used to be only 25,000 people living here and now there are close to 50,000. So in the Bronx where you have one doctor for 700 people, in this part of the Bronx you have one doctor for 10,000 people.

The doctors are working very hard, some of them seeing very many patients a day and making home visits trying to provide care. The only open avenue of care has been the emergency ward at the clinics which are run down and which in no way offer the kind of personal health services that people are looking for and are used to and have as their right to expect.

I want to deal a little bit with some other problems that I have to cope with as a physician that are really out of my control. You talk

about the lack of medical manpower. We have a lack of housing so that if we have a patient, for example, that gets better in the hospital often we don't have the kind of housing in the community especially for an older person who needs an elevator, who needs special kind of cooking facilities. We don't have the housing in the community to look after that patient.

We have the problem of the patient's income. Patients who have to subsist on social security, most of them as you saw this morning are without any other kind of pension where the income really and the kind of food you have and the kind of home you live in is very important for the health that exists.

Another area that I would like to talk about a little is loneliness. The Beatles talk about all the lonely people. I think that of the lonely people I meet the most lonely are the elderly. Really the Eskimos are much more forthright in dealing with the problem; you are put on a piece of ice if you are old and you are sent away.

We have another way of dealing with it here in that families don't seem to want to look after their parents and they isolate them in different ways. We don't really have the kinds of recreation services and we don't have work programs that really can tap the great experience that the elderly have.

We have a training program right across the road, you can see it over there. Our best counselors from life's experience have been those people over 50, and yet no one that I know of has looked to train and employ and utilize people over the age of 65 as social counselors or use them in a part-time way in the health and social service fields and in all the recreation programs.

I think you are sitting in a unique institution. Now recreation programs treat the elderly as if they were children with rah-rah kinds of activities where people as a result deteriorate and begin to stare at television sets. The elderly are really not challenged. As a part of mental health and well-being I think that recreation and housing and income are equally important with the medical care services we offer.

Let me just jump over to some of the approaches to the solution that we have been involved in. One is that we have tried to offer—and I am embarrassed to use the word because it is not really "comprehensive"—it is comprehensive in the old sense in that it looks after the "hard" medical problems but it is not comprehensive in the real sense in that the social problems are often beyond our reach.

One-Step Health Service

We have organized a health system where the services are simple for patients so that you don't have to go to a left heart doctor and a right heart doctor and a kidney doctor, you go to your doctor and if he needs a specialist and he is called in for a consultation then your doctor carries out the treatment. It sounds old fashioned but I am talking about a family doctor.

To the family doctor we have added a nurse and a family health worker and we have organized the way we practice so that we can do it with fewer doctors than most institutions do it. So if most institutions need one doctor per thousand, we think we can give equally good

or better medical services by using fewer doctors and giving the work that doctors don't have to do to public health nurses and family health workers.

The family health worker has extended our care so that she goes into the home and looks after many of the nursing and social service activities and really works together with the doctor as a team to extend his hands. That is how we have organized it and we have recruited in our training program people from the area and trained them for the positions. We think that there are many people now working with us as family health workers or health technicians who under different circumstances would be doctors had they been given the opportunity, and we are going to approach various agencies to see if they can be given this opportunity. There is no reason why somebody in a community who has displayed his competence as a medical technician cannot go on and become a doctor or a family health worker and go on and become a nurse.

This is Mrs. Lopez.

That is really the most traditional part of the medical care that we are involved in. We try to coordinate our services. We have coordinated our services with the home care program at Montefiore so that as soon as our main health center is open we will be able to bring medical care services into the home. You can keep people at home in a much better situation if they can provide meals on wheels, for example. If that is the only reason people are in the hospital and they want to be at home and they cannot cook their meals, there are mechanisms where we can deliver meals right to their bed three times a day, two hot meals.

In recreation and in employment of the elderly I must admit that the oldest person that we have trained is 55 but by next year we plan to pilot a program using people over 65 really as social counselors and to see how they function in this respect.

We are talking about other answers to the medical care shortage here and I think one of the ways that we have to do that is to attract doctors, we have to have attractive facilities for them to work in, we have to pay them good salaries so that they would not lose money by practicing in areas that are not as well endowed as other areas. We might even by paying their way through medical school get from them a contract, a kind of commitment to work in an area that is underdoctored for a period of 3 to 4 years. This is not new, it has been done in other countries.

One of the ways that we cooperate with the Bronx State Hospital would be to take patients who have recovered from their problem and really provide medical and social services for them in the home, and then if it was necessary we always have the backup of the current hospital to fall back on.

I think that the problems of income and the problems of housing are problems that you are much more knowledgeable about, and there are better people than me to deal with this but I am saying that income and housing are as important as the traditional provision of health care in the health of the elderly as well as the health of everyone.

Immediately our concern is, and we are operating on a year to year grant, if they are interested in demonstration I think that they ought

to fund programs for a period of time where they can really be tested out and not have to depend on going back. The mood of Congress each year I think puts these programs in great jeopardy. I don't think that if Congress cuts back on the neighborhood health centers or on any other program without a period of testing, we won't have learned anything from this experience.

I think that I have made really the major presentation I wanted to make. I wonder if Mrs. Lopez or Mrs. Davis want to add to that? It is hard for me really to describe problems of the elderly except as I see them as a physician. [Applause.]

(Dr. Wise's complete prepared statement follows:)

PREPARED STATEMENT BY HAROLD B. WISE, M.D., MONTEFIORE HOSPITAL

A PORTRAIT OF AN OLDER LADY

Mrs. J. O.[1] is a 72-year-old widow living alone on the fourth floor of a walk-up apartment building in the Southeast Bronx. She was born in South Carolina. In 1950 her family moved to Harlem. Her husband was the superintendent of an apartment house. They had three children. In 1961 her husband died. She and her youngest unmarried daughter moved to the Southeast Bronx. Soon afterward her daughter married, and Mrs. O. remained in the Bronx, living alone.

Mrs. O. was in good health until about ten years ago. Then she began to have problems. She had become overweight and complained about numbness in her legs, and was discovered to be diabetic. Five years ago she began to develop pain in her chest and was diagnosed as having angina pectoris—a heart condition. Three years ago the numbness in her legs became increasingly worse; she stumbled in her apartment and fractured her hip. She underwent surgery and had a long convalescence in a general hospital.

While her husband was alive, Mrs. O. received her medical care from a union health plan of which her husband was a member. After his death she had to get her medical care from a variety of charity services. She went to the diabetic and cardiac clinic of a city hospital, and to the clinic of a medical school where she was part of a special research project. When she had acute minor problems she would visit the emergency room of the city hospital. There was a private physician who practiced a few blocks away whom she used to consult for minor problems, but in 1963 he retired from practice.

For the past six months she had increasing difficulty getting around. A neighbor's son did her shopping. She has become somewhat fearful of leaving her apartment, and although she was generally known as a happy person, she has recently become depressed. Her apartment, once known for its cleanliness, has become untidy. She spends much of her time watching television and sleeping. Her daughter, although very troubled about the situation, is unable to take her into her home in Brooklyn because of the small size of her apartment and the demands it would make on her own family.

To summarize her problem, Mrs. O. has rather common chronic disease problems—heart disease, diabetes, neurological problems—requiring her to spend a great deal of time traveling from clinic to clinic, with many hours of waiting in the clinic for treatment. The small amount of money she receives from Welfare and Social Security provides her with a mere subsistence.

At the present time, if left alone, one of three things might happen to Mrs. O.:

1. Her condition would greatly deteriorate. Perhaps she would sustain another fractured hip or develop an acute illness and be taken to a city hospital, there to wait for many months for a bed in a nursing home.
2. If her forgetfulness became manifest, neighbors might call the police and she might then spend the rest of her days in a state mental institution.
3. Perhaps worst of all, her condition would greatly deteriorate and she might be discovered one day dead in bed.

[1] The case history has been slightly altered to protect the identity of the patient.

What is lacking

Medical manpower

Thirty years ago the area we serve was populated by 25,000 people and had a minimum of 25 doctors' offices, many dentists and pharmacists practicing right in the area. At the present time the population has nearly doubled, to 45,000, and there are only 5 doctors practicing in the area, one on a part-time basis. There are 6 dentists, 2 of them on a part-time basis, and 9 pharmacists. The need for medical manpower is critical.

Comprehensive services

At the present time the poor must make their way through a variety of emergency rooms, sub-specialty clinics, and welfare services. For many the emergency room has become the chief source of medical care.

Home care services

Many of the elderly are able to walk and do not require home care services. A large number, however, are somewhat disabled and require some home care services. Others are bed-bound and require the full range of a hospital-based program. Unfortunately, few hospitals have home care programs. For the great majority of the poor home care health services do not exist.

Income

The major concern of the poor is the income and what that income commands. Others have spoken of this problem with much more expertise, but I must reiterate it in its relationship to the health of the elderly.

Housing

Next to income, housing which is individualized to the needs of the person is the second priority of the elderly. There is need to deal with the Twentieth Century phenomenon of children denying responsibility for their parents. Unfortunately, adequate housing for the elderly is in great short supply. Many of the elderly sick poor now find their housing on the wards of general hospitals and the state mental hospitals. This kind of care leads to despair on the part of the elderly and to rapid deterioration. The cost in social and personal terms is enormous. With the spiralling costs of health services, it seems irresponsible that we are providing, at great cost to the taxpayer, "public housing" in institutions wholly unsuited for that function.

Work and recreation

Some societies have been much less hypocritical than ours in dealing with the problems of the elderly. Among the Eskimos, when their time had come, the elderly were placed on floating pieces of ice and set adrift. Loneliness is a characteristic of the elderly poor. The inability to find meaningful work and recreation, and the isolation from the rest of society, lead many elderly people to despair. With a few notable exceptions, recreation programs for the elderly are much like those arts and crafts programs designed for children. The life experience of the elderly has not been systematically examined and utilized in social counselling. The results are that many elderly persons talk of "killing time". This is perhaps misstating the case. Rather the reverse is true—time is killing.

Some solutions

The Neighborhood Health Center program of the OEO provides some answers to the organization of medical services in a way that is human and rational and meaningful to all the consumers, including the elderly. (See Appendix 1, NMCD short summary.)

Medical manpower

a. Group practice.
b. A Physicians' and nurses' corps.

It will clearly fall into the government's lot to provide professional manpower for low-income areas. In return for payment for tuition in colleges and universities, physicians and nurses might be required to serve two or three years in a low-income area to fulfill "service obligations". It seems that financial inducements would be a major method of attracting physicians to low-income areas.

Comprehensive services

The greatest need a patient has is for someone to assist him in co-ordinating the complex medical and social services now available. A family doctor, or a team of a family doctor, a nurse and a Family Health Worker, must assume

responsibility for the co-ordination of the health and social services of their patients. The complexity of modern health services required administrative answers. These should not be left to the patient. The neighborhood health service potential offers the full range of comprehensive services—preventive, treatment and rehabilitative services.

Home care services

All Neighborhood Health Centers should be affiliated with hospitals that have a full range of home care services. Home care programs in Neighborhood Health Centers must be flexible enough to provide the various needs of people with varying degrees of disability.

Housing

In every urban renewal project, in every lower income housing project, and in the greater community the elderly should be provided with individual apartments, or with group living situations, or in foster care environments, or halfway houses, each method individualized to the patient's needs. I would urge the government to prepare model zoning resolutions that reflect the latest research and findings on living arrangements for the aging and will permit flexibility and a response to changing needs. Methods of providing housekeeping services and meals-on-wheels programs have been worked out and are easily administered, and could be adapted to the maintenance of many of the elderly in the home. Institutionalization in nursing homes should be regarded as a last resort. (See Appendix 2, Bronx State Hospital Geriatric Program.)

Recreation and employment

Employment programs must be adapted to accommodate the part-time employee and to utilize the experience of a lifetime that many of the elderly have to offer. Few training programs, if any, have attempted to modify the experience they had during their working days. Neighborhood Health Centers with manpower training programs have the opportunity to train elderly persons and to utilize them as providers of social services in the health center operation.

In the same way recreation must be meaningful and challenging to the elderly. The television set, surrounded by a group of elderly patients in varying degrees of consciousness, or teen-age rah rah programs, are, I think, an insult to the elderly and account for the pattern of withdrawal that is so characteristic.

Federal actions to encourage more widespread utilization of the Montefiore Hospital Health Center:

1. Provide training funds to demonstrate the various kinds of employment for the elderly in the health and social service fields.

2. Make certain that every urban renewal or federal housing project has consulted a hospital with a home care program and has provided for flexible housing, housekeeping maintenance and provision of meals for a large percentage of the elderly.

Provide for a recreation facility to be part of every new project, with required consultation with the elderly for these projects.

3. That funds now available for hospital construction be made available for Health Center and Home Care facility construction, and that financial incentives for home care services be strengthened.

4. 5-year grants

The most time-consuming and wasteful procedure of the Health Center program is the necessity for annual grant submission. Because of this regulation, it is very difficult to recruit professional staff where they cannot be assured of long-term contracts. In addition, key staff spends considerable time preparing for new fund requisitions. I would suggest that the Health Center grants be made on a 5-year basis. I suggest that the present fiscal and auditing controls the federal government has on the program would be equally applicable to a project funded over a 5-year period.

Appendix 1

Neighborhood Medical Care Demonstration

The Neighborhood Medical Care Demonstration is designed to demonstrate a new approach to comprehensive medical care. It was developed in the Division of Social Medicine of Montefiore Hospital in the Bronx, New York, and was funded in July 1966 by the federal Office of Economic Opportunity.

The poor in America have had little share in the benefits of modern medicine; their medical care has characteristically been fragmented, episodic, and anachronistic. They are drawn into a pernicious poverty cycle. It starts with slum living, with inadequate diet and health maintenance; it leads to illness prolonged by inadequate care and environmental redeprivation; it results in loss of income and jobs, thereby forcing the poor ever more into blight.

The N.M.C.D. is trying to attack the health problems of the poor in a manner that is comprehensive and socially meaningful to them. This means providing the best available medical care—comprehensive, hospital-affiliated, family-centered team practice. It involves stimulating community concern to improve its own health care. It confronts the self-perpetuating problem of the unemployed by creating a training program to employ neighborhood residents in the provision of health services. It uses scientific techniques to determine the effect of the Demonstration on the community and the feasibility of applying projects elsewhere in the U.S.A.

THE NEIGHBORHOOD

The neighborhood chosen for the project is a 55-square block area in the east Bronx. It comprises Health Areas 24 and 26 located in the Morrisania Health District. Approximately 11,000 families, or 45,000 people live there. Of these 45,000, approximately 45% are Puerto Rican, 45% Negro and 10% white. The vast majority have received their medical care from the clinics and emergency rooms of nearby hospitals, from the five general practitioners in the area, and from pharmacists and faith healers. Continuity, follow-up and preventive medicine are almost unknown. There is a high infant mortality rate, and a high incidence of tuberculosis. Drug use and crime rates are also high. The area is blighted by run-down commercial buildings, empty tenements and littered vacant lots.

THE PROGRAM

The N.M.C.D. will be organized around a Health Center (located in the center of the neighborhood, at Third Avenue and East 170th Street), and smaller "satellite" centers. The Center will provide a focus for comprehensive therapeutic and preventive ambulatory medical and dental services, as well as social services and community activities. The program has four components:

1. Medical services

Medical services will be family-oriented: each family will have its own team of physician, public health nurse, and "family health worker." The family health worker is a neighborhood resident trained as a health assistant and a social "advocate." He or she will provide patient care and social case aide services, in the home, to all age groups. Local physicians will be employed wherever possible as the family doctors. Specialists in all the medical fields will provide services as required in the Health Center.

At least two satellite health centers will be established at convenient locations to provide referral service, well-baby care, the bulk of the pre-natal and post-natal care, immunizations, baby-sitting and transportation as required. These satellites will be run by public health nurses, aided by family health workers and health technicians. The effect of the satellites will be to extend the services of the health team further into the community. Major medical and surgical procedures will be provided at Montefiore and Morrisania Hospitals, which will also provide in-patient care.

2. Training program for health personnel

The N.M.C.D. training program fulfills two major needs. The first is to provide much-needed jobs, and jobs with a real future, in a community where there is a high level of unemployment. The second is to provide well-trained personnel for the N.M.C.D. health facilities, and other health agencies such as the local hospitals. The shortage of personnel in the health fields is very well known. The N.M.C.D. training program prepares local residents for both existing careers and for new health positions, such as family health workers and physician assistants.

The program starts with an eight-week course ("core curriculum") in basic health skills, a survey of health careers, community resources, and remedial English and mathematics. Following this general orientation period students move on to the on-the-job training of their choice. The positions available include family health workers, laboratory technicians, medical record assistants,

obstetrical technicians and inhalation therapists. Trainees are recruited exclusively from the neighborhood; they may be from age 18 to 55 years; most were previously unemployed. They are paid by the N.M.C.D. during training. On satisfactory completion of their training, the length of which depends on the positions being trained for, there is a reasonable guarantee of a job.

3. Community development

The N.M.C.D. aims to become self-supporting, and to be a model that can be replicated elsewhere. One of its principal objectives is to involve neighborhood residents in the organization, policy planning, operation and provision of services. This is the mandate of the community development department. It is concerned with the two-way process of informing the community about N.M.C.D. and the N.M.C.D. about the community. To this end, the community development staff hold a constant series of meetings—with individuals, neighborhood groups and organizations, in people's homes, in churches, and in schools. They set up meetings of the Advisory Board to which all interested community residents are invited, and which has sub-committees to help plan and run the component parts of the N.M.C.D. program. The Board and the community development staff are also considering ways of establishing a community Board of Directors, which—as soon as feasible—will have the responsibility for guiding the entire project.

4. Research and evaluations

The research department is responsible for providing analytic description and critical assessment of each stage of the N.M.C.D. program, and also of the project's impact on the community. A total census of the neighborhood has been completed, which has provided much valuable information about the community served by the project. By means of on-going evaluation and assessment, the research staff point out the program's strengths and weaknesses and through this "action" orientation help the program meet its goals.

Appendix 2

Community Living Project for the Aged

(A joint project proposal submitted to the NYC Housing Authority by Bronx State Hospital, Hodson Center for the Aged, neighborhood medical care demonstration (Montefiore-Morrisania Hospital), the PIBLY Fund, Inc.)

BACKGROUND

We have a deep concern regarding the problems which increasing numbers of aging people in our population must face. The problems of providing them with adequate income, maintenance housing, leisure time activities, and attending to their medical and psychiatric needs is a major concern in our society.

For a substantial number of our elderly patients with moments of intellectual impairment—without a family to care for them or adequate funds for a nursing home—the mental hospital has become the final "dumping ground". Once a patient has been accepted into a mental institution, though he may have made a recovery, he seems no longer acceptable to existing facilities, e.g., Homes for the Aged, Nursing Homes, etc. The mental hospitals (especially the state hospitals), as a result are becoming the unwilling repository for the aged. Many of these patients can manage in the community with a little support from creative and reaching-out community resources.

OBJECTIVES OF PROJECT

1. Provide community facilities for elderly patients released from mental hospitals.
2. Provide a 24 hour "on call" professional person in close proximity to the living situation of the persons in the project to give social and personal services.
3. Provide the necessary housekeeping and appropriate cooking services.
4. Provide educational and recreational services to those in the project through a recognized social agency providing such services.
5. Provide comprehensive medical care through a medical service in the community.

METHODOLOGY

A. The participants for this demonstration project to be selected by the psychiatric staff of Bronx State Hospital. Criterion for selection to include the following:

1. Demonstrated ability to re-assume community living (through test living in Bronx State's special "Hotel" living arrangement).
2. Must be ambulatory.
3. Previous residence experience (former residence in a low-income housing project would be helpful).
4. Residents of the project area (Health Districts 24 and 26) would be given priority.

B. Selection of 8 apartments in the Claremont Village Housing Authority complex (includes Butler, Webster, Morrisania and Murphy Houses) to house up to sixteen individuals. The apartments to be leased to the Pibly Fund, Inc., (a non-profit philanthropic organization dedicated to the welfare and social needs of the people especially through providing housing for special projects such as this one). The Pibly Fund, Inc., has already entered into a contractual agreement with the New York City Housing for a similar project involving the Bronx State Hospital in the Edenwald Houses. The leasehold would be in perpetuity to the Pibly Fund, Inc., so that turnover of clientele will not affect the continuation of the demonstration project. Selection of individuals for public housing, of course, will be in the hands of the New York City Housing Authority.

C. Recreational and educational services to be provided by Hodson Center, a recognized agency serving elderly members of the Claremont Village area.

D. Comprehensive medical services to be given by Montefiore Hospital's N.M.C.D., through its main Health Center, which will be situated in close proximity to the Claremont Houses.

E. Psychiatric Aides (selected from the Claremont area and trained by the N.M.C.D. Training Program) employed by Bronx State Hospital and living in the Claremont Village Housing area to give daily and round the clock "on call" personal and social services to the project members.

F. Evaluation methods to be worked out.

(The chairman addressed the following questions to Dr. Wise in a letter written subsequent to the hearings:)

1. You have already submitted material giving additional information about your program, but I would like to have some discussion from you on the importance of your family health workers. How many such workers, would you say, will be needed in your overall project? Can other Federal programs be of assistance to you in providing additional training facilities or other services? (You ask in your statement for training funds to demonstrate employment opportunities for the elderly in health and social services, but I am curious as to what agency would conduct such a program).

In areas without OEO Health Centers, can such family health workers be provided through other programs, or would new legislation be needed?

2. May we also have statistics and descriptive material about other individuals trained in conjunction with your Demonstration, or does your September 1, 1967 report give us the latest information?

3. You have given us a proposal for a Geriatric Group Living Project in Claremont Village. What is the status of that proposal?

4. Can you give me additional commentary on your proposal that funds now available for hospital construction be made available for Health Center and Home Care Facility construction? It seems to me that you emphatically believe that such centers should be associated with major hospital centers. Can such centers function well unless supported by an effective hospital center?

(The following reply was received:)

1. THE FAMILY HEALTH WORKERS

The family Health Workers are the multi purpose workers with medical and social service skills. She has incorporated into her role some of the sub-professional functions of the Public Health Nurse, the Lawyer and the Social Worker. Most of their time is involved in making home visits in the community. I am enclosing a paper describing the Family Health Workers, which you may use as you

wish. The Family Health Worker has allowed us to use fewer scarce health professionals and to use them more efficiently without compromising the high quality of medical care provided by Montefiore Hospital.

There appears to be great potential for upward mobility for the Family Health Worker. We are at present negotiating with the City University of New York so that Family Health Workers can be put on a career ladder which would give them at the end of additional training, a Registered Nurse degree and would provide much needed nursing manpower to serve in the out-patient and home care field.

Number of workers necessary

We estimate that we need one Family Health Worker for every five hundred people in the community with an active case-load of about one hundred people.

Financing of training

Although there is some money available through the Office of Economic Opportunity and through manpower training for training of Family Health Workers, it is not really sufficient. There is no money now available allowing the nonprofessional to continue his training to the professional level.

Use of the elderly

Training of the elderly could be of great use in home care services. Social Service roles in recreation roles, those who are fit in Family Health Worker roles. The home care services are sufficiently flexible to accommodate the part-time person as Home Help Aides. Hospitals with organized home care programs or with Health Centers would be, in my mind the best training focus. Funds could be made available for training through HEW or through the Social Services Administration.

Family Health Workers can be readily adapted to other health service institutional roles. For example, Dr. Zwerling of Bronx State Hospital plans to use them in psychiatric service. There is no legislation, however, to provide for the training or support of Family Health Workers as they are presently constituted.

2. ENCLOSED YOU WILL FIND OUR MOST RECENT STATISTICS, DESCRIBING OUR TRAINING PROGRAM

3. GERIATRIC GROUP LIVING PROJECT IN CLAREMONT VILLAGE

Except for the possible legal difficulties, the Housing Authority has accepted the principle of providing housing for the elderly especially those discharged from State and General Hospitals. We have only begun negotiations with the Housing Authority for the Geriatric Group Living Project.

4. FUNDS FOR HEALTH CENTERS

At the present time, the Federal Government puts up one-third matching funds through Hill-Burton for hospitals. Although HUD provides money for multi purpose facilities, no money from HUD has yet been obtained and with the present budget cut that Congress has enacted, it does not look like money is available for new construction of Health Centers. Montefiore undertook the purchase of a building, which the OEO helped renovate. I am sending you a copy of an article from yesterday's New York Times, describing the City's attempt to get the Health Centers financed through use of municipal funds.

STATEMENT BY MRS. DAVIS

Mrs. DAVIS. Senator Smathers, we have a great feeling for old people here in New York and especially in the Bronx. There are many feasibilities that can be reached to lengthen their lives. If something is done when a person is in a hospital and has been cured as far as medical aid is concerned, that person needs to be dismissed from the hospital, put back into society with an active life. I think it is very unfortunate and very unfair to have a person in a hospital when they can be out in society doing a creative job in their own little way and releasing places that they are holding for someone who is ill and really needs it.

Now here in the Bronx in the 24th and 26th Districts with the NMCD we have worked and we have a little idea as to how these things can or may be done which to us will be experimental. We know that you know more about it than we do. However, I would like to say that if we would take about six or eight units and set those units up, make homes for these people who are unable to care for themselves, train homemakers or health workers to look after them, to go in and see that they are kept clean and comfortable, give them their meals—here at Hodson Center this is a center for rehabilitation. I am quite sure they can get recreation and exercise here. Now to do that you would have to ask the better informed to help us, and I think that these people who have given so much are entitled to a little help.

There is a lot more that I could say but the time is short and I think Mrs. Lopez has something to say and I would like her to, but please think it over. [Applause.]

STATEMENT BY MRS. LOPEZ

Mrs. LOPEZ. Well, after listening to Mrs. Davis I don't think that there is more that I can say, but I really agree with her that we really need some help for them because I think they deserve it. [Applause.]

Senator SMATHERS. Thank you very much, Dr. Wise, and thank you, Mrs. Davis, and thank you, Mrs. Lopez, for your very informative and very helpful testimony. You can be certain that we are impressed with what you say.

We do hope the Congress would be of such a mind. Certainly if we could control it, there would be no problem but we have 435 Members of the House of Representatives and 100 Members of the Senate. You can be certain, however, that Senator Kennedy, Senator Javits, and I will do everything we can to keep this kind of a project going. Thank you very much for your testimony.

Is Miss Gertrude Landau, the director, here?

We want to thank you, Miss Landau, for the many, many courtesies which you have extended to us while we have been here.

Miss LANDAU. You are certainly welcome.

Senator SMATHERS. Our next witness is the ranking minority member of the New York State Joint Legislative Committee on Public Health and Medicare, former chairman of the committee when the Democrats were in power, Seymour Thaler, who is New York State senator from the 10th District.

Senator, we are delighted to have you.

STATEMENT OF THE HON. SEYMOUR THALER, NEW YORK STATE SENATOR, 10TH DISTRICT, QUEENS

Senator THALER. First I want to thank you, Senator Smathers, for this opportunity to appear before your committee and present my views on the care of the elderly. Sometimes disappointing is the performance of the National Health Act of 1965 which we commonly refer to as medicare and medicaid. My prepared statement is limited to part B of title 18. However, in view of the somewhat misleading statements about the great performance of part A, I will try and summarize what I have prepared so that I can have some time to talk about the fact that part A in its application is not as rosy as Dr.

Cherkasky would have you believe, and I think perhaps that is not deliberate on his part but he is hardly the typical example of the hospital administrator in the city of New York or State of New York or, I dare say, any place in the Nation.

As far as my formal presentation, it is my opinion based upon documentary evidence which I am submitting to this committee that our elderly citizens are now paying more for their medical bills than any other segment of our society. In short, many doctors are deliberately, although legally, distorting the program to insure a greater economic return for themselves at a greater cost to the elderly people.

Now as you know a doctor has a unilateral choice either to accept assignment, which means to bill the Government directly and then be bound by the reasonable and customary charge, or in the alternative at his own option again to bill the patient. Where the ceiling is nonexistent he can bill any amount he pleases and the patient after paying the bill sends it in for reimbursement and only gets back the reasonable and customary charge.

Now one-third of the doctors in New York City have agreed to take assignments, two-thirds of them have said, "No dice, we are going to bill the patient and let the patient fend for himself," and that is exactly what is happening. He has to fend for himself because we have found that many of the doctors are charging above and beyond what they themselves have set as the locality reasonable and customary fee.

Now let me explain how we arrive in this area at the reasonable and customary fee. Blue Shield by choice of the doctors was made the fiscal intermediary for part B of medicare. Blue Shield in November of 1965 sent a questionnaire to 15,000 doctors and said, "Fellows, fill out this questionnaire and let us know your customary charges for the services performed regardless of the income level of your patients but exclude from that any charity work you do or nominal fee work you do for medically indigent patients."

They said in their letter, and I want to quote, "Gentlemen Doctors, we are doing this in order to develop programs that will provide for more realistic payments." So they gave the doctor the incentive in filling out the self-serving declaration of what his reasonable and customary fee was with advance notice that they were doing this for the purpose of determining what the rates will be to reimburse them for reasonable costs. I think we can assume that the doctors were not too modest nor self-effacing in listing what their reasonable or customary or usual charge was. This when it came back was politely and is politely referred to as the doctor's fee profile.

Now when the bill comes from a doctor after the patient paid for it, Blue Shield takes that bill and compares it with the doctor's own fee profile which as I said was a self-serving declaration and if it is not out of line with his fee profile and not out of line with the prevailing rate in his county, and it is limited county by county, then they pay it subject, of course, to the $50 deductible and the 20-percent coinsurance.

Blue Shield Comments on Fees

I spoke to Blue Shield just yesterday and it confirmed the letter which they answered in response to my inquiry which said that a recent study they have made indicates, and I will read the language, "Doc-

tors' charges in relation to allowed charges indicates that the percentage of allowed charges to doctors' charges is 83 percent." Translated into simple language that means according to their sample survey they admit that 17 percent of the doctors' bills are in excess of their own reasonable and customary fees in that county.

I must add, however, that Blue Shield is being very generous to the doctor because the doctor at any time on his own initiative can file a new fee profile and up his reasonable and customary charge. I understand in excess of 100 doctors have already found out about this and they are beginning to file new fee profiles.

In bread-and-butter terms what does this mean? I have given you Verifax copies of Blue Shield memoranda, and I might add that these cases I have given to you are indicative of hundreds more I can submit to this committee, all of which were chosen at random from union files of laboring people, people in the working field. We are not talking about a wealthy medicare patient, we are talking about a workingman.

Patient A was treated by a doctor Anthony J. Rella and was billed $500. Blue Shield said that the reasonable and customary cost was $175. After you take out the coinsurance Blue paid $140 and the patient paid $360.

Dr. Robert H. Goetz charged patient B $125. Blue Shield set $60 as the reasonable and customary charge. After taking off $50 deductible and 20 percent of coinsurance, Blue Shield gave the patient $10.83 out of a total bill of $125.

Dr. Moskowitz charged patient C $750. Blue Shield said it was only worth $300 so the patient paid $510 and Blue Shield paid $240.

Dr. C. J. Campbell charged $350 to remove a cataract. Blue Shield allowed $175 which meant that the patient paid $214 and Blue Shield $136.

I want to tell you, we have one classic case and I am allowed to get the bills and submit them to you, a woman had a cataract removed just before medicare. The doctor charged her $175. Six months later the same woman needed an operation for a cataract, same operation, on the other eye, same doctor. This time he billed her $500 and she got back a big $100 from Blue Shield.

Let me give you another example. Dr. George W. Fish operated on patient E's prostate gland and charged $1,000. What did he get back from Blue Shield? Two hundred dollars because Blue Shield said the customary and usual fee was $300. So after the $50 deductible, 20 percent coinsurance, the patient paid $800, Blue Shield paid $200.

Incidentally, all this, as I say, is documented in the evidence I have submitted to the committee.

Now what happens if a patient does not go to a private doctor, he goes to one of these clinics that these gentlemen were talking about? Just this morning, to give you an example of patient F, again documented in what I am giving this committee, Mrs. F has a blood condition. She went to Mount Sinai Clinic once a week for years. She was charged $1.50 for a B12 shot and then raised it to $1.75. She never sees the doctor because the nurse knows her, knows her condition, knows what to do.

Immediately after medicare Mount Sinai bills her $20. She pays now for the first two and a half visits at $20 a visit and after 20 percent

coinsurence she pays $4 a visit instead of $1.75. Well her husband told me what public service can do with medicare so far as he was concerned. [Applause.]

Senator SMATHERS. I might ask you there, Senator, just to see how you feel about it, Do you think we ought to do away with medicare?

Senator THALER. Not at all; but I think very seriously that the Congress ought to say that any doctor who treats a patient whose bills are paid by the Government ought to be constrained to accept the reasonable and customary fee in the locality and ought not to be given the privilege of taking Government funds and still charging more.

Incidentally, under H.R. 12080 you are about to compound the felony because up until the present time if a doctor had a poor patient and the patient did not have funds he had to take an assignment because the patient could not get reimbursement unless he paid the bill. Now the way the bill passed the House of Representatives, the patient can send in the bill to Blue Shield before he pays it so that the doctor can grab hold of the reasonable and customary fee and still keep dunning the poor patient for the balance of the fee, and that even makes it worse. It is before the Senate at the present time and I would hope that that amendment to the present legislation is deleted because this will mean that no doctor will hereafter take an assignment, there would be no purpose for him to do so.

More importantly, we are having difficulty, I as a State senator, of any effort to find out what is happening. Blue Cross will not tell us the rates that they pay either to hospitals or to nursing homes, either for in-patient or out-patient care. I called Blue Cross, I spoke to Doug Wohman, and he said Social Security tells us this is confidential information. Why should it be confidential, especially to a State senator?

I then called the State health department. I have spoken to the commissioner of the State health department, the commissioner of the State welfare department, and they tell me that they cannot get the rates that are being paid but if we can see what is happening under medicaid maybe we can come to the conclusion why.

COST-PLUS FORMULA

Now let me tell you how medicaid is reimbursing all these gentlemen you see up here today. They have a cost-plus formula which says, fellows, the more you spend we will reimburse you at a higher per diem rate. Not only will we reimburse you for all your expenditures—and incidentally I looked over some of these statements that are rendered by the hospitals, many of our hospitals buy retail, they buy their food at the corner drugstore. Many other of your major hospitals buy all their necessary furniture and other things through R. H. Macy's, they make no effort to economize. The more they spend, the more they get with no incentive at all for economy. But more importantly, the medicaid formula as approved by the Federal Government says, in addition to all your expenditures you will get 5 percent for research.

Now this does not say, is this hospital qualified to do research? Every hospital is entitled to 5 percent. Nobody goes in and says, fellows, do you have qualified people to conduct research or are you using clinical material to try out drugs for commercial outfits? Nobody says, are the objectives of your research any good? It merely says for every dollar

you spend you get another 5 cents for research if you spend it. So of course they spend it.

Then you get 5 percent more for repairs. It does not make any difference if this hospital needs 12 percent and this hospital only needs 2 percent, but on an across the board 5 percent not based on their need for repairs but based upon their expenditures plus 1½ percent for accumulated obsolescence and that they can accumulate over the years.

Eleven and a half cents is added to the formula based on how much they spend, not on how much they need. And boy they are spending it; it is almost unbelievable. Not for patient care but for desks, for carpets for doctors, for decorations for the offices, for all kinds of fancy personnel—not to increase the available salaries for nurses but the doctors have doubled their fees.

When Dr. Cherkasky says he raised the salary of a radiologist from $14,000 to $29,000, if it were limited to the radiologists I have had no objections but when we signed an affiliation contract just a few months ago they doubled the salary of every doctor because they had Government funds. Those doctors were not quitting. To the contrary, we had hundreds and thousands of doctors who were willing to contribute on a voluntary basis their efforts. You know what happened to them in the city of New York? They were kicked out of the hospitals and replaced by paid physicians.

I will tell you another thing, Senator. In this city of ours with the shortage of doctors, and we have the low level of care available to the people, one-third of our doctors are physically barred from coming into any hospital. They cannot bring their patients into any hospital. They even take care of them in their offices or at homes or they have to assign the patient to another doctor, they cannot get in. Yet every day you read in the newspapers that we can't get interns, we cannot get residents, and that they are flooded with foreign doctors who are poorly trained and can't even communicate with the patient because they cannot speak English.

More importantly, under this new medicaid reimbursement rate what has happened actually? Let me give you figures. Mount Sinai charges $81.85 a day for a ward patient. Let me repeat that. This is an official federally approved per diem rate, $81.85 per day for a ward patient and $17.56 for a clinic visit.

Let me reiterate. I am talking about medicaid officially approved reimbursement per diem rates. Montefiore charges $87.94 a day for a ward and $26.20 for a clinic visit. Presbyterian Hospital charges $76.95 and $15.22, respectively. Roosevelt charges $80.15 and $18.60, respectively. St. Lukes charges $89.91 and $20.30, respectively.

Another gimmick has come up and this is something new; it has never been given any publicity before. They now get an average of $80, let's say, a particular hospital for the patient being in there in a ward. They add to a medicare patient bill a sum of money in some hospitals as low as 3 percent, in some hospitals it goes up to $1.32 per day. In other hospitals it is as high as 20 percent for the availability of anesthesiology, pathology, and radiology—three, as you know, excluded services under part A. This is not for their receiving these services, they have gone into the insurance program. They say, you are paying this percentage because we have these services available in the

institution and that money is distributed among certain of the select doctors in many of the hospitals, it does not go to the hospital. If you need pathology, if you need anesthesiology, or if you need radiology, you get an additional bill which you pay under part B of medicare. So they are saying just because we are a hospital and you have these services here you pay for it and it does not go into the revenue of the hospital.

As a matter of fact, I wrote to the commissioner of the New York State Health Department, Dr. Andrew C. Fleck, Jr. He replied to me on October 11, and I quote:

It is also my understanding that the Social Security Administration has no regulations concerning the hospital's subsequent disposition of such funds.

In other words, this is added to the salaries in many institutions where they are already paying these well-intentioned doctors who are desirous only of doing good for their community.

It would seem to me that we have a great program here in principle but you cannot, in my opinion as a legislator of 9 years, take substantial Government funds and trust it to a private sector that is almost wholly uncontrolled, trust to their conscience, to their morality, to their compassion because that is too frequently an inadequate safeguard to prevent greed. We have a responsibility, you on the Federal level and I on a State level, to make certain that when we commit Government funds—and I might tell you that these gentlemen up here did not bother saying to you that approximately 50 percent of their entire budget is now paid out of medicare and medicaid funds.

On-Spot Audit Sought

Somebody ought to have an on-the-spot audit before expenditures are made as to where they are going, not a postaudit. But it is important enough as we have done under the defense program to have an accountant on the premises to determine whether expenditures are wisely made before they are made. I have gone into hospital after hospital and seen the most complex, sophisticated research equipment while at the same time the interns and the nurses literally cry that they could not get crutches or wheelchairs or electrocardiograms or pacemakers.

I have gone with one of the gentlemen of the press here into voluntary hospital and municipal hospital alike to see how patients were used not for their benefits but as clinical material for the property of science and for the purpose of teacher training. Human life is more important than to live it in the sole jurisdiction of a profession that has demonstrated on many scores that it no longer is bound by the Hippocratic oath. It would seem to me that the senior citizen today in many ways is worse off than he was prior to medicare. [Applause.]

Where Government funds are so largely committed to a basic social program we in the legislature must not permit a private sector to continue to make their own private ground rules. Medicare which was supposed to eliminate indignity and humiliation under the old Kerr-Mills program has nevertheless forced a large percentage of the elderly covered under medicare to still seek additional assistance under

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the medicaid program which is controlled by a welfare administration.

I would like to take one moment and ask, how many of you have medicaid cards? Not medicare—medicaid cards?

This is what has happened to the elderly people. I had an elderly man walk into my office and he said, "Senator, I got a problem." He took out a billfold and he opened up a long line of glass-paned envelopes and he pointed to it and he said in broken English:

> This is my Medicaid card, this is Medicare, Part A. This is my Blue Cross. This is my union health card because I am a retired member of the bricklayers union. And my Medicaid card is limited because I have all these other things.

I said, "What is your problem?"

He said, "I got a bellyache, what do I do?" [Laughter and applause.]

We have so fragmented the most basic social service, we have an obligation to give our citizenry that not even a Philadelphia lawyer could tell him of his rights. There can be nothing more important than preserving the health and life of our people. We live in a peculiar society that says that the child's education is the concern of all of us and its illiteracy is a social disease and we have to pay for his education out of a progressive tax system. But let that little kid get hit by a truck or get a heart attack and then we stop him at the door of a hospital and say, "Wait a minute, are you self-insured? Do you have Blue Cross? Can you pay? If not, plead poverty." [Applause.]

Senator, there is no reason why a courtroom where you and I litigate private rights ought to be paid for by Government, but a hospital where we may have to go to determine a case of cancer be part of the private sector only subsidized by Government. Certainly that hospital is much more a public function than a place to litigate private rights.

In summation I would say there is lots that the Congress could do, unfortunately we don't have enough Senator Smathers in the Senate. I wish we had more who comprehended and understood the problems that are involved. [Applause.]

It would seem to me that the Congress could, if we could have more men like you, give the doctors their just desert but on the other hand recognize that no amount of Government contribution can ever satisfy the uncontrolled and insatiable appetite of a private sector and deprive some members of the medical establishment.

Again my congratulations to you, sir, and my deep thanks for affording me this privilege. [Applause.]

Incidentally, Senator, your staff director, who I must compliment you is a great dedicated human being and terribly efficient, spoke to me at some length about a nursing home problem and I think Dr. Wise touched on it. I have gone through in addition to hospitals a number of nursing homes. We have a lot of people in nursing homes who really don't need nursing homes, they need our homes like these, but they are kept in nursing homes because medicaid won't pay the bill if they go into an old age home or into a home like this. In a nursing home although they are ambulatory and custodial care they are prolonged there so that the Government will pay the costs.

This is backing up into the hospital and the hospital in turn cannot really see the patients into the nursing home. It seems to me that we must define what a hospital is, what an extended care facility is, what

a nursing home is and what an old age home is, and we ought to try and make certain that those yardsticks are adequately enforced and that will eliminate a great deal of the cost involved.

Some day to one of your subcommittees I would like to spell out the conditions we have found in some of these nursing homes, both voluntary and proprietary. I think the committee would do itself a great favor if it could some day visit a few of these nursing homes unannounced. I would recommend you do it before a weekend, you will need at least 2 days to rest up over the mental and physical shock you will receive in looking at how we treat some of our elderly citizenry in this 20th century.

Thank you. [Applause.]

Senator SMATHERS. Thank you very much, Senator Thaler. You certainly made a splendid statement and gave us many constructive ideas.

(The prepared statement of Senator Thaler follows:)

PREPARED STATEMENT OF SEYMOUR THALER, NEW YORK STATE SENATOR, 10TH DISTRICT, QUEENS

Mr. Chairman and members of the Special Committee on Aging.

I am Seymour R. Thaler, New York State Senator and the ranking minority member and former chairman of the New York State Joint Legislative Committee on Public Health and Medicare. I am grateful for this opportunity to present my personal observations on the effect of the much heralded, but somewhat disappointing, performance of the National Health Act of 1965, commonly referred to as Medicare and Medicaid.

It is my opinion that our senior citizens are now paying more for their medical bills, under Part B of Title 18, than any other segment of our society. In short, many doctors are deliberately—albeit legally—distorting the program to insure a greater economic return to themselves at a greater cost to the elderly patient.

Let me explain how this has happened. Under Part B, a person over 65 years who pays $3.00 a month for a total of $36 a year—soon, we hear, to be raised to $4 or $4.50 per month—is supposed to have his medical bills paid by the Federal Government after, of course, the patient pays the first $50 plus 20% of the balance. The law provides, however, that a doctor may not charge government more then "the reasonable and customary fee" for the service rendered.

The legislation, even if not so intended, is helpful only in cases of fairly extensive medical bills. To demonstrate, if a patient's bill amounts to $100, in addition to the annual cost of $36 he has already paid by way of monthly contributions, he must also pay the first $50 plus 20% of the balance, or $10, or a total of $96 for a medical bill of $100. Assuming his medical costs for the year amounts to $200, he would be required to pay $116 out of the total bill—still more then 50% of the total cost.

But there are two gimmicks in the legislation which have been used by many members of the medical profession to milk our elderly citizens.

First, the doctor is permitted, at his own option, to either bill the government directly or to bill the patient who can then seek reimbursement from the government. Most doctors have deliberately decided to bill patients rather then their own fiscal intermediary—in this locality United Medical Service, commonly known as Blue Shield. I am informed that in New York City only one-third of the practicing doctors agreed to "accept assignments", that is, to bill government rather than their patients.

Second, nothing in the legislation prohibits a doctor from charging his patient any amount in excess of the "reasonable and customary fee." He legally can unilaterally determine the size of his bill. The patient, on the other hand, is reimbursed by Blue Shield under the "usual and customary fee" limitations. There is no ceiling of any kind upon the doctor's billing practices except his own conscience, morality or compassion—a barometer which is all too frequently an inadequate safeguard against greed.

In November of 1965, Blue Shield conducted a survey of physicians "to accumulate customary charge data". Some 15,000 physicians were asked to list their usual charge". The phrase, "usual charge" was defined by UMS as "the fee you

charge most of your patients for the listed procedures or services, regardless of the patient's income level" and directed the physician not to "include the many occasions you render care to charity or medically indigent patients without charge or for a nominal fee". Since Blue Shield indicated that the purpose of the inquiry was to "develop programs that will provide more realistic payments" and since the answers were, at best, self-serving, I think it can be realistically assumed that most doctors were neither modest nor self-effacing in listing their "usual charges". The individual questionnaire, when completed, is politely referred to by Blue Shield as the doctor's "Fee Profile".

Nevertheless, many doctors bills are being reduced by Blue Shield. After they compare it with his "Fee Profile" and the prevailing charges in his county, the patient is the scapegoat since he has to pay the difference.

On October 6, 1967, in replying to my inquiry, Dr. Harold J. Safian, Vice-President of Medical Affairs of Blue Shield stated that "a recent UMS study of doctors' charges in relation to 'allowed charges' indicates that, the percent of 'allowed charges' to doctors charges is 83% . . .". In simple language, 17% of the doctors bills are in excess of the "reasonable and customary fees". I must add, however, that Blue Shield is most generous in permitting a doctor, at any time, on his own initiative, to change his fee profile to reflect increases in his so-called customary charges and that many doctors have already taken advantage of this benevolent attitude.

In bread and butter terms, just what has this meant to the individual elderly patient who was already faced by an 8.9% general increase in doctors fees? Let us look at the record.

Patient "A" treated by Dr. Anthony J. Rella was billed $500. Blue Shield allowed as the reasonable and customary fee for the services involved $175. After deducting $35 for co-insurance (apparently he had already used up his $50 deductible), Blue Shield reimbursed the patient $140 and the patient paid $360.

Dr. Robert H. Goetz charged Patient "B" $125. Blue Shield set $60 as the "allowed charge" for the service performed. After the deductible and co-insurance, UMS reimbursed the patient a total of $10.83 out of a total bill of $125.

Dr. Lester Moskowitz charged Patient "C" $750. Blue Shield set $300 as the "allowed charge" so that the patient paid $510 as his share and Blue Shield paid only $240.

Dr. C. J. Campbell charged Patient "D" $350 to remove a cataract. Blue Shield allowed only $175 as the usual and customary fee. As a result, the patient paid $214 and Blue Shield only $136.

We have one case where a patient had a cataract removed prior to Medicare and was charged $175. After Medicare came into effect, the same patient had a similar operation by the same doctor who now charged $500. After Medicare, the patient had to pay a total of $400 whereas before Medicare, he merely paid $175.

Dr. George W. Fish operated on Patient "E" 's prostate and charged $1,000. Blue Shield set $300 as the usual and customary fee which meant the patient, after the deductible and co-insurance, paid $800 and Blue Shield paid $200.

Copies of these Blue Shield memoranda with the patients names deleted are annexed to my testimony submitted to this Committee.[1] I must emphasize that the patients are all working people since these, and many other similar cases, come out of union files.

Just how is this affecting the elderly patients who visit a clinic? Let me tell you the story of Mrs. "F" who, due to a blood condition, visits Mt. Sinai clinic weekly for a B12 injection. She seldom bothers the doctor since the nurse is familiar with the case and performs the needed service. Prior to Medicare, she was first charged $1.50 and then $1.75 per visit. The moment Medicare began to *help* her, the hospital billed $20 a visit which meant that she was required to pay for the first 2½ visits or $50 plus 20% of all subsequent visits or $4 a visit—instead of $1.50 or $1.75. Her husband told me what we could do with Medicare as far as he was concerned.

It might interest you to know that it would appear that a fraud is being practiced on the elderly persons since Blue Cross is only paying 60% of the billed charges, at the present time, which means that the hospital is only collecting

[1] In committee files.

$12 per visit from Blue Cross, but that the patient pays his deductible and 20% co-insurance based upon $20 a visit.

It might further interest this Subcommittee to know that Blue Cross refuses to disclose inpatient and outpatient rates paid to individual hospitals and nursing homes since Social Security, I am told, insists that such information is confidential . . . Why? State officials have also been rejected by Federal Government and Blue Cross. Whatever information we have is gathered through incidental exposure to individual patient's bills. However, if we can judge Title 18 rates on the basis of the officially promulgated and federally approved Title 19 rates, the statistics are awesome and fantastic. Let me give you some examples of Medicaid rates in this area.

Mt. Sinai charges $81.85 per day for a *ward* patient and 17.56 for a clinic visit. Let me reiterate: I am talking about the *officially approved Medicaid* rates. New York Hospital charges 84.92 per day for a ward patient and 20.25 per clinic visit. Montefiore Hospital charges 87.94 per ward day and 26.20 per clinic visit. Presbyterian Hospital charges 76.95 and 15.22 respectively. Roosevelt Hospital 80.15 and 18.60 respectively. St. Lukes 89.91 and 20.30 respectively.

Further, many hospitals now add a per diem charge to a Medicare inpatient's bill for the availability of such services as anesthesiology, radiology and pathology, not covered under Title 18, Part A. This additional sum of money (ranging in some cases from 3% of the total bill to $1.32 per day in one hospital) is in some hospitals distributed to selected members of the medical staff and is billed to the patient whether or not he receives any such services. In fact, in spite of this per diem charge, if the patient does receive such excluded services, he is billed an additional amount of money for the specific services under Part B of Medicare. In response to my inquiry, Deputy Commissioner of the New York State Health Department, Dr. Andrew C. Fleck, Jr. replied on October 11, 1967 "it is also my understanding that the Social Security Administration has no regulations concerning the hospital's subsequent disposition of such funds".

To make matters worse, H.R. 12080, passed by the House of Representatives, introduced still another gimmick to enable doctors to avoid adhering to the "reasonable and customary fee" principle.

Under the present statute, a doctor who refuses to accept an assignment so that he can bill the patient above the "allowed charges" must be paid by the patient *before* the patient can submit the bill for reimbursement. As a result, if a patient does not have enough money to pay the doctor, the doctor has been forced to take an assignment and, therefore, be bound by the "allowed charge". Under the new amendment, patients would no longer be required to pay the bill before seeking reimbursement. This, therefore, would enable a doctor to collect the "reasonable and usual fee" from even the poorest patient and still dun him for any balance.

It is my hope that you, gentlemen, will make every effort to delete this unconscionable provision in an effort to arrest the ever spiralling cost of medical services to our elderly. *Many, if not most, of our senior citizens are worse off today than they were prior to Medicare,* and doctors bills to the rest of us are daily being increased to match Medicare rates. Where government funds are so largely committed to a basic social program, the Legislature should not permit a private sector to continue to make their own ground rules.

Medicare, which was supposed to eliminate the indignity and humiliation of the old Kerr-Mills Program, has nevertheless forced a large percentage of our elderly to seek additional assistance under the Medicaid Program still controlled by a welfare administration.

I think it is apparent that no amount of government contribution can ever satisfy the uncontrolled, insatiable appetite of many members of the medical establishment. We must have corrective legislation.

Again, Senator Smathers and gentlemen, thank you for affording me this privilege of testifying before your Subcommittee.

Senator SMATHERS. Our next group of witnesses we are going to ask to come up together. I would like for Mrs. Ethel McDonough, Mr. James Tobin, and Miss Patricia Carter to come together. Miss Carter is the director of the consumer education project, Hudson Guild-Fulton Center. Mrs. McDonough and Mr. Tobin are from the Fulton Senior Association, Manhattan.

STATEMENTS OF ETHEL McDONOUGH, FULTON SENIOR ASSOCIATION, MANHATTAN; BERNARDO NEGRON, HUDSON GUILD-FULTON CENTER; AND PATRICIA CARTER, DIRECTOR, CONSUMER EDUCATION PROJECTS, HUDSON GUILD-FULTON CENTER

STATEMENT OF MRS. ETHEL McDONOUGH

Mrs. McDONOUGH. Senator and members of the committee, I am now employed by Project FIND—friendless, isolated, needy, and disabled.

During the spring of 1966 I was hired by the Community Progress Center on West 34th Street in Manhattan to serve as a community aide. Like most aides I was assigned to a social agency. My agency was Hudson Guild, my job was that of friendly visitor.

Following are two cases that I worked on during the year, Mrs. Kathryn McCarthy, an 83-year-old widow lived on a pension of $27 monthly and was supplemented by New York City Public Department of Welfare. She lived in a tiny room two floors up. She had a cardiac condition and also suffered from arthritis.

Miss Simmons, our VISTA worker at Hudson Guild, found Mrs. McCarthy unconscious on the floor the month before and asked me to visit Mrs. McCarthy and to assist her with clinic visits and shopping. During this period I took Mrs. McCarthy to the clinic eight times by cab. Mrs. McCarthy was not capable of walking more than three or four blocks and we spent on the average of six and a half hours waiting in the clinics for service.

Since Mrs. McCarthy was a cardic case she was also in need of money for special diets. She was in the salt-free diet during this time and I did her food shopping. We made several calls to the New York City Department of Welfare for help but with no results. Demands for cabfare refunds were not answered during this period. Mrs. McCarthy had four different investigators, none of whom visited her.

Finally, after accumulating a cab bill of $11.50 from Mrs. McCarthy and over $30 for other shut-ins, Miss Simmons reported this to Hudson Guild officials. Mr. Pilpel gave Miss Simmons a check from the Hudson Guild to cover this and suggested that we not accumulate any more bills for elderly shut-ins as the agency was not financially able to supplement them.

Finally we got an increase in welfare for Mrs. McCarthy's food allowance but never the cabfare refunds.

Another case is Mrs. Anna Burke, a client of welfare. She had trouble walking and had a cardiac condition. In October 1965 the man from the Chelsea Elliott housing project called Miss Simmons and asked her to visit Mrs. Burke and get her rent. Although Mrs. Burke received a monthly check from the New York City Department of Welfare, she always refused to pay her rent. After working with her a couple of months, Miss Simmons referred her to me. I spent hours shopping and talking to her. At nights at home and on weekends I would get calls from Mrs. Burke to please come visit. I finally became known as her woman.

One weekend in late 1967 Mrs. Burke suffered a heart attack and died at a local hospital. Thus ended nearly 2 years of Hudson Guild service to Mrs. Burke.

For a period of 2 years as a community aide I did friendly visiting and shopping for over 300 people. I have done the following for these people: found cleaning women, had prescriptions filled, cashed welfare checks to pay rent, taken people to the clinic, visited people in the hospital. All these services were needed because the people had no relations, no one to turn to when they needed help, and by the way they still need help.

Thank you so much. [Applause.]

Senator SMATHERS. All right.

Miss CARTER. This is Bernardo Negron who is a VISTA worker at the Hudson Guild.

Senator SMATHERS. All right, sir. You go right ahead.

STATEMENT BY MR. NEGRON

Mr. NEGRON. Senator Smathers, ladies, and gentlemen, I am a Puerto Rican by birth and a VISTA worker at the Hudson Guild-Fulton Center. I am 68 years old and have been attached to the Hudson Guild-Fulton Center for the past 2 years. I have worked closely with medicare alert. Miss Carter has submitted a copy of the medicaid literature for the committee to see. It is impossible to understand, and as a result we must explain the program, on a person-to-person basis and we must help the people fill out their applications. This is very time consuming, and we are not able to reach all of the people eligible for medicaid.

I have taken many people to the hospital for clinic visits and we have had to wait all day for treatment. As you are aware, clinic waiting rooms are very ugly and uncomfortable places. There is a lack of concern about people's feelings, and sometimes they are treated very roughly because they are very poor and sometimes cannot speak English well. Many times elderly people are not treated because of the number of people waiting for treatment, and they are told to come back the next day. So they spend day after day in clinic waiting rooms.

Angel Lopez, a crippled man, age 73, lived alone in a public housing project. One morning I took him to the clinic and I could not stay because of other visits and agreed to come back later that day to pick him up. In the afternoon I received a telephone call to come and pick him up because nothing could be done for him. A few days later I took him to another hospital where they hospitalized him until I could make arrangements for him to be admitted to the Sailor's Snug Harbor Home for the rest of his life.

As you can see, gentlemen, there is a great need for improved health services for older people. In my own case I have not been able to get medicaid because I have a $3,000 savings account in a bank. I have not been able to get medicare because I went to a hospital and there I had some treatment not covered by medicare and I got a bill for $162 but I was glad because I was under Blue Cross and Blue Shield who took care of that and paid.

I thank you ever so much for this opportunity that you have given me. My recommendation before I leave is that any treatment received by any patient ought to be signed by this patient because we have cases

where patients have been sent a bill for things they have not used. I have a case of a lady who was sent a bill for 3 pints of blood and she never saw any blood in that hospital. We ought to have the patient sign the bill before it is paid.

Thank you ever so much. [Applause.]

Senator SMATHERS. All right. Miss Patricia Carter, director of consumer education project.

STATEMENT BY MISS CARTER

Miss CARTER. Thank you very much.

The Hudson Guild's consumer education project sponsored by the New York State Office for the Aging has been vitally concerned about the best use of the health dollar. We have found that consumer education is very different from our original conception of it and we have had to get into many other areas. For example, we cooperated in a Medicaid Alert campaign for this purpose. We found that older people negatively associated medicaid with welfare and that many would not take advantage of the program for this reason. The major fears were that their bank accounts and insurance would be taken away and that this program would be as demoralizing and stigmatizing as is public assistance. It was necessary to work on a person to person basis to explain and assure people of the program's validity.

As Mr. Negron mentioned, the literature is unreadable and this added to our job.

The list of participating doctors and services distributed by welfare was inadequate. Several people were asked to leave doctors' offices when they presented their medicaid card. The word about this quickly spread throughout the Fulton Center and further complicated the situation. We finally had to call up doctors and services individually to find out if they would accept medicaid patients and at what times. We found that some doctors didn't want poor people cluttering up their offices at times when wealthier patients were there, and they admitted this to us.

The cost of maintenance drugs is prohibitive to a person who is not on medicaid. Some of our people have not been accepted for medicaid simply because of a few hundred dollars and it is these people on the borderline who are so drastically affected by high drug costs. We have started a cooperative arrangement with the drug plan and have been saving amounts from 69 cents to $5 on prescription costs.

As you know, most doctors do not apply for medicare, the patient does this. The redtape being what it is, older people must wait from several weeks to several months before they are reimbursed. This amount can be substantial and what does a person living on a minimum income do?

Persons on medicaid who have not been reimbursed for the $3 medicare cost also have a problem. A woman came to me about this saying that the $3 would mean a lot to her. It would mean $61 a month rather than $58.

You already have been told about the lack of concern at hospital clinics. One of our members has discovered a lump on her neck. Of course, her first thought is cancer. She has been waiting 5 weeks for a

diagnosis. She has gone to the clinic, been examined and given another appointment. Can you imagine what turmoil she is going through?

Since hospital beds are scarce, patients are sent home as quickly as possible. Who then is responsible for caring for them? A 75-year-old woman was hit by a car and sent home the same night. She cannot walk well and is bruised. Who is to take her to the clinic? Who is to prepare her food? Who is to check on her occasionally?

A number of people have been found dead or unconscious in their rooms both in roominghouses and the public housing projects. Some have been found with the telephone in their hand. Who is responsible for them?

Also, gentlemen, do not confine health interests to hospital and doctor care. It is not to a man's best health interest when he has a heart condition and must walk up six flights of stairs because there is not enough adequate housing, and it is not to a person's best health interest when there is not enough money to eat well.

I would like to close by telling you about one of our members. Mr. Joffee was going to have an operation. One day he came into the Center crying. He was holding a note from his doctor to "Admitting." The note described the operation and noted that Mr. Joffee was a "very poor risk." He had a heart condition. I will never forget the last time that I saw him. He knew so emphatically that he was going to die. After all, his doctor said so. He had a heart attack during surgery and was sent to a nursing home to recover. He had another heart attack and died. Was the note influential in his death. Who can say? But what does a man feel going into surgery knowing that he is expected to die?

Thank you. [Applause.]

Mr. Oriol. The other witnesses have described the long waiting at clinics for attention now. A few years ago at the Center you had a health maintenance project, did you not?

Miss Carter. Yes; we did.

Mr. Oriol. And that project managed to keep people out of clinics, didn't it?

Miss Carter. It was worked in cooperation with the St. Vincent's Hospital and it did save a lot of time because many of the cases were sort of screened through this health maintenance clinic and very simple things could be done there.

Mr. Oriol. You had almost a neighborhood approach?

Miss Carter. That is right.

Mr. Oriol. And the reason it was successful in your area, especially successful, as I understand, you did have a high concentration of elderly and you still do.

Miss Carter. Yes. It was located in a public housing project and 500 old people live there alone.

Mr. Oriol. So it is a very simple matter for them to come to their health maintenance center. What has happened to that program?

Miss Carter. That program was closed before I started at the guild which was about a year ago and nothing has been done since then.

Mr. Oriol. As a result people who formerly went to the health maintenance center are now waiting in the clinics.

Miss Carter. That is right. One of the advantages of such a clinic, for example, one lady who has very poor eyesight clipped her toenails

and got an infection. She had to go to the hospital and wait all day to get this fixed. It was such a little bit of care that a health maintenance clinic could clip her toenails for her. This sort of small thing, we could save a lot of time.

Mr. ORIOL. For the record I just would like to note that we have asked Mr. Carpenter, the director of your center, to submit a statement on that program and what has happened because it no longer exists.[10]

There is a representative of the Queens Bridge health maintenance project here today. That project has managed to keep going with help from various sources, but I understand that the director there is very concerned that there, too, they may have to stop operation.

Miss CARTER. I understand so.

Mr. ORIOL. I noted that in Dr. Brown's testimony this morning his reference to the fact that he did not believe that neighborhood centers need be established solely to help the elderly but it would seem from your experience that under certain circumstances this kind of program might be helpful.

Miss CARTER. It would seem that the elderly need so much little kinds of care—explanations of diets, help to find proper drugstores, clipping of toenails, this kind of thing, that really does not need to be the concern of a large metropolitan hospital.

Mr. ORIOL. That statement will be in the record and we will forward a copy of it to Dr. Brown for his comment, with the Chair's permission.

Senator SMATHERS. Yes.

Mr. ORIOL. Another question I wanted to ask, what is the advice given by social workers and others in New York City to elderly applicants for medicaid who have a small nest egg and are fearful that they may not be able to keep that nest egg if they are enrolled in medicaid?

FEAR OF LOSING "NEST EGG"

Miss CARTER. In our center we have almost had to do it on a "you do me a favor" basis. We promise them that they are not going to have their nest eggs taken away, and if "you do me a favor you will apply. All you will get is refused, if you are not eligible."

Mr. ORIOL. So the fear of losing a nest egg is a big problem?

Miss CARTER. Tremendous.

Mr. ORIOL. One other thing. You were very kind in sending me the official literature of the city of New York to people who want medicaid and you wrote in certain questions about what does this mean and what does that mean. I don't have the answer, I didn't understand it any more than you did. Again with the chairman's permission, perhaps we could forward those questions to the proper officials and ask them about some of these things.[11]

Miss CARTER. I think that would be a good idea.

Mr. ORIOL. Thank you.

Senator SMATHERS. Thank you very much.

(The chairman addressed the following questions to Miss Carter in a letter subsequent to the hearings:)

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[10] Additional discussion of health maintenance programs on p. 543.
[11] See letter by Commissioner Ginsberg, p. 572.

1. I believe that our record would be incomplete if we did not have a brief description of the Consumers Demonstration Project conducted by you with funds from the Administration on Aging. May we have a paragraph or two?

2. How can such consumer information projects be coordinated with other services such as visits to elderly isolates, Project FIND, and home health services?

3. Your vigorous criticisms of informational literature distributed on Medicaid lead me to wonder whether you have recommendations for improving such literature. Would you, for example, be in favor of the Social Security Administration's establishing an advisory board of specialists from the communications media to help review such publications and send their recommendations to state and city agencies that distribute literature?

(The following reply was received:)

Answer 1. The Hudson Guild's Consumer Education Project is supported with the New York State Office for the Aging under the Older American's Act of 1965.

Consumer education can be defined as helping people to use financial resources to effectively achieve family goals. However, consumer education as it relates to the older persons involves a complex network of physical, social and financial problems. Two basic principles of consumer education are (1) to do for one's self rather than purchase services and (2) to look and shop around before buying. Elderly persons with aching bones, heart conditions, and minds which are not as clear as in previous years often find the efforts needed to save a few pennies just more than they can invest.

The alternatives usually available in decision making are not open to the elderly person. And the pitifully inadequate income coming from Social Security or combined Social Security and public assistance does not give the older person a dollar that can stretch. Thus, we have approached the program by attempting to deal with the major areas of an older person's life which can cause him financial or physical problems and emotional strain. We felt it necessary to create a broad base of security in these areas in which the people can depend, then they will be more receptive to involving themselves in programs outside the scope of their immediate needs.

Our program has (1) demonstrated a need for adequate food programs; (2) cooperated in a Medicaid Alert; (3) developed a Drug Plan; (4) attempted to involve older people in Social Action; (5) initiated an information program with Welfare; (6) held a city wide conference on consumer problems of older people; and (7) began testing various educational techniques. Our next year will be focused on social action and the development of a family security program.

Reports of the project can be obtained by writing to Hudson Guild, 119 Ninth Avenue, New York, N.Y. 10009

Answer 2. As we discovered at the Hudson Guild, a consumer information project covers food, clothing, health, cost of services, family security; as well as Welfare and Social Security grants. It also involves group work, case work and community organization. Thus, an effective consumer information project associated with visits to elderly isolates; Project FIND; and home health services programs would necessitate a strong coordination of direct service agency programs and business to insure that needs of older people are considered in program development; that existing programs and projected programs are not duplicated and that information flows freely. This plan, of course, assumes that agencies would commit themselves to giving up a bit of their autonomy for the good of the whole. In some respects, this is what Dr. Cherkasky talked about in relation to hospital services.

As a necessary part of this, it would be important to include at the neighborhood level a consumer specialist who would funnel this program from the planning level to the older people and return information regarding needs back up the line.

The consumer specialist could; (1) test the effectiveness of educational material and new educational techniques; (2) serve as a central neighborhood source of general consumer information because she would have at her fingertips the results of the central planning body's efforts; (3) work with staff at the neighborhood level to develop and implement consumer programs, to fill the local need.* Again, this is similar to what rural extension has been doing on a general level.

*For example: If the older people have not been receiving their entitled grants from Welfare, the consumer specialist could in cooperation with the central planning committee implement a program with the local Department of Welfare to bring older people up to standard.

Answer 3. I vigorously criticized Medicaid literature because that was what we were discussing. I would also vigorously criticize Social Security literature, federal pamphlets and so forth. It seems to me that great and valuable lessons could be learned from advertising firms; how to get an idea across and how to interest people in buying a new product or changing a brand. They also are able to gear their advertising to the interests and levels of people who will provide the market.

Yes, I certainly would be in favor of the establishment of a communications advisory board to review publications and make recommendations. But I would not confine it to Social Security but would expand the program to include all government informationals which are intended to be read by the general older public.

I would caution, however, about the danger of becoming bogged down in reviews of the recommendations and re-reviews. There must be a real committment on the part of the agencies to implement and test the suggestions.

STATEMENTS BY MISS HELEN M. HARRIS, EXECUTIVE DIRECTOR, UNITED NEIGHBORHOOD HOUSES OF NEW YORK; MRS. EDNA YOUNGBLOOD, MEMBER, WILLIAM HODSON COMMUNITY CENTER; LEON FRAITER, MEMBER REDSHIELD DAY CENTER, MANHATTAN; MRS. SUSAN KINOY, PROJECT DIRECTOR, PROMOTING HOME HEALTH AND SOCIAL SERVICES TO NEW YORK'S AGING, COMMUNITY COUNCIL OF GREATER NEW YORK; AND WALTER NEWBURGHER, PRESIDENT, CONGRESS OF SENIOR CITIZENS

Senator SMATHERS. Our next group of witnesses, Mrs. Edna Youngblood, of the Hodson Community Center; Mr. Leon Fraiter, member of the Redshield Day Center, Manhattan; Mr. Walter Newburgher, president, Congress of Senior Citizens; Mrs. Susan Kinoy, project director, Promoting Home Health and Social Services to New York's Aging; and Miss Helen M. Harris, executive director, United Neighborhood Houses.

Our first witness will be Miss Harris.

STATEMENT OF MISS HARRIS

Miss HARRIS. Thank you. My name is Helen M. Harris and I am the executive director of United Neighborhood Houses of New York, the federation of some 60 settlements and neighborhood centers located in the least advantaged areas of the city. These are old neighborhoods with a sizable population of elderly people. More than half of our member settlements run programs for the elderly and are acutely aware of their problems and needs.

Their No. 1 problem, and I don't have to say that to this group, outside of food and shelter is medical services—their availability, their accessibility, and above all, their cost.

When medicare became a reality and medicaid a possibility, it seemed as though the No. 1 problem was about to be licked, and all of us who had been working for health insurance these several decades rejoiced along with our elderly neighbors. But it turned out to be not quite so simple as we and they expected. Medicare, part B, had to be explained and sold before a deadline. Language was often a problem and a great deal of interpretation was necessary, mostly on a 1-to-1 basis, to get across to people just what they were entitled to and what they had to do to receive the benefits of the programs.

We particularly rejoiced when New York State passed its liberal, far-seeing medicaid program, designed to break the back of that dreaded specter "medical indigence." Now we hear that Congress is prepared to strike a mortal blow at our New York State program by mandating lower income ceilings. This would make ineligible thousands of persons who for nearly a year now have been receiving health services under medicaid. To force a retrogression to "indigency" instead of "medical indigency" would be shortsighted, indeed. We urge the committee to prevent such action in the Congress and permit the more advanced States to set their own standards. To do otherwise would be to stifle a constructive, preventive health program before it could get off the ground and be fully tested.

For those on welfare, medicare and medicaid brought almost instant benefits. And in the beginning doctors, dentists, and druggists went along with the program in most neighborhoods. People reported quicker, more kindly, reception and service, even in hospital clinics. Dentures and eyeglasses came unbelievably fast for some who had waited months for them. To choose one's own doctor and be treated with respect like any paying patient enhanced one's innate dignity.

But for those who had managed to stay off of welfare there were problems. Literature about the program was confusing and hard to understand. Application forms were long, complicated, and too demanding. Producing the last eight wage stubs, bank balances, insurance policies, and savings accounts was often so difficult many an elderly person threw up his hands and refused to complete the application. And for those who did complete it, 3 and 4 months might elapse before they received their card, and then they were faced with the hated words "department of welfare" on all the forms and the identification card. This business of being identified with the department of welfare has been a stumbling block for many and a reason that many refused it.

The greatest problem medicaid presents for many elderly persons not on welfare, who desperately need the program, is the matter of their savings. Many have worked in "uncovered" jobs all their working lives, been able to save a little and steadfastly refused to accept relief even though in their so-called golden years their social security payments may be as little as $35 a month. Almost all the elderly in our settlement neighborhoods live on unbelievably small incomes. They live in wretched houses, pay very low rent, and cannot afford to move to public housing because the rents are higher there.

Yet many of these have little more savings than medicaid allows. Some count on their savings to eke out their low incomes. Some are afraid to use any, against the day of greater need. Many refuse to reveal the amount as it was said here before for fear it will be taken away from them. All resent this intrusion into their privacy. They are the proud, independent elderly for whom the thought of a major illness that could wipe out their savings is a constant worry. These are the truly "medically indigent" for whom medicaid was designed.

These, too, are the people who are unable to pay the new $11 clinic fee our city hospitals have imposed, where before no fee was charged, and have stopped going for regular checkups. When in dire need they go to a private doctor and pay him $7 or $8 a visit. Unfortunately, as

has also been said here today, the doctors, too, are raising their fees and the elderly who for whatever reason refuse or are ineligible for medicaid are in a tight squeeze.

Part B Premium Causes Problems

For the same reason, the thought of an increase in the part B fee from $3 to $4.50 a month has caused real consternation.[12] When you haven't got enough to live on anyway, even $1.50 a month would mean less carfare or food or some other necessity. In a number of our settlements, the elderly have raised the question of the $50 deductible in medicare. "Couldn't it be lowered?" they say, "or eliminated altogether?"

Another great difficulty—increasing, unfortunately—which again you heard today is the shortage of doctors and dentists who will accept medicaid patients. In the beginning, as we said earlier, many more doctors participated in the program. However, the long delays in receiving payment from the city and the extra and time-consuming paperwork involved in filling out forms have caused many doctors to refuse medicaid patients. At one settlement in East Harlem, the LaGuardia House, the director reports that the only way they can get one doctor to accept their patients is for the settlement staff to agree to do the paperwork for him. Those doctors who remain in the program are often overworked, their offices overcrowded, and find themselves unable to give as much time as they would like to each patient.

The same is true of dentists. It is increasingly difficult to get dental care and where 6 months ago many persons were delighted with their new dentures and their "family" dentist, today there are more complaints of inferior quality of treatment and dentures. This is not universally true, of course, depending on the particular neighborhood and dentist, but true enough to be brought to your attention.

As for service in hospital clinics, there is tremendous variation from hospital to hospital in New York City. Some older persons report excellent diagnoses and treatment, others try to avoid certain hospitals except in an emergency because examinations are superficial, waiting time from 2 to 4 hours. The waiting continues to be long in even the best hospitals.

Are the elderly generally less satisfied with health services available to them or more satisfied? Interestingly, in our settlements fewer report being less satisfied in spite of their complaints. The majority are more satisfied though some of these feel the service falls far short of their expectations.

United Neighborhood Houses has made every effort to find out from the participants themselves—both the givers and the receivers of services—what their experience has been, how they feel about it and what are the major problems. We conducted a hearing last April called "Witness for Medicaid" before Members of Congress and city and State health and welfare officials that gave us some of the answers. Settlement neighbors, most of whom happened to be on welfare, spoke movingly of the wonderful benefits they were receiving. But all of the problems just described were brought out, too, by hospital officials, a

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[12] Pursuant to his authority periodically to set new rates for medicare pt. B premiums, HEW Secretary Gardner on Dec. 30, 1967, increased the premium from $3 to $4 per month, effective Apr. 1, 1968.

dentist, a druggist and settlement workers who were engaged in trying to sign people up. I commend this brochure to you if you have not seen it which contains the words of the witnesses taken from the transcript.

Just this past week we have surveyed the field again, getting answers from the elderly themselves and from staff workers, to the questions your committee sent to us.

In spite of the obvious drawbacks and roadblocks and the inevitable mistakes in starting so enormous a program, "Witness for Medicaid" and our recent survey convince us that a new day has dawned in providing health services to the elderly that will brighten as the problems discussed here are solved. Medicare and medicaid, no matter what the problems they present now, are fine first steps in what must inevitably come in our country, the recognition that good health is everyone's birthright and health services everyone's right—regardless of ability to pay. We are years behind other countries in our commitment to health as a broad social policy. I hope the words of those most in need may help to hasten the day.

Thank you. [Applause.]

Senator SMATHERS. Thank you, Miss Harris. We are going to make the brochure a part of the record at the conclusion of your statements.[13]

(The chairman addressed the following questions to Miss Harris in a letter written subsequent to the hearings:)

1. Do you plan to submit excerpts from the letters received by your member neighborhood houses, or will your statement stand as a summary of the letters received as a result of the Subcommittee inquiry?

2. May we have more specific information on the complaints of inferior quality of dentistry and dentures? Is it your feeling that the advent of Medicaid has caused a lowering of dental standards generally throughout the city?

3. The Subcommittee has received some information about the work of volunteer elderly health visitors in the Henry Street Settlement House area. May we have additional details on the program, the importance of such services, and the relationship to the Gouverneur clinic?

(The following reply was received:)

I am sending you, as you requested, the following:

1. The transcript of my testimony which needed no editing.
2. A report on Services For The Elderly By The Elderly from Henry Street Settlement.[1]
3. Two copies each of five letters, which we received from our settlements, that are typical of the comments received from a total of 19 houses.[2]

With regard to your question concerning dental services, as I stated in my testimony the situation is quite varied throughout the city. Some of our houses report a lowering of standards and great difficulty in finding dentists who will accept Medicaid patients. Others have found in their neighborhoods that dental care has greatly improved. It all depends on the social point of view of the dentist and also his ability to wait a long period of time for payment.

I am also enclosing two copies of the memorandum we sent out hastily to our houses with your list of questions. Since many of them replied without restating the questions, I thought you might need this memorandum. I do hope you will find our material a help to you.

We are most grateful to you for your persistence in bringing the facts with regard to Medicare and Medicaid before the United States Senate. If I can be of service in any way, please let me know.

Senator SMATHERS. Our next witness is Mrs. Edna Youngblood, member of the Hodson Center group.

Mrs. Youngblood.

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[13] See p. 510.
[1] In committee files.
[2] See app. 1, p. 527.

STATEMENT OF MRS. YOUNGBLOOD

Mrs. YOUNGBLOOD. As stated, I am Edna Youngblood, a member of this wonderful Hodson Center. I want to greet all of our distinguished guests and thank you for bringing this hearing to us.

I say from the beginning this is Hodson Center's medical needs. We all know that both medicare and medicaid have been a help to a great many of us senior citizens. It has given us a degree of better medical health and a longer life but it has made us wait and wait for our refunds and expenses of over $50 allowed to us. I know of several cases where our senior citizens have sought admission and were sent from one place to another so many times, going to different hospitals and different distances, have spent bus fare in vain and then waited for months before talking to the right person who in turn promises results but then more waiting.

We here at Hodson need a representative of medicare for all of our senior citizen day centers to talk to and explain to us even if it is on a limited basis. What is needed is some help for those on medicare and medicaid who are unable to shop or carry packages due to disability to even go to laundromats. This would keep them living as they wish to in dignity and cleanliness.

Medicare also limits us senior citizens, due to small lifetime savings, from getting dental services, good chiropody services—which means care of our feet—to help us go back and forth to places—and glasses, as a lot of us really need. These three services are very important to us as senior citizens at this time of life.

Our doctor fees have increased from $5 to $7 to $10. This keeps some from getting medical attention while waiting for refunds of former bills. Doctors are very hard to get at night and more so over weekends when a lot of illness occurs. We know our doctors are human, they need vacations, they need time with their families, but this is the career they chose and took an oath to care for the sick.

Our doctors don't want to visit in some neighborhoods. Would it be possible that our doctors could call the local police and ask for protection in making these calls?

Our visiting committee who I must say are doing a great service for our center describe conditions in some nursing homes as one of neglect and that many of the older people don't want to accept this sort of care and therefore delayed their recovery.

Drugs are getting so expensive, yet some unions are offering discounts and there are some discount houses but this means we have to travel and in most cases we are not able to do this. Could not a set price be put on certain drugs prescribed by our doctors? Is it possible for our doctors to have a cost price list at their office to help relieve us of this terrible expense?

Medicaid does cover so many of the services we senior citizens really need such as dental, foot care and glasses and sometimes special braces and shoes and drugs. Could not those on medicare be extended these services on the doctor's special orders? This would give us a desire to live a more useful and healthful life at a time when we can really enjoy it in dignity and cleanliness and encourage us to indulge in hobbies and to encourage others to help us at our day centers.

I wish to end up by saying I am a witness of care that was given me through medicaid. When I first moved into the neighborhood I was a cardiac patient. After moving into a housing development and being able to stop walking up stairs I slowly progressed. I am now able to be very active here at my second home.

Thank you very much.

Senator SMATHERS. We also have a statement from a caseworker at Hodson Center.

(The statement follows:)

STATEMENT OF MRS. HELEN WEITZMAN, CASEWORKER, WILLIAM HODSON COMMUNITY CENTER

DESCRIPTION OF SOME MEDICAL PROBLEMS BROUGHT BY MEMBERS TO THE CASEWORK DEPARTMENT

Many health problems that were presented to the casework department stemmed not only from the individual member's personality and financial situation, but many problems arose because of the lag between the member's need and the lack of suitable resources in the community to provide service for this need. For all age groups, and most particularly for people over 60 years, a health problem has to be met not only with medical and drug therapy but must also be met with service therapy.

At this point, most of our members are familiar with the fact that they can secure extensive medical care through Medicaid and Medicare. Some people have deep seated resistance to applying for any service that is associated with public welfare. The complexity of the language used in the medicaid application and its explanatory booklet help to solidify the resistance such members feel. The forms should be written in simple words that an applicant can complete either by himself or at the most, with the help of family. The present application forms actually forbid rather than encourage use of Medicaid.

When a person receives his Medicaid card, he should be given personal individualized interpretation as to what he is entitled. This is particularly true for the person who is not using a city hospital but is using private resources. Many older adults who used clinics on a sporadic basis before Medicaid have no relationship to a family doctor and they need help with such information as which doctors take Medicaid and where they can obtain drugs. Many of our members who went on Medicaid did not know that they could apply to a Health Insurance Group. This is an important resource in the over 60 age group because such groups do provide 24 hour medical service including home visits during the night and free transportation to the physician's office when this is necessary. The casework department had many situations where a member suffered with severe anxiety because he had no assurance of medical care and where this anxiety abated after the member was referred to a Health Insurance Group.

Medicaid provides home health aides. However, it remains up to the individual to find such an aide. A person who is ill is not in a position to explore the community for such a resource. Many older adults do not have families or friends to do this for them. The physician who prescribes such a service should have agencies where he could immediately forward his prescription for attention. This procedure would ensure that there is a continuity of the medical treatment that the patient requires.

Many older adults find themselves growing dependent on assistance from housekeepers in order to remain in their own homes because of growing enfeeblement physically. It is common practice for the caseworker to offer guidance to a member who wants to establish his eligibility for household help. After the necessary medical verification is submitted to the Department of Social Services, it happens frequently that the member returns to us because the basis on which the Department of Social Services approved the number of hours a housekeeper was to work was too unreal. The average number of housekeeping hours for our members usually amounts to 4 hours weekly. The Department of Social Services suggests that people use the New York State Employment Service inasmuch as that agency only sends out homemakers in very special cases. The New York State Employment Service recently advised the Center's caseworker that it is

impossible for them to find anyone who will work less than 6 hours. The Department of Social Services is willing to consider an increase in hours but the member must again go through the process of contacting his physician, securing a new medical report and seeing that it is forwarded to the Department of Social Services. Many doctors are not sympathetic to this duplication of effort and they express their negative feelings to the member. Procedures required by the public agency should be geared to facilitating the achievement of the services and not to result in antagonizing the relationship between the medical resource and the member.

Another illustration of the lag between the need and dearth of local community resources is found with nursing homes. Some families of our members have come to the casework department with the problem that in applying for admission under Medicaid, they were informed by the nursing homes that there was a waiting period. I have known about situations where the families were able to meet the cost privately and admission was more rapid.

I would also like to point out that more older adults want admission to a Home for the Aged than there are facilities. Many homes, particularly those who are associated with the Jewish Federation, have a waiting period of several months to a year. In some instances, members who are on public assistance or who live on an income slightly above the minimum adequate level, have to wait for a crisis before they can gain the security of a protective environment. At the time of crisis, they enter the hospital and remain for an indefinite period. The Department of Social Services does offer a foster home program that aims to bridge the gap between application and admission but most of our members expressed discomfort at the idea of moving in with a family and preference was indicated for a nursing or aged home.

Emergency Clinic Problem

Many older adults who live alone find that their physical symptoms become more acute during the night. One of the most urgent problems presented to us is how to cope with this situation. Any individual, whether or not he is on Medicaid, can telephone the emergency number of the Police for an ambulance that takes them to the City Hospital in their district. After the symptoms are treated in the Emergency Clinic the result most often is that the patient is found suffering more from fright than actual severe illness necessitating hospitalization. The patient is then dismissed by the hospital with no provision for transportation home. The members have had to sit in the Emergency Clinic for hours either until daybreak or until someone on the hospital staff realized the situation and assisted the member with finding a taxi. People on public assistance have little or no money to put out for such an exigency as taxi fare. While the Department of Social Services reimburses the members for the cost, he must show proof of the expenditure and there is again a wait for the cash. Members who have had this experience have indicated their belief that it would help their emotional as well as their physical well-being, if they could be guaranteed medical service in the home at night; or if they must use the Emergency Clinic, provisions should be made for transportation back home. Perhaps, the same ambulance that took them should see that they get safely back in their apartment.

Another serious problem that we have seen in our casework practice is concerned with older people who become senile. There is no day center in our community to provide such a case with supervision as well as with medical and psychiatric treatments. There is medical substantiation that in some cases of senility, the rate of deterioration can be slowed if the person receives proper attention. Older adults who are senile and come to the Center, feel that they are not accepted by the healthy members and this aggravates their condition. The presence of a senile person also has an adverse affect on the well members of the Center. Furthermore, the Center is not staffed to offer any constructive service to such a member. Again, there are not enough Homes for the Aged who service this group. Much suffering ensues for the spouse who is well and who must cope not only with the emotional aspect of seeing one's mate grow unrelated to reality, but must also cope with the hard work that results if the senility takes the form of incontinency and inability to handle dressing and eating.

Some members of Hodson Center show symptoms of emotional disturbance although they can function in the community. Because of the paucity of mental health facilities in our community such situations are usually not referred for a

psychiatric evaluation or treatment. Referrals are usually made of the occasional member, whose symptoms indicate interference with his continued functioning in the community. While we have Morrisania and Bronx Lebanon Hospitals which offer mental hygiene clinics, it takes a long time for a referral to be processed by them because of their waiting lists. This community needs more mental health resources where referrals can be made simply and where they will be processed quickly. We also need resources that would be adequately staffed so that they could forward the psychiatric evaluation of a member's condition to the agencies like this Center. Such a procedure would be of considerable help in enabling staff to work more effectively with these members. It is also conceivable that with proper mental health care, the extent of emotional disturbance can be checked and the individual can remain in the community until his death.

Senator SMATHERS. All right. Our next witness is Mr. Leon Fraiter.

STATEMENT OF MR. FRAITER

Mr. FRAITER. Ladies and gentlemen, thank you very much for inviting me here. I am a man of 75. I have a cardiac condition. Some years ago I joined the Redshield Day Center and became very active among the senior citizens. I teach, I take an active part in the dining room. I do almost anything around the center. I am still a patient at the hospital getting treatment for my heart and high blood pressure. I have no trouble with medicine. I get a low number, I go and get my medicine and when that is exhausted I get another refill. I find myself getting along nicely and I am very grateful that I am strong enough to help others who are less fortunate than I am at the center.

Thank you. [Applause.]

Senator SMATHERS. Thank you.

From the Citizens Committee on Aging of the Community Council of Greater New York we are now going to have Mrs. Susan Kinoy, project director, Promoting Home Health and Social Services to New York's Aging.

Mrs. Kinoy.

STATEMENT OF MRS. KINOY

Mrs. KINOY. Thank you very much, Senator Smathers. It gives me great pleasure to be here today to testify, especially because this project that I am privileged to direct is funded under the Older Americans Act which you and your committee had a great deal to do with. We commend your committee for the work that was done in funding so many of these projects. I think there are over 20 in New York State right now. I hope they are continued and expanded.

There are now about 1 million people 65 and over in New York City. Ninety-six percent of this group live in their own homes and outside of institutions. Most elderly people wish to remain living independently in their own communities.

The vast majority of the aging live alone or with a spouse. The average base of their incomes is under $110 a month social security. This is supported by private benefits, savings, contributions by children, and welfare benefits.

For the most part, the elderly are scattered throughout the five boroughs of New York City, often living in walkup apartments, remaining in deteriorating or changing communities because they cannot afford to live in rent-controlled apartments. Although the ma-

jority of the elderly live below the "poverty line" they frequently do not cluster in "poverty areas" in which community progress centers and the community corporations have been established and in which plans for neighborhood health centers are underway. So when we plan health services for the elderly we have to think in terms of citywide services, not merely services in special areas.

The elderly receive fragmented medical care. They may attend a union health center for an annual medical checkup; they may travel to an arthritis clinic, a cardiac clinic, or a diabetes clinic on different days in one or more hospitals, and may, in addition, visit one or more neighborhood doctors when they feel too ill to travel to clinics or feel they cannot wait long periods in the emergency rooms. Different medications and courses of treatment are prescribed by individual doctors.

Medicare has provided welcome changes in patterns of payment for medical care. It has provided much-needed emergency care and medical insurance for catastrophic illnesses and serious operations—care that previously might have bankrupted an elderly person or his family. But serious problems exist in the workings of medicare. Some problems are to be expected as new legislation begins. But it is now apparent that there are weaknesses and gaps in the legislation and in the way it is being utilized that must be remedied.

Many of these have been mentioned today and I am not going to go through them in detail. I would like to summarize along with the many people who testified today, who feel as we do.

The deductibles must be removed; they impose an extreme hardship on aging persons with fixed incomes.

We recommend the standardization of rates acceptable to physicians that will be made available to elderly patients prior to the provision of services. We just get too many complaints from a person being charged $500 for an operation thinking this is the fair and equitable fee and thinking that he will get back 80 percent of this and he finds that he is going to get back 80 percent of $300 and has to pay the remainder.

A patient should have the option to request the assignment of fees by private physicians.

There must be additional coverage under medicare for hearing aids, prostheses, eyeglasses, dental needs and drugs.

We are alarmed by the probable increase in monthly medical premiums for persons with fixed incomes. Increases, if ordered should be accompanied by corresponding increases in program benefits.

We think that larger amounts of savings should be permitted under medicaid.

The gap between a person who cannot manage the payments under medicare and yet has too large a lump sum of savings to benefit under medicaid is too large. The financial gaps must be closed between these programs.

To Prolong Independent Living

In the few minutes allotted to me, however, I would like to emphasize the great need for services in New York City that can improve and prolong the independent living of older persons in their

own homes, services that can prevent, shorten or postpone institutionalization. With properly organized and adequate home health services some elderly can, at a lower cost to the community, avoid extensive prolonged hospital stays or premature extensive and traumatic institutionalization in nursing homes or homes for the aged.

I quote from a letter from a hospital which is quite typical of many we receive. "Over 1,000 extra days of hospital care were necessary during the period of 8 months because of lack of facilities in the community to provide nursing homes, chronic care and home health for patients 65 or over in this institution. It was possible in some instances to send patients home with homemakers and various types of home help.

In one instance, which is typical of many, a patient was sent home having waited 26 days for admission into a nursing home. There was a problem in obtaining the needed services and special funds had to be used to meet the cost until a voluntary homemaker agency could meet the need. If home help had been more readily available, the patient could have been sent home earlier. It is of interest to note that many patients do so well at home when there is help, often to an unanticipated degree that applications for nursing home care have often been canceled.

One of the services in shortest supply to the elderly in their own homes is that of homemakers, home health aides and housekeepers, all subprofessionals, who, under the supervision of doctors, nurses, and social workers can provide personal care and homemaking assistance to the elderly. These services, mainly part time, are in great demand by the aging. They are less expensive to provide than institutional care.

Today in New York City there are about 900 homemakers or home health aides, less than half of whom are used to meet the needs of the aging in the five boroughs of New York City. Only 4 to 6 percent of the elderly in New York receive assistance from the department of social services and one-half of these homemakers are employed by that department. Therefore, there are even fewer of these subprofessionals available to the majority of the elderly. It is our estimate that a minimum of 4,000 homemakers or home health aides are needed to begin to meet the needs of the elderly in New York City today.

We appreciate that provision has been made for home health services under both titles 18 and 19. These services have been expanded in New York since the inception of medicare and medicaid legislation but the services have not as yet begun to meet the need of the 1 million elderly in New York City today.

About 35 hospitals and four visiting nurse services are certified as home health agencies under titles 18 and 19. Only four of these agencies, however, the three voluntary nursing agencies and the Dominican Sisters of the Sick Poor, now provide home health aides under this program. These four agencies have done an excellent job of recruiting, training, and supervising these aides, but the approximately 150 that are now in this program can't begin to meet the need that we see, and you heard this need explained by the people you visited at lunch today.

In order to expand needed services in the home it is necessary to plan very boldly and creatively and to use all existing resources. I would like to report on some of our recommendations very briefly. We hope that the three visiting nurse services will continue to expand their very excellent services. We hope in addition they will subcontract with the existing homemaker services of the voluntary homemaker agencies so that more persons can be trained by the homemaker agencies and thereafter be part of the personnel available through the visiting nurse services.

We propose that the nonmedical voluntary agencies in addition to subcontracting creatively expand their services.

Third, we propose that the Bureau of Public Health Nursing of the Department of Health become a certified home health agency providing bedside nursing service when necessary and public health nursing responsibility for the supervision of home health aides. This would make possible contracting with the Department of Social Services, division of homemaker services or the voluntary homemaker agencies, of employing their own subprofessionals, thus providing additional homemaker/home health aides.

Fourth, we recommend that the Department of Social Services work, as we said, with the Department of Health and that, in addition we recommend the expansion of their entire program of homemaker services. They are now in the process of almost doubling their homemaker staff.

Fifth, we recommend that some hospitals with careful community and administrative planning, employ their own staff of home health aides and provide for the necessary bedside nursing and public health nursing supervision of these aides.

Sixth, we recommend that community health centers which are hospital based, with careful community planning, expand their existing staffs of public health nurses and employ home health aides.

Finally, in New York State, unlike the rest of the country, home health aides must be supervised wherever possible by public health nurses. Because there is such a tremendous shortage of public health nurses we suggest that crash programs be organized for the recruitment and training of such personnel. We hope that you will take leadership in planning for such an expansion of training of nurses.

We call for an additional number of reimbursable home visits under the medicare legislation.

Finally, we suggest that experimentation in order to provide greater expansion of home care be encouraged under the Hill-Staggers legislation.

In conclusion, I would like to repeat that medicare and medicaid have answered some of the most acute medical problems of the elderly. We wish to call attention to some of the legislative shortcomings and gaps in services that still must be filled.

Finally, we would like to emphasize the need for the rapid expansion of home health services so that more of this Nation's elderly can remain in their homes, thus freeing needed hospital and institution beds.

Thank you.

(The prepared statement by Susan Kinoy follows:)

STATEMENT OF THE COMMUNITY COUNCIL OF GREATER NEW YORK, PRESENTED BY MRS. SUSAN K. KINOY, PROJECT DIRECTOR, PROMOTING HOME HEALTH AND SOCIAL SERVICES TO NEW YORK CITY'S AGING

My name is Mrs. Susan K. Kinoy, Project Director of a program at the Community Council of Greater New York entitled, "Promoting Home Health and Social Services to New York City's Aging."

This is a three-year Project, funded under Title III of the Older Americans' Act through the New York State Office for the Aging. Its goal is to promote increased home-health services and housing for the elderly in New York City. (A Summary of our Project is attached).[1]

There are now one million people age 65 and over in New York City today. Ninety-six percent of this group live in their own homes and outside of institutions. Most elderly people wish to remain living independently in their own communities.

The vast majority of the aging live along or with a spouse.

The average base of their incomes is under $110 a month social security. This is supported by private benefits, savings, contributions by children and welfare benefits.

"Last year. in the United States, there were close to 7 million families with heads aged 65+. About 41% or 2 out of every 5 of these older families had incomes of less than $3,000; half of them with less than $2,000.

More than a quarter of a million older families had incomes of less than $20 a week or $1,000 for the year; a half million families had incomes between $1,000 and $1,500; and three-quarter million families had between $1,500 and $2,000. At the other end of the scale, 10% or about 700,000 older families had incomes of at least $10,000 and some 75,000 of them had $25,000 or more.

A quarter of the almost 5 million older people living alone or with nonrelatives had incomes of less than $20 a week ($1,000 a year) and well over another quarter had between $20 and $25 per week ($1,000 to $1,500 a year)".[2]

For the most part, the elderly are scattered throughout the five boroughs of New York City, often living in walk-up apartments, remaining in deteriorating or changing communities because they cannot afford to live in rent controlled apartments. Although the majority of the elderly live below the "poverty line" they frequently do not cluster in "poverty areas" in which community progress centers and the community corporations have been established and in which plans for neighborhood health centers are under way.

The elderly receive fragmented medical care. They may attend a union health center for an annual medical checkup; they may travel to an arthritis clinic, a cardiac clinic or a diabetes clinic on different days in one or more hospitals, and may, in addition, visit one or more neighborhood doctors when they feel too ill to travel to clinics or to wait in emergency rooms. Different medications and courses of treatment are prescribed by individual doctors.

Medicare has provided welcome changes in patterns of payment for medical care. It has provided much needed emergency care and medical insurance for catastrophic illnesses and serious operations . . . care that previously might have bankrupted an elderly person or his family. But serious problems exist in the workings of Medicare. Some problems are to be expected as new legislation begins. But it is now apparent that there are weaknesses and gaps in the legislation and in the way it is being utilized that must be remedied.

MEDICAL COSTS

Many older people with ongoing chronic illnesses are paying more for medical care now than they did prior to Title XVIII. Some of the people are receiving less medical care for money spent. They are paying the $40 deductible under Part A, the $50 deductible under Part B, and the $36 per year premiums totalling $126 plus the 20% coinsurance. Medical fees have increased steadily since the start of the program. The elderly complain that they are often not told in advance the doctor's "fair and reasonable" rate for a medical service. They may be billed $400 for an operation expecting to pay only 20% of this fee and find instead that the "fair and reasonable" fee was $300 and that they were responsible for paying

[1] See app. p. 531.

[2] A Profile of the Older American, by Herman B. Brotman. Paper presented October 16, 1967.

20% of the $300 plus the additional $100. For years Blue Cross and Blue Shield have been able to establish reasonable fees for medical services. Could not this practice be adopted under Part B of Medicare?

ASSIGNMENT OF FEES

The problem of rising costs is compounded by the fact that the elderly often are expected to pay private physicians (sometimes borrowing from families or from loan companies to do so) and then must await reimbursement by the carriers. Although private doctors may assign fees, many do not do so.

UNREIMBURSED SERVICES

There are important services not covered by Medicare. These include surgical and orthopedic services, prostheses, hearing aids, eye glasses, dental needs, and drugs. Many elderly must pay $10 to $20 per month for medicines, and frequently report not buying or refilling prescriptions because their budgets will not permit this expense.

DIFFICULTY WITH FORMS

Finally, many older persons with poor education find difficulty filling out the medical claim forms.

PROPOSED INCREASE IN PREMIUMS

If the monthly premium is increased next year because of the escalation of medical costs, this will mean excessive financial hardship for the aged without any corresponding increase in program benefits. We suspect that this will mean that large numbers of the elderly will be unable to continue their participation in the Part B program.

MEDICAID

We see a serious gap between those people who cannot now afford Medicare but who are not eligible for Medicaid in New York State. A senior citizen may qualify for Medicaid in terms of his monthly income, but because he has savings of $1,000 or $2,000 more than the approximately $1,000 or $2,000 permitted, he is ineligible. The line between the totally indigent and medically indigent is too thin. One senior citizen said the other day, "The person who has tried to be thrifty during his working years is penalized under Medicaid".

In New York City, as has been frequently reported, private physicians are not participating in the Title XIX program in large enough numbers. This forces a particular hardship on the home-bound elderly, unable to attend clinics, who previously had been aided by panel physicians who visited them in their own homes, assigned by the Department of Welfare (now called the Department of Social Services). These patients must now seek their own private doctors and frequently have difficulty locating adequate medical help.

Because Medicare and Medicaid rates differ in nursing homes, it is reported that frequently patients following their 100 days institutionalization under Medicare are asked to leave proprietary institutions because the Medicaid fees are lower.

We recommend therefore—

1. The removal of the Medicare deductibles as imposing an extreme hardship on aging persons with fixed incomes.
2. The standardization of rates acceptable to physicians that will be made available to elderly patients prior to the provision of services.
3. The assignment of fees whenever possible by private physicians.
4. Additional coverage under Medicare for hearing aids and other prostheses, dental needs and primarily drugs and medication.
5. We are alarmed by the probable increase in monthly medical premiums for persons with fixed incomes. Increases, if ordered, should be accompanied by corresponding increases in program benefits.
6. A larger amount of savings should be permitted under Medicaid.
7. Finally, the financial gaps and services gaps between Medicare and Medicaid should be closed so that a continuum of health planning is possible.

In the few minutes allotted to me, I should like to emphasize the great need for services in New York City that can improve and prolong the independent liv-

ing of older persons in their own homes, services that can prevent, shorten or postpone institutionalization. With properly organized and adequate home health services, some elderly can (at a lower cost to the community) avoid extensive, prolonged hospital stays, or premature expensive and traumatic institutionalization in nursing homes or homes for the aging. I quote from a letter sent by a hospital in New York City which is typical.

"Over one thousand extra days of hospital care were necessary during a period of eight months because of lack of facilities in the community to provide nursing home, chronic care and home help for patients 65 or over, in this institution.

"It was possible in some instances to send patients home with homemakers and various type of home help. In one instance which is typical of many, patient was sent home after waiting 26 days for admission into a nursing home. There was a problem in obtaining the needed services and special funds had to be used to meet cost until a voluntary homemaker agency could meet the need. If Home Help had been more readily available, patient could have been sent home earlier.

"It is also of interest to note that many patients do so well, at home when there is help, often to an unanticipated degree that applications for nursing home care have often been cancelled.

"There are also many instances in which type of care is needed is debatable and with rejections for nursing home care and from chronic care institutions, adequate planning seems to reach a deadlock and thus making it necessary for patients to remain in the hospital for long periods of time. In the case of one patient, a plan for patient's care at home was evolved with help through Medicaid. A hospital bed, wheelchair and home attendants were provided and family members also took turns in caring for patient. Despite the cost involved, this was less expensive than hospital or institutional care. It did take two weeks of concentrated activity to work this plan out to obtain needed services.

"How many patients, of those who were finally admitted to a nursing home or chronic care institution directly from the hospital, could have been cared for at home, even for a limited time is not definitely known. However, one can rule out patients who require tube feeding. But experience has shown in many illustrations, that patients have been sent home when it was necessary and possible and that patients for the most part did well, and some to such a degree that nursing home care planning was dropped. If more home help was readily available, we would think in these terms.

"Too often nursing home care has been planned only because nothing else was available. This has seemingly resulted in a poor use of nursing home facilities.

"We are now noting that many patients and their families are resistive to nursing home care. One reason given is their concern about crowded conditions, lack of care, and often a depressing atmosphere. Another is their feeling that patient will be more comfortable and do better at home, and this is true. Experience through the years has demonstrated this".

The demand for home health services does not reflect the need because so many elderly as well as professionals do not know of the existence of such services. In addition, professionals are often discouraged from requesting these services because they have tried so often to obtain them, without success.

One of the services in shortest supply to the elderly in their own homes is that of homemakers, home health aides, and housekeepers—all subprofessionals, who, under the supervision of doctors, nurses and social workers, can provide personal care and homemaking assistance to the elderly. These services, mainly part-time, are in great demand by the aging. They are less expensive to provide than institutional care.

Today there are about 900 homemaker-home health aides, less than half of whom are used to meet the needs of the aging in the five boroughs of New York City. The rest are used to serve younger families, usually with children. These homemaker-home health aides are provided and supervised by voluntary and public social agencies and by nursing agencies. About 400 of these are employed by the Homemaking Department of the Department of Social Services (formerly the Department of Welfare). Since only 4% to 6% of the elderly in New York City receive public assistance, few of New York's elderly are served by these 400 homemakers.

It is our estimate that a minimum of 4,000 homemaker-home health aides are needed to begin to meet the needs of the elderly.

Provision is made for Home Health Services under Titles XVIII and XIX. These services have been expanded since the inception of Medicare and Medicaid legislation. But the services have not as yet begun to meet the need of the one million elderly in New York City today. (See attached: *Homemaker-Home Health Aide and Related Services—Existing Patterns and Projected Plans*).[1]

About 35 hospitals and 4 Visiting Nurse services are certified as home health agencies under Titles XVIII and XIX. Only four agencies, however, the three voluntary nurse agencies and the Dominican Sisters of the Sick Poor, now provide home health aides under this program. These four agencies have done an excellent job of recruiting, training and supervising home health aides. But the approximately 150 home health aides that are now under this program could not begin to meet the need of patients referred by hospitals and by community agencies.

In order to expand needed services in the home it is necessary to plan boldly and creatively. It is important to utilize all financial resources provided by Medicare and Medicaid. Office for Economic Opportunity and other federal and state funds, as well as private philanthropy, and to coordinate the work of all existing agencies in the health and welfare field. It is imperative that high standards of training, care and supervision be maintained.

I would like to report on proposals that this Project has made for increasing the number of homemaker-home health aides in New York City.

1. *Visiting Nurse Agencies*

We hope that the three visiting nurse agencies will continue to expand their excellent services to the entire community. Cooperative contractual arrangements with the non-medical voluntary agencies such as the homemaker departments of Jewish Family Service, Catholic Charities, Self Help, etc., should be encouraged. In this way, trained homemakers can be utilized and reimbursed under Titles XVIII & XIX as home health aides by the visiting nurse agencies. In turn, the voluntary agencies will be able to recruit trained and supervised agency staff.

2. *Non-Medical Voluntary Homemaker Agencies*

We propose that the non-medical voluntary agencies, in addition to subcontracting with the visiting nurse services (see above) will creatively expand their services.

3. *Department of Health*

We propose that the Bureau of Public Health Nursing of the Department of Health become a certified Home Health agency, providing bedside nursing service when necessary and public health nursing responsibility for supervision of home health aides. This would make possible contracting with the Department of Social Services, Division of Homemaker Services or the voluntary homemaker agencies to provide homemaker-home health aides. It might also be possible for the Department of Health to employ, on an experimental basis, its own staff of home health aides. Such additional responsibility for the Department of Health, Bureau of Public Health Nursing would, of course, require re-evaluation of the total services for which the Bureau is responsible and the setting of priorities. This proposal is in keeping with new patterns of community cooperation to utilize the resources of Medicare and Medicaid which are developing all over the country and in many counties in New York State, thereby making possible the rapid expansion of services.

4. *The Department of Social Services, Division of Homemaker Service*

We recommend—

(a) That the Department of Social Services work with the Department of Health as described above and thereby become eligible to provide homemaker-home health aides for Medicare and Medicaid patients;

(b) The expansion of homemaker services, even greater than that already planned, to meet the needs of the increasing number of aged in the community. We are especially concerned about the large number of the aging for whom medical problems may be secondary to feebleness and social problems due to age. (At this time, the Department is planning to double its staff).

[1] See app. 1, p. 532.

5. Hospitals

We recommend that some hospitals, with careful community and administrative planning, employ their own staffs of home health aides and provide for the necessary bedside nursing and public health nursing supervision of the aides. Thirty-three hospitals have some type of Home Care program and are already certified as Home Health agencies.

6. Community Health Centers

We recommend that Community Health Centers which are hospital based, with careful community and administrative planning, expand existing staffs of public health nurses and develop new programs for homemaker-home health aides and other therapeutic services. Since the Office of Economic Opportunity and the Department of Health, Education and Welfare, now on a federal level, have contractual arrangements for comprehensive care, there are likely to be more funds available for training, demonstration and ongoing services. Qualifications and training of staff should have the long-range goals of reimbursement under Medicare and Medicaid.

7. Community Progress Centers and Community Corporations

We propose that the Community Progress centers and Community Corporations (now almost totally youth oriented) use their staffs imaginatively on behalf of their communities' elderly. This Project will encourage the Community Progress Center leadership to use their block workers and other staff, for case-finding, information and referral, escorting, friendly visiting, "meals-on-wheels", and employment of the aging in the Community Progress Center structure, in the community and at home.

ADDITIONAL RECOMMENDATIONS

In New York State, unlike the rest of the country, home health aides must be supervised wherever possible by public health nurses. We suggest that crash programs be organized for recruitment and training of such personnel.

We call for an additional number of reimbursable home visits under the Medicare legislation. Finally, we suggest that experimentation in order to provide greater expansion of home care be encouraged under Hill-Staggers legislation—Public Law 89–749.

CONCLUSION

In conclusion, Medicare and Medicaid have answered some of the most acute medical problems of the elderly. We wish to call attention to some of the legislation's shortcomings and the gaps in services that still must be filled in. We would like to emphasize the need for the rapid expansion of home health services so that more of this nation's elderly can remain in their homes, thus freeing needed hospital and institution beds.

Senator SMATHERS. Thank you very much.

(The chairman addressed the following questions to Mrs. Kinoy in a letter written after the hearings:)

1. Your comment, "Too often nursing home care has been planned only because nothing else was available," is of considerable significance. Have you any information on the extent of such assignments to nursing homes? Have you additional information on individuals who must remain in hospitals because homemakers, home health aides, or housekeepers are not available?

2. What is the basis of your estimate that a minimum of 4,000 homemaker-home health aides are needed in New York City for the elderly alone?

3. How, as suggested on page 7 of your written statement, could the resources of the Office of Economic Opportunity be used to promote home health services.

4. May we have additional details on your proposals for—

a. "Crash programs" for recruitment and training of public health nurses to supervise home health aides;

b. "An additional number of reimbursible home visits under the Medicare legislation;

c. "Experimentation in order to provide greater expansion of home care be encouraged under Hill-Staggers legislation—Public Law 89–749."

5. Dr. Wise of the OEO Neighborhood Health Service Demonstration in the Hodson Center area has discussed the often critical role that housing can play

in accelerating the discharge of elderly individuals from hospitals or other institutions. You pay considerable attention to housing needs in your overall project, and I would appreciate some discussion from you on work relationships needed among municipal agencies to provide housing in such cases.

6. The description of your project puts great emphasis on the need for city-wide action. Do you envision the ultimate establishment of a municipal agency to implement coordinated programs for health and social services?

7. Can you give us any details at this time on your plans for the two pilot projects now contemplated?

(The following reply was received:)

My comment "Too often nursing home care has been planned only because nothing else was available" is part of a letter to Community Council from a New York City voluntary hospital. The complete quotation begins on page 5 through the middle of page 6 of my mimeographed testimony. I believe that several of the statements within this total quotation support the statement to which you refer.

The following is a typical situation which clearly illustrates need:

A municipal hospital recently reported to the Council the case of an 84-year-old woman initially hospitalized for a three-week period but requiring an additional month's hospitalization, at taxpayers' expense, due to the unavailability of a homemaker-home health aide. The patient, hospitalized because of a stroke, had been cared for by a daughter in her fifties. The daughter, an arthritic with edema, along with a sprained ankle, was now also partially bedridden. The Department of Social Services was able only to provide a homemaker 12 hours per week. This was not enough care for the patient. A nursing home was suggested by the Department of Social Services, but this was rejected by the family. During the patient's additional stay at the hospital, the daughter recovered sufficiently and was thereafter able, with the help of the 12-hour per week homemaker-home health aide, to care for her mother as well as herself.

At present, most institutions do not keep a statistical report of individuals who must remain in hospitals because homemaker-home health aides or housekeepers are not available. One of our undertakings, in the course of this three-year project, is to attempt to document this need. Any data we collect will, of course, be made available to you.

I was interested to note in the New York Times' report of the hearing, that Dr. Israel Zwerling, Director of the Bronx State Hospital, stated "* * * 25% of the hospital's 448 elderly patients could be discharged if there were homes to receive them." Not having read his testimony, I make the assumption that Dr. Zwerling was not only referring to nursing homes but private residences as well. Obviously, a person going back to his own home would, no doubt, need some assistance from a homemaker-home health aide.

Helen Gossett, Consultant, Nursing Homes, United Hospital Fund, having analyzed the Nursing Home literature, states that ten to twenty percent of people admitted to nursing homes are sufficiently alert and mobile to remain in their own homes with homemaker services, but are not able to take full and independent responsibility for themselves.

It is our estimate that a minimum of 4,000 homemaker-home health aides are needed to begin to meet the needs of the one million persons 65 and over in New York City. Dr. Ellen Winston estimates that for families with children, as well as aging chronically ill families, provisions should be made for one homemaker-home health aide per 1,000 population. This is based both on the British and the American experience. In its Fourth Annual Report, the National Council for Homemaker Services states that 200,000 homemaker-home health aides are needed in the United States today.

The resources of the Office of Economic Opportunity could be used to promote home health services in several ways. Training funds could be utilized in increasing amounts for programs to train sub-professionals as homemaker-home health aides. Block workers and other community workers now employed by local Community Progress Centers or Community Corporations could be sensitized to the needs of the elderly. They could be trained to seek out the elderly, provide information about community resources to the aging, and could be taught to provide escort, friendly visiting and shopping services to them.

We call for an additional number of reimbursable home visits under the Medicare legislation. The one hundred visits permitted under Part A plus the 100

visits permitted under Part B of Title XVIII must be divided between all home health disciplines, i.e., doctor, nurse, physical therapist, occupational therapist, speech therapist, medical social worker and homemaker-home health aide. For some patients this is an adequate number, but for others it is not sufficient. If, for example, a nurse were to visit a patient in his home twice a week, and a homemaker-home health aide were to go in for three 3-hour sessions weekly, this would consume the first 100 visits in 20 weeks, or five months. If a medical social worker or a physical therapist were needed as well, the 100 visits might be totally utilized at the end of two or three months. We suggest, therefore, that the legislation be amended to allow as many medical, nursing, and other home health personnel visits as the doctor and nurse prescribe as an adequate medical plan for the patient. Then, following a stated period of time, a review committee would re-evaluate the case and would recommend a continued plan.

Because some limited experimental funds are available under the Hill-Staggers legislation—Public Law 89-749—we suggest that some voluntary and municipal hospitals consider experimentation whereby they can build homemaker-home health aide services into their own programs to supplement those presently in existence.

The elderly population of New York City is scattered throughout the five boroughs. There are few areas where the elderly are concentrated. Only 15 percent live in public housing. The majority remain in rent-controlled housing. Twenty-one percent of housing rented by the elderly, and nine percent of the housing owned by the elderly in New York City is deemed unsatisfactory.

Patients frequently cannot be discharged from hospitals nor can they be properly cared for in their homes because they live in walk-up or basement apartments that are unfit in terms of heat, light, sanitary facilities, privacy and safety. Sometimes medical authorities state that housing conditions of patients are too poor for the utilization of medical personnel in patients' homes.

Various kinds of housing are required to meet the needs of different aging people with medical problems. Community health centers should be available in *all* neighborhoods where hospital services are distant, so that persons in all types of housing can have access to medical care. Some elderly merely need good, inexpensive housing. Some need good housing with home health services built in. Others need the protection of a resident-hotel type of living arrangement, with a strip kitchen and central dining and/or recreational facilities. Still another group needs foster care and on up the continuum to homes for aging or nursing homes.

"Model City" Possibilities

It is necessary for the Departments of Health, Hospitals, Housing and Social Services (Welfare) to work cooperatively to provide satisfactory living arrangements for the elderly. In New York City, planning among all city agencies is beginning under the *Model Cities Program.* Perhaps methodology of joint planning between governmental agencies will be established in these three experimental areas which can be utilized in the city as a whole.

New York City is so complex, and the unmet needs are so great, that at the present time it is impossible to visualize the ultimate establishment of a municipal agency to implement coordinated programs for health and social services.

The Community Council of Greater New York feels that responsibility for health planning and coordination between public and voluntary agencies should be given to a publicly accountable body responsible to the Mayor. (See attached statement "Organization of Comprehensive Health Planning for the City of New York.")

In order to most effectively implement coordinated programs for health and social services, a two-pronged approach must be utilized. The first is the utilization of Mayor Lindsay's plan for the coordination of all city services under the four categories, Human Resources Administration, Housing and Redevelopment, Health Services Administration, and Environmental Protection. Second, on the neighborhood level community multi-function centers should be established in which personnel from both voluntary and city agencies provide "one-stop" services to any local resident.

[Enclosure]

COMMUNITY COUNCIL OF GREATER NEW YORK, HEALTH DIVISION

ORGANIZATION OF COMPREHENSIVE HEALTH PLANNING FOR THE CITY OF NEW YORK

The Health Division of the Community Council recommends that the Comprehensive Planning Agency for New York City be constituted in much the same way as the counterpart agency set up for the State of New York as a whole. The New York City organization should be an official agency of the City of New York. The advisory committee as in the State, should have a clear majority of representatives of consumer health services. The Health Division believes it is essential that the official planning body, following the pattern established by the State, have a full time planning staff and other necessary technical personnel. We recognize that if Comprehensive Planning is to operate effectively, the City of New York must arrange for adequate staff with adequate salaries. We are prepared to work with other community groups to achieve this goal. We believe that the planning agency must plan. It should not confine its activities to the collection of statistics. We also think that organizations such as the Hospital Review and Planning Council of Southern New York might be delegated specific technical functions under contractual arrangements with the local planning agency and thus avoid unnecessary staff duplication.

Senator SMATHERS. Our last witness on this panel is Mr. Walter Newburgher, president of the Congress of Senior Citizens, the witness of whom we have heard a great deal.

STATEMENT OF MR. NEWBURGHER

Mr. NEWBURGHER. Thank you. I want to express my appreciation for being granted the opportunity to appear before this fine committee. I also want to express my gratification to Senator Smathers for the fine statements that he made yesterday, which gives us the hope that the social security bill of 1967 might still be enacted before the Congress recesses.

If the amendment that you expressed opposition to had been tagged on as a rider to the social security bill, I daresay we would not have a social security bill for at least another year.

From as far back as I can recollect I have always cherished a great admiration for the medical profession, their oath of Hippocrates, and their dedication to what they term the ethics of their profession. It is only fair to say that many doctors conscientiously live by these precepts. However, a great many others, particularly since the advent of medicare, are resorting to practices which are not only deplorable but tend to destroy the image created by the millions of compassionate physicians serving humanity throughout the centuries.

Those ethical doctors whose devotion is almost a religion should be the first to cry out loudly condemning those men of their profession who have traded Aesculapius for Mercury, who have traded their professional status for that of the merchant. The escalation of medical fees are fragmented and the statistics do not really tell the whole story because they equate some modest increases with a fantastic doubling and tripling and you come up with an average that is completely unrealistic.

The great majority of the elderly are poor, and the reason is obvious. This is the generation that weathered the depression. Here in New York they actually constitute 28 percent of the poverty stricken. Were it not for medicare, they could never avail themselves of modern medical care, they would just die a little sooner.

Almost all doctors and surgeons will treat our junior citizens under the schedule of the fees established by Blue Shield. Why then must senior citizens make supplementary payments, particularly to surgeons? Is it not hardship enough that they must almost invariably borrow to meet the $40, $50, and the 20 percent? The deductibles and the coinsurance in most instances are a heavy burden.

As the leader of an organization of more than 150,000 organized senior citizens in the Greater New York area, improper action by doctors come to my attention almost daily. To get these people to be a witness publicly is practically impossible. They are scared. They are terribly afraid that the transgressor physician will wreak vengeance on them in some way or other. Life is precious to us all.

I want to relate to this committee a case which came to my attention only 3 weeks ago and I have promised faithfully that I would not reveal their names nor that of the doctor and the surgeon. These people had easily qualified for medicaid. They have no savings at all, no other income except very modest social security benefits. The husband became so violently ill that the wife had no recourse but to call the police who immediately summoned an ambulance and he was transported a a city hospital.

The wife signed him in and then phoned her family doctor who was well acquainted with their financial status and the fact that they had been enrolled under medicaid. The doctor appeared concerned that the wife had signed her husband into a city hospital and suggested that she sign him out again and remove him to a private hospital where he could take care of him.

Upon her arrival at the suggested hospital she was asked to pay $75. Luckily she had just cashed her social security check. Some days later she received a bill for $35 from an anesthetist and at this point she appealed to me. I contacted the hospital and explained that these people were on medicaid, only to be told that this particular hospital does not take medicaid patients and that as far as they were concerned this man was on medicare.

The original payment was $40 to part A and $35 for part B. I then spoke to the doctor and reminded him that these people were enrolled in medicaid. He merely shrugged his shoulders and reiterated that this hospital does not take medicaid but that this was all they would have to pay. When I reminded him there was still the matter of the 20 percent coinsurance, he stated as a rule the surgeon accepts the 80 percent as a total payment.

A week later the man underwent surgery which produced another bill from the anesthetist which the wife was able to borrow from friends.

After the operation the surgeon notified the wife that he wanted to see her in his office. She went there with trepidation fearing that a malignancy had been uncovered. However, the surgeon explained to her that his fee for such an operation was $750 but all he would derive under medicare was $400, which evidently was all that the operation was worth. He would, however, in view of the couple's financial condition be satisfied if she would send him a money order for $100.

The wife in her elation that no malignancy was involved borrowed the $100 and paid. Total cost $285, the equivalent of three social secu-

rity checks, despite the fact that medical service without cost whatever were available under medicaid.

The enactment of medicare was a great step forward. It certainly must be hailed as a great achievement by the Congress, and its mere existence has given hope to a multitude of the aged in the Nation. After 2 years operation it is showing a need for improvement. However, the amendments of 1967 that have emerged from the House of Representatives are definitely a move in the wrong direction.

Deductibles a Bar to Prevention

The retention of the deductibles is a bar to preventative care. The emasculation of medicaid menaces the health of young and old alike and the minute increase in benefits continues to condemn the vast majority of the aged to end their span of life at an unthinkable subsistence level. It is my belief that the rumored increase of the registration fee for part B would prove financially disastrous to the Social Security Administration. My information from the directors of the many clubs and centers affiliated with the Congress of Senior Citizens assures me that dropouts would prove momentous and that such cancellations would come mainly from those senior citizens who are in good health and are in no financial liability to the medicare program in the first place.

I want to close with these observations. The medicare law is a great boon to the elderly of the Nation. It does need further improvement in order to operate properly. It is my opinion that the Congress enact legislation providing a schedule of fees similar to those in operation by Blue Shield and accepted by the medical profession in general and that the Congress remove the deductibles and the coinsurance stipulations which are a deterrent to preventative care.

Medicare is indeed a fine program, let's make it a better one.

I thank you. [Applause.]

Senator SMATHERS. Thank you very much.

(The chairman addressed the following questions to Mr. Newburgher in a letter subsequent to the hearings:)

1. May we have some additional discussion on your point that the "retention of the deductibility is a bar to preventive care" under Medicare?

2. Your statement said that examples of improper action by doctors come to your attention almost daily. If you can possibly do so, I would like to have, in descriptive terms, examples of several of the actions you consider abusive or unethical.

(The following reply was received:)

In the statement that "retention of the deductibility is a bar to preventive care" a phrase I did not elaborate on, as it seemed to me quite obvious. To the great majority of the elderly, the $50.00 constitutes a sum much needed for the purchase of food and if he indulges in self diagnosis he will attempt to cure what he believes to be a mild disorder by resorting to some patent cure-all purchasable at the drug counter at a minute expenditure. In most cases the disorder can be a warning of serious trouble, where a visit to the doctor can bring about the control of a serious illness, cure the patient, which would result in considerable pecuniary savings to the Social Security Administration by making hospitalization and the services of a surgeon unnecessary.

On the 2nd question I want to say that I used the particular case quoted in the testimony because I became personally involved and therefore knew for certain that the facts were indisputable, however, as I stated many other cases came to

my attention which I did not pursue and where I confined myself to the assuage of the members ruffled feelings. I might however quote some of these cases:

An elderly lady at one of our affiliated Clubs in the Bronx accosted me after a meeting, to express her gratification at the Medicare program. She had to undergo a cataract operation for which the surgeon demanded $750.00—she borrowed the money from her children and promised to restitute the sum when she gets the 80%. Medicare was wonderful indeed. I had a rather unpleasant obligation to explain to this lady that the most she could look forward to was $320.00 80% of $400.00 and that she would have to find $430.00 more to repay the loan.

Another case that comes to mind is where a surgeon charged $500.00 for a minor surgical procedure involving the removal of growths from the face and neck. The possibility that these might be malignant motivated the patient to react to the urging of his doctor. His reimbursement will be less than $100.00.

Another area of abuses, not to be overlooked is the sudden increase in house calls by practitioners who have been more and more reluctant to make these calls, but it appears that when it comes to Medicare patients it is profitable to drop in daily for a minute or so.

My statements should not be construed as an indictment of the Medical profession per se. There are many fine men, ethical men engaged in curing the ill (and I am thinking of my own doctor) but a good percentage of physicians particularly in the urban communities are resorting to practices which could undermine the Medicare program and that would indeed be a tragedy.

Senator SMATHERS. Those are very excellent statements and we are very grateful to each of you. Thank you very much for your appearance.

Ladies and gentlemen, we have two more witnesses. This committee is going to have to adjourn at 5 o'clock. It is now 4:25. We have Dr. Himler who is the coordinator of the Council of the County Medical Societies of New York City. We have Mr. James A. Brindle, president of the Health Insurance Plan of Greater New York City, accompanied by Mr. Samuel Shapiro, vice president and director of Research and Statistics.

Then we have Dr. Leo Gitman, director, Department of Community Health and Multiphasic Screening Program.

I want first for Dr. Himler to come up. I don't want to limit Dr. Himler's testimony too stringently because he and his group have been the subject of considerable criticism, and he is entitled to have some time to answer. We now have 35 minutes. Dr. Himler, how long will it take you to get through with your statement?

Dr. HIMLER. I think I can cover the presentation in 12 or 15 minutes. I will be very happy to edit what I have to say as well as I can.

Senator SMATHERS. We will be very happy if you would do that. We will let you take over then and proceed.

STATEMENT OF GEORGE HIMLER, M.D., COORDINATOR, COUNCIL OF THE COUNTY MEDICAL SOCIETIES OF NEW YORK CITY

Dr. HIMLER. Thank you, Senator Smathers.

Gentlemen of the committee and ladies and gentlemen.

Senator, for the information of your committee I brought up two or three other statements that I have made elsewhere, they are relevant to this subject although not directly. I have only two copies of each but I would like to leave them with you.

Senator SMATHERS. If you desire, we will make them a part of this record.

Dr. HIMLER. I would be glad to leave it to the discretion of the committee. They need not be part of the record.

Senator SMATHERS. We will read them and make that determination.

Dr. HIMLER. My name is George Himler, M.D. I am chairman of the Coordinating Council of the five county medical societies of New York City and chairman of the Technical Advisory Committee of the Medical Society of the State of New York to the New York State Department of Health on matters pertaining to medicaid.

I have been asked to assess the impact the title 18 and title 19 programs have had on the availability of medical services to the elderly and the effect they may have in the future. The question is clearly not a simple one but, to make a beginning, I will divide it into its separate components of medicare and medicaid and then further subdivide the discussion into ambulatory, hospital, and posthospital or extended care services.

Judging from the statistics that have been made available on the first year of medicare operation, the program has had virtually no effect on the number of ambulatory services received by the elderly. The number of office visits has not increased and our municipal and voluntary clinics were already working at capacity before medicare went into effect. There are two ways of explaining this finding.

It is possible that the elderly were not previously deprived of care to the significant extent because of health insurance protection, private means, family assistance or Government assistance. There would then have been no appreciable backlog of necessary medical services to create an increased demand. A more likely explanation is that the benefits provided by medicare do not differ substantially in kind or extent from those of the usual type of health insurance. It has deductible and coinsurance features which are characteristic of voluntary health insurance. There are no benefits for drugs, sickroom supplies, prostheses, eyeglasses, hearing aids, and other services and supplies. These limitations and exclusions may still be serving as a deterrent to the elderly from seeking ambulatory health services.

The picture is somewhat different when we consider inhospital care. Immediately before the implementation of medicare, much apprehension and even alarm was expressed by physicians and hospital administrators that there would be an uncontrollable "run" on hospital beds by the elderly. Fortunately, the expected deluge did not materialize. It is true, however, that those over 65 now occupy a proportionately larger number of hospital beds than they did before medicare. The increase is in the neighborhood of 20 percent. This is probably due to a backlog of previously neglected conditions which are now in the process of being corrected.

Part of the reason for the rise in bed occupancy is also to be found in the requirement that medicare beneficiaries be in a general hospital for at least 3 days before admission to an extended-care facility. This 3-day stay is often greatly protracted because these patients are admitted to the general hospital whenever a bed can be found for them, whether or not arrangements have been made for subsequent transfer to a convalescent or nursing home. Since long-term care accommodations are scarce, there is often a delay in transferring them, during which time they continue to occupy general hospital beds. It appears likely, however, that as in part B of medicare, the deductible and co-

insurance provisions of part A have had some effect in limiting utilization.

I will skip the extended-care benefits because I don't think it is germane to this discussion.

It seems a fair statement that medicare has had only a moderate impact on the totality of medical services. Its greatest effect has been an exacerbation of preexisting shortages of hospital beds and personnel.

Medicare Coverage Called Inadequate

In evaluating the effectiveness of medicare, it is apparent that the scope of coverage is inadequate. In my opinion, this is due to the cost limitations imposed by extending it to all persons over 65 years of age, regardless of need. The most important gaps in coverage are the deductibles in both part A and part B. Limitation of hospital benefits to 90 days often works a hardship in an age group where hospitalizations tend to be prolonged. Finally, as I previously pointed out, the provision for extended-care benefits falls far short of the needs.

On the credit side, the administrative policies established for the program are practical and fit well into the practice patterns of physicians and patients alike. They have utilized the existing facilities of the insurance industry and, as a result, there has been only minimal confusion, dislocation of patients, or deprivation of benefits due to administrative difficulties. So much for medicare.

In discussing medicaid, I will limit my remarks to its implementation in the State of New York which differs from that in other States in many important respects. The program offers comprehensive coverage. There are complete benefits in and out of the hospital. Provision is made for payment for drugs, prostheses, sickroom supplies, eyeglasses, and whatever other health services and supplies the recipient may require. Benefits are provided for extended-care facilities. There are no dollar or time limitations on the assistance available. To this extent, the program is admirable and it has had the support of the medical profession from the day of its implementation.

Beyond this point, however, professional and public enthusiasm fall abruptly to the vanishing point. From the administrative point of view, the program is completely disorganized. In spite of repeated urging by the Medical Society of the State of New York, the Department of Social Services in Albany has failed to develop a uniform coherent program. It has acted on the premise that the local welfare districts are autonomous and cannot be forced to submit to State regulation. As a result, there are as many programs operational as there are social service districts. Each district has its own invoice forms and its own regulations. The capacity of the various local offices to cope with their new administrative responsibilities varies greatly but administration and professional relations have generally been poor.

Since the processing of claims is a new venture for the district offices, at least on this scale, most of them have fallen badly behind in the payment of bills from physicians and other providers of services. In some areas, payment has been delayed by as much as 10 or 12 months. Some districts are just beginning to catch up with invoices now, after 18 months of operation, while others are 3 to 4 months behind and will be indefinitely.

At the same time, the physician cannot charge the State more than the fee schedule allows. Under these circumstances, with large numbers of their patients potentially eligible for the program, physicians understandably began to take a much keener interest in fee schedules than they had in the days when the number of patients receiving medical assistance was low and they, the doctors, were content to give the State the usual "welfare discount."

Basis for Fee Structure

The State medical society therefore undertook a negotiation with an interdepartmental task force of New York State. After prolonged efforts to arrive at a fair reimbursement formula for physicians, the negotiations broke down and the departments of health, welfare, and budget unilaterally promulgated a maximum fee schedule for the State of New York. The fee structure was based on the society's relative value scale with a conversion factor of $4 for surgery and $5 for nonsurgical procedures.

The actual amounts of the fees ranged from parity with customary fees in a very few rural areas to 40 percent below in high-cost areas such as New York City. It has been estimated that, on a statewide basis, the maximum fee schedule is 35 percent below the prevailing rates charged by physicians in private practice. The clamor about the inadequacies of the established fees become so great that the State was forced to grant so-called interim increases in six specialties. Even with these increases, the rates are below the prevailing rates in almost all communities.

A large number of physicians of the State, faced with an administrative shambles, unnecessary and excessive paperwork, low reimbursement rates, and delays in payment, declined to participate in the program. It should be made clear at this point that the Medical Society of the State of New York, although justly and publicly critical of the administration of medicaid, never wavered in its support of the principle on which it is based. The decision on whether or not to participate was therefore left to each individual physician and there was never a boycott of the program as has occasionally been charged.

Oddly enough, the public has shown relatively little enthusiasm for medicaid, particularly in New York City. It is my opinion that this is largely because enrollment was left in the hands of the welfare department or the department of social services as it is now called. The establishment of eligibility, registration, and administration were still conducted in a manner strongly reminiscent of old welfare methods. The welfare connotation of the assistance program were apparently sufficiently strong and distasteful to outweigh its possible benefits in the minds of the recipients. In New York City, after prolonged effort, less than one-half of the estimated 3 million eligibles have been enrolled to date.

In spite of these limitations on utilization, the costs of the program have increased spectacularly. The major reason was an apparently uncontrollable increase in hospital per diem rates. A second factor was a huge demand for nursing home and convalescent care, payment for which had now become primarily a Government responsibility. The

implementation of title 19 became so costly that some upstate communities found it necessary to curtail their school programs and other essential services to avoid crushing tax increases.

Some counties have threatened not to put medicaid into full effect because even their 25-percent contribution to the total cost would entail an unacceptable rise in taxes. It is gradually becoming clear that the New York State program, excellent though it is in concept, is overly ambitious. There is evidence that a very substantial number of citizens do not wish to support so large a program through taxation and the recommendations of the House Ways and Means Committee suggest that Congress may not wish to commit the Federal Government to providing matching funds on the required scale.

An assessment of the present status of medicaid in New York State indicates that it has had little effect in changing the manner in which services are provided for the medically indigent. Its main effect has been to reapportion the responsibility for the costs of medical care. The basic intent of the legislation, which was to improve the quality of health services and to allow the recipients to receive those services in a dignified manner, has not materialized.

If maladministration, a dissatisfied medical profession, and a disinterested public were medicaid's only handicaps, it would still qualify for a guardedly favorable prognosis, since most of these could be overcome in time. Unfortunately, the attitude assumed by State officials toward the medical profession and the medical societies will require drastic revision if physicians are to give the program the support it must have. The State law makes the commissioner of health responsible for the quality and availability of medical care. This is reasonable since the State is the paying agency. The corollaries that the commissioners of health and social welfare have adopted to the basic theorem are not quite so reasonable.

Efforts by Medical Societies

Beyond this, the State officials, in their fee discussions with the medical society, have obviously worked on the assumption that, unless rigid State controls were established, physicians would abuse the program. I have heard some reports of similar sentiments expressed here today. The medical societies have already offered the services of their grievance committees and boards of censors to curb excesses where they existed. These have obviously been trivial since, after 18 months of operation in New York City, the health and welfare departments have identified only a dozen or so cases for the societies to look into as possible instances of abuse. These cases have not yet been formally submitted.

These attitudes, which still persist and are not necessary to the proper functioning of the program, are resented by physicians who are justly proud of their record, unequaled among the professions, in policing the quality of their services and unethical practices among their members.

The preceding portion of this presentation covers what I believe to be the operating failures of medicaid in New York State. It is the medical society's hope that many or all of these will be corrected and

our committees will continue to meet patiently with State representatives, even though progress from our point of view has been agonizingly slow.

There is one fundamental defect in the New York State implementation of medicaid which may influence not only its effectiveness for medical assistance recipients, but may affect medical services to all the people of the State. I would like to develop this theme briefly because I consider it to be of major importance.

It is clear to everyone that health needs are essentially the same for persons under 65 years of age as those over 65. Employed and solvent individuals and those covered by adequate health insurance have the same health requirements as the indigent. Patients, even in relatively high income brackets, often cannot pay out of pocket for the care of chronic or catastrophic illness without incurring a financial malaise proportional to their physical one. Those of us who have been active in the field of voluntary health and hospital insurance have long been aware of the urgent need of comprehensive coverage for all segments of the population regardless of their age, income, or the source of their health-care financing.

The private health insurance industry, commercial and voluntary, is at present our only mechanism for providing protection against the costs of illness through prepayment. I am aware that there are still many deficiencies in the coverage they offer but the record shows a steady improvement in the scope of protection. It is important that this trend continue. It is essential that we consider the health needs of the entire Nation rather than fragment it into groups according to age, income level, disabilities, and other irrelevant conditions. It is true that the problems of the aged and indigent with respect to payment for health care are more acute than those of the rest of the population and that they require more immediate assistance, but that assistance must be offered in the context of ultimately creating comprehensive health insurance for all.

Role of Insurance Industry

Congress apparently recognized this need when it directed that medicare be extended through the private insurance industry. The intermediary role assigned to the carriers has not been entirely comfortable, but it is amenable to correction or conversion to a true carrier role which would probably be more effective. Nevertheless, the major immediate effect of involving the private carriers has been to encourage them to develop insurance mechanisms that are more effective than current ones and that will apply uniformly to everyone. Within the limits of their actuarial restrictions, they are experimenting with wider coverage, better utilization control, new payment policies, and have made strides toward more efficient administration. Their experiences with medicare have been and will continue to be useful in improving their own product.

Most States that have implemented title 19 have employed the insurance industry in its administration. Not so New York State. From the very beginning, the Medical Society of the State of New York has insisted that the title 18 intermediaries administer title 19. Legislation

was sponsored in the New York State Legislature to make it permissible for the welfare districts to choose this type of operation. The carriers have indicated their willingness to undertake the task. The New York State Department of Social Services, again taking refuge in the home-rule rights of the welfare districts, has declined even to encourage the use of intermediaries. The local offices, on the other hand have indicated that they would not consider such a move unless they were told to do so by Albany.

As a result, almost all of them are administering their own plans. The city of New York has installed expensive data-processing equipment which is not really needed, since it duplicates the machine capacity of Blue Cross and Blue Shield. The department of social services has had difficulty in putting the program into operation and has caused needless shortages in personnel and delays in payment.

If this trend toward self-administration is not quickly reversed, it will become permanent and we will have two programs for medical assistance or insurance existing side by side and duplicating most of their facilities. The development of a uniform, comprehensive, and economical health-care program based on the prepayment principle and applying to all the population will have been retarded or permanently impaired.

If I were asked to write one or two simple prescriptions to put New York State medicaid on its feet, I would recommend that the physicians, through the State medical society, be given a partnership role in its development and policymaking. The second prescription would be that the insurance carriers of the State be given the administration of the program with the proviso that they make it uniform throughout the State.

This is the end of my formal presentation.

Senator SMATHERS. Why don't you submit your prepared statement for inclusion in the record at this point and permit us to include your supplementary material in the appendix? (See p. 536.)

(The complete statement of Dr. Himler follows:)

PREPARED STATEMENT OF GEORGE HIMLER, M.D.

My name is George Himler, M.D. I am Chairman of the Coordinating Council of the Five County Medical Societies of New York City and Chairman of the Technical Advisory Committee of the Medical Society of the State of New York to the New York State Department of Health on matters pertaining to Medicaid.

I have been asked to assess the impact the Title XVIII and Title XIX programs have had on the availability of medical services to the elderly and the effect they may have in the future. The question is clearly not a simple one but, to make a beginning, I will divide it into its separate components of Medicare and Medicaid and then further subdivide the discussion into ambulatory, hospital and post-hospital or extended care services.

Judging from the statistics that have been made available on the first year of Medicare operation, the program has had virtually no effect on the number of ambulatory services received by the elderly. The number of office visits has not increased and our municipal and voluntary clinics were already working at capacity before Medicare went into effect. There are two ways of explaining this finding.

It is possible that the elderly were not previously deprived of care to a significant extent because of health insurance protection, private means, family assistance or government assistance. There would then have been no appreciable backlog of necessary medical services to create an increased demand. A more likely

explanation is that the benefits provided by Medicare do not differ substantially in kind or extent from those of the usual type of health insurance. It has deductible and co-insurance features which are characteristic of voluntary health insurance. There are no benefits for drugs, sickroom supplies, prostheses, eyeglasses, hearing aids, and other services and supplies. These limitations and exclusions may still be serving as a deterrent to the elderly from seeking ambulatory health services.

The picture is somewhat different when we consider in-hospital care. Immediately before the implementation of Medicare, much apprehension and even alarm was expressed by physicians and hospital administrators that there would be an uncontrollable "run" on hospital beds by the elderly. Fortunately, the expected deluge did not materialize. It is true, however, that those over 65 now occupy a proportionately larger number of hospital beds than they did before Medicare. The increase is in the neighborhood of 20%. This is probably due to a backlog of previously neglected conditions which are now in the process of being corrected. Part of the reason for the rise in bed occupancy is also to be found in the requirement that Medicare beneficiaries be in a general hospital for at least three days before admission to an extended care facility. This three-day stay is often greatly protracted because these patients are admitted to the general hospital whenever a bed can be found for them, whether or not arrangements have been made for subsequent transfer to a convalescent or nursing home. Since long-term care accommodations are scarce, there is often a delay in transferring them during which time they continue to occupy general hospital beds. It appears likely however, that as in Part B of Medicare, the deductible and co-insurance provisions of Part A have had some effect in limiting utilization.

As far as extended care benefits are concerned, the hardship caused by co-insurance is relatively minor. The major deficiency is the 100 day limitation on payments since most patients have long stays in these facilities and a significant number of those entering nursing homes do so never to leave again. Long-term care accommodations have always been in short supply. Medicare did not aggravate the situation; it merely brought it to public attention. On the other hand, the reimbursement formula adopted may perpetuate the shortage by discouraging the investment of private capital in convalescent and nursing homes.

It seems a fair statement that Medicare has had only a moderate impact on the totality of medical services. Its greatest effect has been an exacerbation of pre-existing shortages of hospital beds and personnel.

In evaluating the effectiveness of Medicare, it is apparent that the scope of coverage is inadequate. In my opinion, this is due to the cost limitations imposed by extending it to all persons over 65 years of age, regardless of need. The most important gaps in coverage are the deductibles in both Part A and Part B. Limitation of hospital benefits to 90 days often works a hardship in an age group where hospitalizations tend to be prolonged. Finally, as I previously pointed out, the provision for extended care benefits falls far short of the needs.

On the credit side, the administrative policies established for the program are practical and fit well into the practice patterns of physicians and patients alike. They have utilized the existing facilities of the insurance industry and, as a result, there has been only minimal confusion, dislocation of patients or deprivation of benefits due to administrative difficulties.

New York State Policies

In discussing Medicaid, I will limit my remarks to its implementation in the State of New York which differs from that in other states in many important respects. The program offers comprehensive coverage. There are complete benefits in and out of the hospital. Provision is made for payment for drugs, prostheses, sickroom supplies, eyeglasses and whatever other health services and supplies the recipient may require. Benefits are provided for extended care facilities. There are no dollar or time limitations on the assistance available.

To this extent, the program is admirable and it has had the support of the medical profession from the day of its implementation.

Beyond this point, however, professional and public enthusiasm fall abruptly to the vanishing point. From the administrative point of view, the program is completely disorganized. In spite of repeated urging by the Medical Society of the State of New York, the Department of Social Services in Albany has failed to develop a uniform coherent program. It has acted on the premise that the local Welfare Districts are autonomous and cannot be forced to submit to State

regulation. As a result, there are as many programs operational as there are Social Service Districts. Each District has its own invoice forms and its own regulations. The capacity of the various local offices to cope with their new administrative responsibilities varies greatly but administration and professional relations have generally been poor.

Most claim forms are much more involved than the SSA form 1490 which has only six or seven questions for the physician to answer. The rate of claim rejection has been high and physicians are often forced to resubmit claims because of unimportant errors or omissions. As a result, those who treat Medicaid patients are inundated with paper work.

Since the processing of claims is a new venture for the District Offices, at least on this scale, most of them have fallen badly behind in the payment of bills from physicians and other providers of services. In some areas, payment has been delayed by as much as 10 or 12 months. Some Districts are just beginning to catch up with invoices now, after 18 months of operation, while others will be three to four months behind indefinitely.

As far as regulations and administrative processes governing physician participation are concerned, each District is required to submit a plan for approval by the State Department of Health. It is interesting to note that the New York City plan, which was prepared entirely without consultation with the physicians of the City, is now in its fifth or sixth draft and has not yet been approved. The New York State Medicaid Program is therefore essentially a patchwork of local programs in various stages of development.

The income levels for eligibility for medical assistance that were adopted by the State Board of Social Services have been controversial in the extreme. They have been challenged by the Medical Society of the State of New York and many taxpayer groups as being entirely too high. The rule of thumb sets the income of a family of four with one wage earner at $6,000 per year after certain deductions. This compares with the $5,300 *gross* income ceiling under the old Kerr-Mills legislation. By these standards, physicians found that one-third to one-half of their patients were eligible for medical assistance. In some areas, the potential eligibility of the population was as high as 80%. Since medical assistance is based on vendor payments, a physician who accepts a patient for private care under Medicaid cannot bill the patient directly because the patient cannot claim reimbursement. At the same time, the physician cannot charge the State more than the fee schedule allows. Under these circumstances, with large numbers of their patients potentially eligible for the program, physicians understandably began to take a much keener interest in fee schedules than they had in the days when the number of patients receiving medical assistance was low and they, the doctors, were content to give the State the usual "welfare discount."

NEGOTIATIONS FOR REIMBURSEMENT

The State Medical Society therefore undertook a negotiation with an Interdepartmental Task Force of New York State. After prolonged efforts to arrive at a fair reimbursement formula for physicians, the negotiations broke down and the Departments of Health, Welfare and the Budget *unilaterally* promulgated a maximum fee schedule for the State of New York. The fee structure was based on the Society's Relative Value Scale with a conversion factor of $4.00 for surgery and $5.00 for nonsurgical procedures. The actual amounts of the fees ranged from parity with customary fees in a very few rural areas to 40% below in high cost areas such as New York City. It has been estimated that, on a statewide basis, the maximum fee schedule is 35% below the prevailing rates charged by physicians in private practice. The clamor about the inadequacies of the established fees became so great that the State was forced to grant so-called interim increases in six specialties. Even with these increases, the rates are below the prevailing rates in almost all communities.

A large number of the physicians of the State, faced with an administrative shambles, unnecessary and excessive paper work, low reimbursement rates and delays in payment, declined to participate in the Program. It should be made clear at this point, that the Medical Society of the State of New York, although justly and publicly critical of the administration of Medicaid, never wavered in its support of the principle on which it is based. The decision on whether or not to participate was therefore left to each individual physician and there was never a boycott of the program as has occasionally been charged.

It should also be emphasized that the reluctance of physicians to participate did not mean that needed services were withheld. In many instances, those eligible for Medicaid had health and hospital insurance either privately or through their employers or unions. Their situation remained essentially unchanged. Those who were previously on the Welfare rolls as money assistance recipients continued to receive their care in voluntary and municipal clinics and on the Welfare supported wards of hospitals. These individuals still do not lack for medical care. They have merely been deprived of the hoped for improvement in its quality and the manner in which it is rendered. Finally, most Medicare patients who also qualified for Medicaid benefits had purchased the supplementary insurance offered by Senior Care, so that they too were left with more or less adequate coverage. Nevertheless, it is clear that the failure of the State to implement its Medical Assistance Plan in a fashion that would make it possible for physicians to participate wholeheartedly has caused the Program to fall far short of its goals.

Oddly enough, the public has shown relatively little enthusiasm for Medicaid, particularly in New York City. It is my opinion that this is largely because enrollment was left in the hands of the Welfare Department or the Department of Social Serivces as it is now called. The establishment of eligibility, registration and administration were still conducted in a manner strongly reminiscent of old welfare methods. The welfare connotation of the assistance program were apparently sufficiently strong and distasteful to outweigh its possible benefits in the minds of the recipients. In New York City, after prolonged effort, less than one-half of the estimated three million eligibles have been enrolled to date.

In spite of these limitations on utilization, the costs of the program have increased spectacularly. The major reason was an apparently uncontrollable increase in hospital per diem rates. A second factor was a huge demand for nursing home and convalescent care, payment for which had now become primarily a government responsibility. The implementation of Title XIX became so costly that some upstate communities found it necessary to curtail their school programs and other essential services to avoid crushing tax increases. Some counties have threatened not to put Medicaid into full effect because even their 25% contribution to the total cost would entail an unacceptable rise in taxes. It is gradually becoming clear that the New York State program, excellent though it is in concept, is overly ambitious. There is evidence that a very substantial number of citizens do not wish to support so large a program through taxation and the recommendations of the House Ways and Means Committee suggest that Congress may not wish to commit the Federal Government to providing matching funds on the required scale.

An assessment of the present status of Medicaid in New York State indicates that it has had little effect in changing the manner in which services are provided for the medically indigent. Its main effect has been to reapportion the responsibility for the costs of medical care. The basic intent of the legislation, which was to improve the quality of health services and to allow the recipients to receive those services in a dignified manner has not materialized.

If maladministration, a dissatisfied medical profession and a disinterested public were Medicaid's only handicaps, it would still qualify for a guardedly favorable prognosis, since most of these could be overcome in time. Unfortunately, the attitude assumed by State officials toward the medical profession and the medical societies will require drastic revision if physicians are to give the program the support it must have. The State law makes the Commissioner of Health responsible for the quality and availability of medical care. This is reasonable since the State is the paying agency. The corolaries that the Commissioners of Health and Social Welfare have adopted to the basic theorem are not quite so reasonable. Postgraduate study requirements were established for general practitioners who wished to participate in the program beyond March 1, 1968. The Medical Society objected on the grounds that this was more properly a function of the State Education Department and that if done at all, it should be done by that body in cooperation with the Medical Society. The argument was advanced that these requirements constituted a secondary and possibly illegal licensure by the State Health Department. Objection to this principle is still keeping large numbers of physicians from participating.

Qualifications were also required of specialists which, although acceptable in themselves, were completely unnecessary. It is common knowledge that a specialist, by the nature of his work, requires a hospital in which to practice.

The requirements established by hospitals for specialists are more stringent than those adopted by the State and are more than sufficient to prevent unqualified physicians from rendering specialists care.

Beyond this, the State officials, in their fee discussions with the Medical Society have obviously worked on the assumption that, unless rigid State controls were established, physicians would abuse the program. The Medical Societies had already offered the services of their Grievance Committees and Boards of Censors to curb excesses where they existed. These have obviously been trivial since, after 18 months of operation in New York City, the Health and Welfare Departments have identified only a dozen or so cases for the societies to look into as possible instances of abuse. These cases have not yet been formally submitted.

These attitudes, which still persist and are not necessary to the proper functioning of the program, are resented by physicians who are justly proud of their record, unequalled among the professions, in policing the quality of their services and unethical practices among their members.

Exclusion of Physician Groups

A final and most important source of friction has been the deliberate exclusion of physician groups from even the possibility of influencing or modifying the Medicaid Program. Physician representation to the Departments involved has been only through advisory committees in spite of the fact that the State Medical Society has repeatedly assured them that its members will not implement programs that they have no voice in forming and under conditions they cannot negotiate. To put it simply, the medical profession has not been taken into partnership in implementing the program, as they have in other states. They have merely been handed a fixed plan, deficient in most major operational respects, and told to make it work. Important numbers and even more important segments of the profession have declined to do so.

The preceding portion of this presentation covers what I believe to be the operating failures of Medicaid in New York State. It is the Medical Society's hope that many or all of these will be corrected and our committees will continue to meet patiently with State representatives, even though progress, from our point of view, has been agonizingly slow.

There is one fundamental defect in the New York State implementation of Medicaid which may not influence its effectiveness for medical assistance recipients, but may affect medical services to all the people of the State. I would like to develop this theme briefly because I consider it to be of major importance.

It is clear to everyone that health needs are essentially the same for persons under 65 years of age as those over 65. Employed and solvent individuals and those covered by adequate health insurance have the same health requirements as the indigent. Patients, even in relatively high income brackets, often cannot pay out of pocket for the care of chronic or catastrophic illness without incurring a financial malaise proportional to their physical one. Those of us who have been active in the field of voluntary health and hospital insurance have long been aware of the urgent need of comprehensive coverage for all segments of the population regardless of their age, income or the source of their health care financing.

The private health insurance industry, commercial and voluntary, is at present our only mechanism for providing protection against the costs of illness through prepayment. I am aware that there are still many deficiencies in the coverage they offer but the record shows a steady improvement in the scope of protection. It is important that this trend continue. It is essential that we consider the health needs of the entire nation rather than fragment it into groups according to age, income level, disabilities and other irrelevant conditions. It is true that the problems of the aged and indigent with respect to payment for health care are more acute than those of the rest of the population and that they require more immediate assistance, but that assistance must be offered in the context of ultimately creating comprehensive health insurance for all.

Congress apparently recognized this need when it directed that Medicare be extended through the private insurance industry. The intermediary role assigned to the carriers has not been entirely comfortable, but it is amenable to correction or conversion to a true carrier role which would probably be more effective. Nevertheless, the major immediate effect of involving the private carriers has been to encourage them to develop insurance mechanisms that are more effective

than current ones and that will apply uniformly to everyone. Within the limits of their actuarial restrictions, they are experimenting with wider coverage, better utilization control, new payment policies and have made strides toward more efficient administration. Their experiences with Medicare have been and will continue to be useful in improving their own product.

There are additional benefits to be derived from the involvement of the insurance industry in programs supported by public funds. The general relationship between physician and patient remains unchanged. Over the years, they have become accustomed to the usual insurance procedures and are fairly comfortable with them. Physicians have found Medicare forms and health insurance forms in general to be simple. They eliminate the need for additional secretarial and accounting help to keep payment records straight. By contrast, Medicaid has been a severe penalty.

Finally, the economies inherent in utilizing the existing facilities of the insurance carriers are almost too obvious to mention. If there is any doubt in anyone's mind concerning the capacity of the insurance carriers to manage the burden of the administration of Medicaid, the Medicare record speaks for itself. It is true that Medicaid is a much more massive program, but the operating efficiency and the data processing capacity that the insurance companies have developed over the years will take a long time to duplicate in government and will be wasteful in the bargain. Commercial and voluntary health insurance now cover approximately 150 million people in this country and disburse more than $9 billion annually in payment for services. They can certainly expand to include Medicaid.

Most states that have implemented Title XIX have employed the insurance industry in its administration. Not so in New York State. From the very beginning, the Medical Society of the State of New York has insisted that the Title XVIII intermediaries administer Title XIX. Legislation was sponsored in the New York State Legislature to make it permissible for the Welfare Districts to choose this type of operation. The carriers have indicated their willingness to undertake the task. The New York State Department of Social Services, again taking refuge in the home rule rights of the Welfare Districts, has declined even to encouage the use of intermediaries. The local offices, on the other hand, have indicated that they would not consider such a move unless they were told to do so by Albany.

As a result, almost all of them are administering their own plans. The City of New York has installed expensive data processing equipment which is not really needed, since it duplicates the machine capacity of Blue Cross and Blue Shield. The Department of Social Services has had difficulty in putting the program into operation and has caused needless shortages in personnel and delays in payment.

If this trend toward self-administration is not quickly reversed, it will become permanent and we will have two programs for medical assistance or insurance existing side by side and duplicating most of their facilities. The development of a uniform, comprehensive and economical health care program based on the prepayment principle and applying to all the population will have been retarded or permanently impaired.

If I were asked to write one or two simple prescriptions to put New York State Medicaid on its feet, I would recommend that the physicians, through the State Medical Society, be given a partnership role in its development and policy-making. The second prescription would be that the insurance carriers of the State be given the administration of the program with the proviso that they make it uniform throughout the State.

Before concluding, I would like to respond to those specific questions that were asked of me that I have not covered earlier in this presentation.

(1) Regarding the controversy on the scaling of physicians' fees:

There is an unquestionable difference in the fee practices of physicians in different areas of the State. The demand of the Medical Society of the State of New York for payment on the basis of the usual, customary and prevailing fee is based on this fact. A fixed fee schedule, under these circumstances can result in paying some physicians more than they would usually charge for a service. This is wasteful. Parenthetically, this is not too likely to happen in New York because the schedule is set at such a low level. On the other hand, the same fixed fee schedule may result in underpaying other physicians who may thereupon withdraw from participation.

The Medical Society of the State of New York is in the process of setting up a fee study to determine the extent and validity of regional fee differences. The New York State Department of Health may institute a limited pilot project in four counties from which we may derive some conclusions on the impact of the usual and customary payment concept and administrative difficulties if any.

(2) The question of eligibility levels has been covered earlier in this presentation. I am reluctant to advocate a specific reduction in income ceiling. In general, I consider the proposal of the House Ways and Means Committee of a progressive reduction ranging from 150% to 133% and finally to 125% of income ceiling for eligibility for money assistance to be excessively severe in this State. This would cut the income ceiling for eligibility for medical assistance for the mythical family of four to $3,900 per year as compared to $5,300 under Kerr Mills. If I were forced to quote a figure, the $5,300 level, with possible minor modification, would be my choice for the present.

(3) The City of New York was not 60 days behind in paying doctors for Medicaid services in September 1967. From what we have been able to gather (and our requests for information are not rewarded with a profusion of verifiable data), it was 90 to 120 days behind at that time. Claims that were submitted prior to the installation of electronic data processing machinery were being processed individually by hand and were many months behind. It is the stated objective of the City's Department of Social Services to be caught up with past claims and to process new claims within 60 days by November 15, 1967.

In closing, I would like to thank the Committee for this opportunity to present the views of the medical profession on these extremely important questions.

Senator SMATHERS. All right, sir. Thank you very much, Doctor. We appreciate your courtesy in coming and your cooperation.

If there are any additional questions we want to ask you, we will correspond and you may answer them for the record.

(The chairman addressed the following questions to Dr. Himler in a letter subsequent to the hearings:)

1. The Subcommittee is primarily concerned with the effects of Medicare and Medicaid upon existing and further health services available to the elderly. We would welcome some thoughts from you on this subject.

2. The controversy about the need for a scaling of physicians fees, based on upstate New York and metropolitan New York City current practices, conceivably could have great importance to the future of the Medicaid program. May we have your views on this subject?

3. The New York Daily News of September 21, 1967 quoted you as saying that too many individuals in New York State are now available for Medicaid. What reduction do you advocate? The same article says that the city is 60 days behind on paying doctors for treatment given under Medicaid. Has the situation improved since that time? Do you—as the article says—advocate placing Medicaid in the hands of a statewide intermediary, such as Blue Cross?

(The following reply was received:)

NOVEMBER 6, 1967.

DEAR SENATOR SMATHERS:

* * * * * * *

In answer to your questions:

(1) I do believe that it would be wise to repeal the requirement that Medicare beneficiaries be in a general hospital for at least three days before admission to an extended care facility.

(a) Repeal would save Medicare funds because most patients who are admitted to a long term care facility have had sufficient preliminary work-up to make hospitalization unnecessary. The hospitalization plus the attendent laboratory work are much more costly than an equivalent stay in a nursing home. In addition, due to the scarcity of extended care accommodations the hospitalization, once initiated is often extended unnecessarily because there is no nursing home bed immediately available for the patient.

(b) Practitioners have no ethical problem in admitting patients for three days of prior hospitalization since it is required by law. Their main problem is to get the patients into the hospital and then to move them on promptly.

(c) Elimination of the prior admission to a general hospital except where the patient's condition requires it would certainly be sparing of scarce hospital beds. In most instances there is enough information regarding the patient's condition already available to make it unnecessary. In those instances where there is not, the physician should be permitted to admit the patient to a general hospital for necessary work-up.

(d) The main effect would be savings in total cost and better distribution of accommodations in short supply. It can be argued that care in a general hospital is at least as good as that in long term care facilities.

(2) I was not present when the statement you refer to was made but I think my statement before the Subcommittee should suffice to show that organized medicine, rather than being antisocial, has shown a very responsible attitude toward Medicare and Medicaid. It is true that physicians, through their Societies have called for fees equivalent to their usual charges to their private patients. As you are aware, physicians are generally in short supply and, as a result, most of them are busier than they wish to be. It is unlikely that they will accept large numbers of additional patients at fees that are substantially below their customary charges.

At the same time, in New York State at least, the State Medical Society took a keen interest in the Kerr-Mills implementation and is on record as having recommending that its benefits be expanded. This can hardly be construed as antisocial.

As far as linking standards of quality to fees is concerned, it should be obvious that there is a very definite relationship between the two. In New York City, most of the indigent, elderly or otherwise, have received their medical care in clinics, on the wards of municipal and voluntary hospitals or from closed panel groups. The purpose of the Medicare Law, as I understand it, was to make it possible for the indigent and elderly to receive their medical care in the same fashion as persons of greater means. This would include the privilege of being treated by their personal physician. If reimbursement rates are far below standard, it is clear that they will have difficulty in finding physicians of high caliber to accept them. This is the link between payment rates and quality of care in general. At the same time it should be emphasized that once a physician accepts a patient, he has only one standard of care regardless of the reimbursement.

(3) I did have an opportunity to hear Senator Seymour Thaler's testimony. He made a great point of the fact that 17% of physicians were charging fees in excess of the prevailing fees in the New York Area. He based this on a letter he had received from a vice-president of Blue Shield. The finding is hardly surprising when one considers that the prevailing fees were set in such a fashion as to include 83% of physicians' fees which is about the median fee plus a standard deviation. The statement, taken out of context, distorts the facts.

(a) In every community there are a number of physicians who charge fees considerably in excess of those that prevail among their colleagues. These are often highly qualified, experienced men with large practices. Part of the reason for the high fees is the desire to keep those practices within manageable proportions. I believe that the medical societies would not condemn fees that are in excess of Medicare allowances *provided* that those fees did not work a hardship on the patient and that they were discussed with him in advance. In this connection, many medical societies have encouraged their physicians to have such fee discussions whenever possible, prior to rendering care.

(b) It would be helpful to know the extent of the problem before prescribing a remedy. As I stated earlier, it was expected that about 17% of the physicians in our community would charge fees above the prevailing level because it was at that percentage that the fees were pegged. Most of these physicians have patients who are in the higher income brackets and I believe that their charges cause no hardship and are not a problem per se.

In those instances when the fees are a hardship to the patients and have not been discussed and agreed on with them in advance, we have offered the services of our Medical Society Grievance Committees. Although such committees do not have the power to order physicians to reduce their fees, they have been quite effective in controlling excesses, purely through moral suasion. If this mechanism should not prove to be effective, the Medical Societies would have to develop wider authority which they do not now legally have.

(c) In answer to your final question, my personal opinions are almost identical with the recommendations I have set forth above since I was involved in developing many of these principles.

I would strongly urge that your subcommittee make an effort to document the extent of overcharging by physicians in the Medicare Program. This should be done in the light of the criterion that the fee is a burden to the patient and that he has not agreed to it beforehand. A few lurid instances do not indicate general abuse by the profession, although they are often so interpreted. I would venture to say that you will find that only a very small percentage of physicians attempt to take advantage of their patients or the Medicare Program.

Once you and the Medical Profession know precisely how many physicians are charging excessive fees, I am sure that the Medical Societies at all levels will cooperate whole-heartedly in curbing them. I therefore urge that the Federal Government do nothing at the moment and that, when the necessity for action is demonstrated, the Medical Societies be given the task of policing their own members. Our record in this regard should leave no doubt that we can do so effectively.

I would like to thank you and the other members of the subcommittee for having given me the opportunity of presenting the views of organized medicine in this area.

Sincerely yours,

George Himler, M.D.,
Chairman, The Coordinating Council.

We now have Mr. James A. Brindle, president of the Health Insurance Plan of Greater New York City, accompanied by Mr. Samuel Shapiro, vice president and director of research and statistics. I understand you rearranged your travel plans to be here. I appreciate your courtesy and your patience.

STATEMENT OF JAMES A. BRINDLE, PRESIDENT, HEALTH INSURANCE PLAN OF GREATER NEW YORK CITY, ACCOMPANIED BY SAMUEL SHAPIRO, VICE PRESIDENT AND DIRECTOR OF RESEARCH AND STATISTICS

Mr. Brindle. Thank you. I appreciate being here even though it is late in the day. I did get some benefit out of the day from hearing the other witnesses and it was not a wasted day for me by any means.

I have included in my written presentation a description of the health insurance plan. Particularly relevant to this hearing is the fact that this plan addresses itself not just to the payment of medical care, which preoccupies most health insurance, but it is vitally concerned with the important problem that was brought to your attention this morning by the distinguished physicians who were sitting here. They pointed out a number of times that our concern is not so much how to round up the money to pay for medical care, because in our insurance systems, private and public, we are pretty well along down that line. We have to learn how better to organize medical care. In short, we need to address ourselves to the organization, efficiency, economy, and productivity of medical care systems.

Group Practice Benefits Demonstrated

You also heard advocated by another witness that there be experiments with the organization and operation of medical services. Actually experimentation is often used as a way to say let's look further at the question and postpone making a decision. You don't need experimentation to demonstrate the validity of group practice prepayment where the physicians are functioning as a team. Their cost effective-

ness has been amply demonstrated in the Federal employees health benefits program, which shows that you get better integrated and a much lower rate of hospitalization out of prepaid group practice programs.

I want to turn now to the Government-financed program of medicare and medicaid. Generally in these programs you have a very broad range of benefits, broader than in most insurance plans. Prepaid group practice can play a very important role in furthering continuity of care by having the family physician take responsibility for coordinating the whole course of treatment of a patient. The physicians in the group act as a team both when the patient is ambulatory and when he is hospitalized. He does not go from one clinic to another, from one physician to another.

A critical component of prepaid group practice is its concern with preventive health services. Also, it goes beyond traditional medical care by utilizing social services and health education. These benefits apply in HIP to the 115,000 people enrolled under medicare and medicaid just as they do to the 645,000 other enrollees in the plan.

Another characteristic of the group practice prepayment plans is that you do not have additional bills; the premium paid by the Government and by the member of the plan in the case of medicare actually covers the cost and there are no large out-of-pocket payments to be made.

We have a formula for controlling costs and providing quality care but help is needed. Just as after World War II the grave deficiencies of the hospital system brought about massive Federal help through the Hill-Burton Act for the construction and development and repair and upgrading of hospitals, if we really want to get our money's worth for the vast government and private expenditures in health care, it is now time to turn our attention to more limited but equally important subsidies to get a better organization of medical services.

We have done pretty well in providing reasonably adequate hospitals for the population of the United States but we have seriously neglected the 85 percent of health care—for the aged 75 percent of health care—that does not take place in the hospital. It takes place in the doctors' offices or in clinics. Subsidies similar to those under Hill-Burton are now required in more modest measure to develop more of these group practice prepayment plans which I am convinced have already demonstrated their value.

We have a limited provision now in HUD for the guarantee of mortgage loans for medical centers. This is for 90 percent of the cost of a medical center. But the center may not be in a hospital—the ideal location for such a facility—it has to be free standing. There are so many limitations around this that I think in the 6 or so months that it has been operating it has been applied to only one such center. Federal grants and loans and loan guarantees are needed to help spread prepaid group practice. A program like HIP, which now serves three-quarters of a million people, requires further development for which outside resources are essential.

Also, there is considerable knowledge within HIP and other prepayment group practice plans (the largest being Kaiser-Permanente, which serves one and a half million people) that needs to become accessible to others. We have been asked to help develop a group

practice prepayment plan in cooperation with some labor unions and health officials in Providence. We tried to get staff to do this but what we really need to do is develop an educational system in existing plans to train people to spread this kind of more efficient and effective medical care in other areas. Key expenditures are needed to get such a program started.

In the past, labor unions, foundations, and industries like the Kaiser industry on the west coast have put up the kickoff money to start group practice. However, if we don't make new sizable expenditures to spread and develop these plans, I think we will be coming back here for another hearing in 10 years and deploring the rapid increase of cost and the inefficiency of medical care. The ability to do something significant to change the picture is within our grasp. My suggestion is that we turn our attention to precise Federal subsidies administered by people who know the group practice prepayment field to help spread this kind of program around the country.

Thank you, Senator.

Senator SMATHERS. Thank you very much.

(The prepared statement of Mr. Brindle follows:)

PREPARED STATEMENT BY JAMES BRINDLE, PRESIDENT, HEALTH INSURANCE PLAN OF GREATER NEW YORK

My name is James Brindle. I am President of the Health Insurance Plan of Greater New York (HIP). I am grateful for the opportunity to testify before your committee and to bring to your attention some of the problems of those involved in group practice prepayment. It is also gratifying that the committee comes to an area in which the problems of protecting the health of the people are most difficult and complex.

The Health Insurance Plan of Greater New York is a prepaid group practice plan that has been providing comprehensive medical care since 1947. It is incorporated by the State of New York as a nonprofit organization and has as its goal delivering high-quality care through physicians functioning as a team in well-equipped medical centers. The policy-making body of the Plan is the Board of Directors whose members come from civic groups, trade unions, universities, financial institutions, and government.

HIP enrollees are entitled to receive comprehensive medical care from physicians associated with 31 medical groups distributed throughout New York City and Nassau County. Coverage includes preventive and diagnostic medical services as well as therapy for specific illness, from family physicians and specialists, in the office, home, and hospital. When unusual medical skills are required, such as in cobalt therapy or heart surgery, patients are referred to highly specialized facilities in the area for diagnosis and therapy. These are the basic benefits available to HIP members at no cost beyond the premium [1]—i.e., there are no deductibles or coinsurance payments for such services. On payment of a supplemental premium, members receive additional benefits that cover a major part of the bills for anesthesia, special duty nursing, prescribed drugs. All HIP members are covered for Blue Cross hospital benefits or some similar hospital insurance.

Medical groups are affiliated with HIP through contracts which specify subscriber benefits and payments to the groups, and provide for adherence to professional standards. Thirty of the 31 groups are partnerships; one is hospital based and its physicians are salaried. HIP's payments to medical groups consist of a monthly capitation fee that is the same for all groups; differential payments determined by the extent to which the group is meeting program objectives set by HIP; and bonus payments to increase the likelihood of recruiting well-trained physicians on a full-time basis.

At present 760,000 persons are enrolled in the Plan. Practically all of these members had the opportunity to make a choice between HIP and other health insurance plans. About half of the Plan's members are employees of the City

[1] Except for a $2 fee which may be charged for home calls requested and made between 10 p.m. and 7 a.m.

of New York and related agencies. Other sources of enrollment are health and welfare funds of trade unions and management in non-government industries and the employees of State and Federal agencies. About 115,000 of HIP's members are enrolled through Medicaid or are Medicare Part B beneficiaries. The composition of this group on August 31, 1967, follows:

Medicaid enrollment	68,132
Under 65 years of age	47,129
65 years of age or older, living at home (almost all on Medicare)	17,341
Patients in nursing homes (mostly persons over 65 years of age and on Medicare)	3,662
Medicare enrollment	46,827

There are two points of special interest to this committee about the Medicaid and Medicare enrollees. First, they are eligible for the same range of basic benefits as all other enrollees in the Plan and the medical groups make no distinction between them and the other subscribers in rendering services; the sole consideration is the need for preventive and therapeutic medical care. Second, consistent with the general policy of HIP to provide benefits without financial barriers on a service basis rather than on an indemnity or fee-for-service basis, there are no deductibles or coinsurance out-of-pocket payments to be met by the HIP members. Costs are met through capitation payments by governmental agencies for the Medicaid enrollees. In the case of Medicare beneficiaries not receiving Medicaid, a capitation payment is made by the Social Security Administration which meets the cost of covered services less the average value of the deductible and 20 per cent coinsurance under Part B. Costs for uncovered services, which include important immunizations, eye refractions, and general physical examinations, and for the deductible and coinsurance are met through the payment of an additional premium of $1.50 per month.[1] This additional payment is made directly by the beneficiary or by a health and welfare fund on his behalf. By payment of an additional monthly premium of $1.94, the Medicare HIP member is also entitled to supplementary coverage under the most common Blue Cross contract.

This then is a brief description of the membership and scope of benefits of HIP. I now want to deal in somewhat greater detail with several aspects of the program which are relevant to this hearing.

The decision in the early 1940's to organize HIP on a group practice basis with fully prepaid basic benefits was reached after careful deliberation. It was predicated on the principle, visionary at the time, that medical knowledge and technology would soon become so complex that the ability to provide high-quality care at a reasonable cost would be greatly enhanced by having physicians practice as a team in well-equipped facilities.

What does the record show? Increasingly leaders in industry, medicine, and government have reached the same conclusion as the originators of HIP. In his recent volume, "The Doctor Shortage," Rashi Fein of the Brookings Institution examined approaches to increase output of medical care services, to improve the quality of care, and to control costs. His conclusion was that the advantages in favor of group practice were so compelling that its development should be fostered on a broad scale.

Experience in HIP provides strong support for this assessment. Most of the examples do not relate specifically to the aging population. However, any measure that has an impact on the economics or quality of medical care in general is, of course, important for those in the more advanced age groups.

No "Runaway" on Physician Services

Contrary to the forecasts of runaway utilization when costs are fully prepaid, the use of physician services in HIP has been at about the same rate (approximately 5 physician visits per person per year) as is reported for the general population. It is clear that removing the economic deterrent to receiving medical

[1] This supplemental premium is applicable for Medicare beneficiaries who were previously enrolled in HIP under a group contract; the premium is $3 per month for beneficiaries joining HIP as individuals after age 65.

care has not resulted in abnormal use of services. In fact, hospital utilization is substantially lower in HIP than in the fee-for-service medical insurance in this area. This finding was reported earlier based on experience during the late 1950's. The largest and most comprehensive of the studies conducted on the issue compared City employees and their dependents enrolled in HIP-Blue Cross with other large employment groups of persons covered by Blue Shield-Blue Cross. The hospital admission rate in the study year (1955) for HIP subscribers was 81.1 per 1,000 and for those covered by Blue Shield was 93.0 per 1,000. (These rates are adjusted for differences in age-sex composition.)

More recent data for City employees and their dependents enrolled in HIP indicate that there has been almost no change in the hospital admission rate since 1955; in 1962 it was 78.1 per 1,000 and in 1964 it was 84.0.[1] On the other hand, hospital rates in the general community have slowly increased over the ten years, 1955–1964.

Lower hospital utilization is not unique to HIP. In the Federal Employee Health Benefits Program, wherever prepaid group practice exists, members of the group practice plan have far lower hospital utilization than Federal employees and their dependents in other plans. The margin varies from about 35 per cent to 45 per cent. In our opinion, the savings in costly hospital days result principally from the availability of medical group centers with diagnostic facilities, capitation reimbursement of the medical group in contrast to the situation outside of group practice where the physician's fee is directly linked to the service rendered, and the use of highly qualified specialists.

Two other studies will be cited. In 1951, four to five years after the start of service, HIP became part of a comprehensive study which compared morbidity levels, disability due to illness, and medical care practices in HIP and in the city at large. It was found that a larger proportion of the HIP membership saw a physician during the year; they were more likely to receive preventive health services; more of them had family doctors, pediatric care for their children, and dental attention, than did the general population. Also, HIP members appeared to have a lower threshold for recognizing acute illnesses and they tended to seek medical care earlier in the course of illness than was the case in New York City as a whole.

In September 1962, the Department of Welfare enrolled about 13,000 recipients of public assistance in seven of the medical groups affiliated with HIP in the largest of its experimental efforts to bring Welfare clients into the mainstream of medical care rather than to isolate them in special programs and clinics designed to serve only the poor. Twelve thousand of the new enrollees were receiving Old Age Assistance (OAA) and living in their own homes. They represented about 38 per cent of the OAA caseload in the city at the time. The other new enrollees were patients in proprietary nursing homes and made up about 30 per cent of the Welfare clients in such homes.

Comparisons were made of the medical and hospital care experience of a sample of Old Age Assistance recipients in HIP and those not so enrolled; similarly for nursing home patients (Exhibit). Physician visit rates were almost identical among those in HIP and the non-HIP group; hospital utilization rates were consistent with the differences found before the demonstration program started. However, the proportion of those in HIP who received *no* ambulatory care went down whereas the corresponding proportion in the non-HIP group remained unchanged. There was a major change in where the HIP patient saw the physician, the shift being from high dependence on home visits to the receipt of most out-patient care in the medical group center. This change was partly due to special measures taken to increase the possibility that the OAA's, like all other members, would obtain their medical care at the group centers where laboratory tests, X-rays, and immunizations could be carried out.

Another observation was that the kind of patients who tended to be lower utilizers were likely to get more service when they were enrolled in HIP than they did otherwise. For instance, Puerto Ricans, a relatively low utilizing group, saw doctors more often if they were enrolled in HIP than if they were not. Finally, during the study year, the death rates among the OAA recipients in HIP and those not in HIP were about the same; in the next year and a half mortality aming the HIP group was lower than among the others: 11.7 per 100 as compared with 13.3 per 100—a difference of 13.7 per cent.

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[1] The rate for 1964 includes the experience among persons who died during the year; earlier data do not. Inclusion of deaths accounts for the difference between the 1962 and 1964 rates.

Nursing Home Patients

With regard to nursing home patients, the rates of physician and hospital use were very similar for HIP and non-HIP patients. Hidden in this similarity of rates were significant changes in type of care received. Welfare officials visiting nursing homes indicated that the shift to HIP resulted in substantial improvements in the quality of medical attention. This was reflected in part by the greatly expanded use made of laboratory services. Welfare officials also pointed out that a more rational use was being made of drugs. In the nursing homes under HIP care, the cost for drugs averaged $17.80 per patient in the study year; the corresponding figure for other nursing home patients was $23.18.

We are no longer engaged in a demonstration program. Medicaid is here and all of those enrolled can select as their source of medical care physicians in the community at large willing to accept them as patients, out-patient clinics in hospitals, or HIP. Medicaid members of HIP are covered for both out-of-hospital and in-hospital medical care from the Plan's physicians. In the demonstration program, Welfare regulations required that hospital admissions of Welfare clients be made to general service ward accommodations and HIP physicians could not continue to assume responsibility for the Welfare patient's care when he went into the hospital. Medicaid has changed this, thereby eliminating the critical break in continuity of care that previously existed.

HIP continues to be intensely interested in determining the impact that its system has on utilization, mortality, and disability rates of both Medicaid and Medicare enrollees. When more time has elapsed, ways will be found to examine this issue further.

The public normally thinks of medical care in terms of physicians and hospitals ready to provide services when illness strikes and by and large this is the content of medical care in the community at large. Prepaid group practice, typically, is concerned with a program of care that enlarges on this concept. It is concerned with the totality of health care—not just the treatment of illness. For example, HIP emphasizes preventive health services. As an aid to the physician, it distributes a quarterly bulletin to subscribers and assists the medical groups in organizing and programming health education meetings for the members. When the Welfare demonstration project was started, and later under Medicaid, special brochures were prepared by the Plan and distributed to the new members to familiarize them with the benefits and how to obtain them. Long before Medicare, the program included educational meetings in the medical group centers on physical and emotional problems of the aging. These have been intensified (Exhibit).

In addition to health education, the Plan through a highly qualified staff of social workers provides consultation services to physicians and administrative personnel of the groups in dealing with patient problems requiring community resources. A nutritionist staff is also available for consultation and aids the physicians in regulating diets for diabetics, hypertensives, the obese, and many other groups of patients requiring a special diet regimen.

Opportunities for testing the practicality or value of innovations in medical practice and benefits exist in group practice in a way that cannot readily be duplicated in fee-for-service solo practice. HIP and other group practice plans are exploiting these opportunities in a number of critical areas with great potential benefit to the aging. Glaucoma detection is an important preventive health measure but its incorporation into medical practice has been difficult principally because of the shortage of ophthalmologists. Several years ago HIP initiated a program through which well-trained nonmedical personnel could be used to perform tonometry and thereby locate patients for whom more definitive tests should be performed by the ophthalmologist (Exhibit). A significant aspect of this effort is the training and use of nonphysicians to perform tasks usually carried out by physicians. There is almost universal agreement that an expansion of this approach on a selective basis to other branches of medicine is essential to conserve physician manpower.

Screening Research Underway

HIP is currently engaged in a highly complex research project which has as its end goal determining whether periodic screening for breast cancer by means of clinical examination of the breast and mammography (a relatively new soft tissue x-ray procedure) will result in a reduction in mortality from breast cancer.

About 6 per cent of the women during their lifetime develop breast cancer and half die within five years of cancer detection. The tragedy of this condition is that despite the attention given to it, there has been no reduction in the rate of mortality from breast cancer in over thirty years. The hope is that early detection through screening will change this picture. HIP was selected by the National Cancer Institute for the project because of the Plan's long record of successful research, its access to patients, and the ability to provide follow-up medical care at no additional cost to the patient. Preliminary findings are encouraging; between 65 and 70 per cent of the breast cancers in the screened group of women are detected in a localized stage as compared with 47 per cent in a comparable group not screened.

An example of breaking new ground in providing services is found in a demonstration program HIP is conducting to determine costs, personnel, and organization needed to provide mental health services. Fears about high costs have delayed the inclusion of psychiatric treatment as a benefit in health insurance plans. When such services are covered, they are usually accompanied by large deductibles or coinsurance. HIP's demonstration project, supported by a grant from the New York Foundation and the Public Health Service, has as its objective establishing a mental health service which is fully prepaid. Currently the psychiatric benefit in HIP is limited to consultation. For demonstration purposes this benefit was expanded in the largest of the Plan's medical groups to include treatment from phychiatrists, psychiatric social workers, and clinical psychologists. Information from the project is now being used to plan three regional mental health centers where psychotherapy will be available for HIP members as a prepaid benefit. It is expected that the broadened program will start in mid-1968 with about 200,000 persons, including those on Medicare and Medicaid, enrolled for this benefit.

Under active consideration in HIP is an automated multiphasic screening program. The pioneering experience at Kaiser-Permanente, the largest prepaid group practice plan in the country, has encouraged us to consider ways in which multiphasic screening can be incorporated in our Plan. There seems to be little question about the ability to detect disease early through this type of screening program at far less unit cost than is ordinarily the case. We are impressed by the need to establish a close link between the screening center and the physicians responsible for follow-up care. It is often worse than useless to uncover a condition if such a link does not exist. Automated multiphasic screening in prepaid group practice is an integral part of a single system of medical care, and problems of follow-up are far less serious in this system than outside. It is also clear that the maximum value of screening lies in reaching the population long before they are old enough to receive Medicare benefits. The objective of early detection is either to reverse the disease or place it under control soon enough to delay serious consequences. While disabling illness cannot be postponed indefinitely, it is hoped that early detection of disease will permit the individual to lead a more productive life over many more years than at present.

In summary, group practice in HIP has led to:

(1) Changes in the pattern of using medical services, with greater emphasis on care early in illness.

(2) A broadened concept of the responsibilities in the field of prepaid medical care to include health education, social services, and nutritionist consultation.

(3) Moderate levels of utilization of services accompanied by demonstrated savings in costs for hospital care.

(4) Innovations in health benefit coverage; the latest benefit to be offered shortly is comprehensive mental health services.

(5) Demonstration of the use of nonphysician personnel as in glaucoma screening and research in the value of new screening procedures as in breast cancer screening which utilizes mammography (soft tissue x-ray).

(6) Availability of high-quality, comprehensive medical care from medical groups on a fully prepaid basis to all segments of society including Medicare beneficiaries and Medicaid enrollees.

The emphasis in this presentation has been on HIP experience. However, to a considerable extent this is paralleled by the performance of other prepaid group practice plans. There seems to be little question but that a major part of the solution to the shortage of medical manpower, control of utilization and costs, and the problem of rapidly implementing new advances in medical knowledge depends

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on the spread of group practice. This will, however, be a slow process unless the Federal government acts to assist and stimulate the growth of group practice prepayment plans. Direct loans and grants are needed to meet developmental and start-up costs for new programs and to construct and improve facilities in existing programs.

(The chairman addressed the following questions to Mr. Brindle in a letter written after the hearings:)

1. Mr. Haughton, Deputy Administrator of the New York City Health Services Administration, has informed the Subcommittee that many OAA recipients served by H.I.P. expressed some reluctance to leave the municipal clinics, which were so familiar to them. Did this attitude in any way cause serious problems?

2. You mentioned that Medicaid recipients now served by H.I.P. do not pay deductibles or coinsurance because a municipal agency pays such charges. May we have additional details and comments on the desirability of such arrangements?

3. Your comment about H.I.P.'s quarterly bulletin, and your emphasis on preventive health services reminds me of an amendment I have proposed for this year's Social Security legislation. It would instruct Secretary Gardner to conduct a study of the desirability of making health screening a Medicare benefit. May I have your reaction to this proposal.

4. I also believe it might be a good idea to have appropriate agencies authorize preparation of a health care manual that could be distributed to Medicare recipients at an appropriate time. Would such a publication be helpful, if carefully prepared, possibly with the help of leaders from the communication media? (Your experience in health education programs at HIP certainly should give us helpful insights.)

5. Your demonstration program relative to mental health services is of great interest to the Subcommittee. I hope you will keep us informed of your progress.

6. Your statement strongly suggests that Medicaid patients could be served effectively through group health practice on a per capita fee basis. I would like some additional comments on services provided through HIP, as compared to services provided to others eligible in New York City for Medicaid, but not served by HIP. I would also like your views on whether similar programs could be established elsewhere. As I understand it, there are relatively few group practice plans in the nation. Can we expect growth of such plans at a rate that will have significance for Medicaid recipients, even with the kind of Federal help you suggested in your testimony?

7. Mr. Oriol has informed me that you participated in the proceedings of the final day of the National Conference on Group Practice at the University of Chicago on October 20 and 21. Perhaps that conference has suggested additional points that you may wish to make to this Subcommittee. If so we would be happy to receive them.

(The following reply was received:)

(1) I believe Dr. Haughton was referring primarily to OAA recipients who were receiving medical care from highly specialized out-patient clinics in municipal and voluntary hospitals. Arrangements were made for these recipients, on request, to remain with the clinics rather than transfer to HIP. The number involved was quite small, about 100 out of the 12,000 ambulatory OAA's in the program. With regard to the others, there was evidence that confusion existed initially among the OAA's about their HIP benefits and where they were to receive medical care. Special efforts were made by HIP and the medical groups to clarify the situation. These included, in addition to health education material and invitations to visit the groups for evening meetings, a home visit to many new enrollees to explain the HIP system and urge that an appointment be made for a medical examination. We think these measures have paid off, but we recognize that the change from past, poor medical practices to a desirable pattern requires sustained effort.

(2) In this question, I assume you are referring to Medicaid recipients also eligible for Medicare, Part B. The arrangement being made with Social Security Administration is for HIP to be reimbursed by this agency for the per capita cost of services covered under Medicare, less the average value of the deductible and 20 per cent coinsurance. The Social Services Department of New York City

has agreed to pay HIP on a capitation basis for the uncovered services, deductible, and coinsurance. Accordingly, between these two agencies, the total cost of medical care made available or arranged for by HIP is being met. We have welcomed this arrangement, since it is consistent with our policy to serve the broadest possible range of social and economic groups in the New York area.

As indicated in my written statement at your Subcommittee's hearings in New York City on October 19, 1967, the non-indigent Medicare beneficiaries in HIP pay a small supplemental premium as payment for the Medicare-excluded services, the deductible, and coinsurance. The removal of deductibles and coinsurance for specific services has not resulted in unusual utilization either by the aged covered under Medicaid or by the non-indigent aged enrolled in HIP.

(3) I agree with your proposal to make general physical examinations a Medicare benefit. It is strange that Part B excludes not only such examinations and eye refractions but immunizations, which can be life-saving, as for example in an influenza epidemic. The concern about unnecessary utilization that may have prompted such exclusions should be dealt with through controls rather than by eliminating payment for these medically important services. It must also be recognized that "health screening," to be of maximum value, should be initiated before a person becomes aged and should be conducted under conditions that assure continuity between findings and followup by the patient's personal physician. I hope that Federal legislation on health examinations will not stop with Medicare, Part B, but will deal with these broader requirements.

(4) The type of publication mentioned would be very useful and we, at HIP, would be happy to cooperate in its preparation. There are many difficulties in developing suitable educational material for the Medicare beneficiaries and the activity would have to provide for a careful statement of what the desired goals of the manual are, field studies to test material, and evaluation of its effectiveness.

(5) We will be glad to keep you informed about our progress in the field of mental health services.

(6) The Medicaid program in New York City and the participation of HIP are still comparatively new events. No factual information of a comparative nature is available as yet. However, from past experience, we would expect on the basis of the Welfare Demonstration Project that, over time, our Medicaid enrollees would develop a utilization pattern in which more preventive health services were obtained than elsewhere, a higher proportion of the enrollees saw a physician during the year, very low utilizers of medical service increased their utilization, and greater use was made of highly qualified physicians. We would expect these changes to occur without a burdensome increase in overall physician utilization and at a per unit cost less than in the general community.

Prepaid group practice programs could be established elsewhere, and soon. There is abundant evidence that with the Federal assistance I mentioned in testimony, such programs would grow at an unprecedented rate. Medicaid would be affected, since an underlying principle of prepaid group practice plans is to serve the community, and Medicaid recipients are part of the community.

(7) A National Conference on Group Practice called by the Secretary of Health, Education, and Welfare was held at the University of Chicago on October 20 and 21, 1967. The objective of the conference was to find ways by which the group practice of medicine and prepaid group practice could be encouraged through action at the Federal level. A very broad range of occupations and interests was represented at the meeting. There were top leaders from the field of nonprofit prepayment (Blue Cross, Blue Shield, and the group practice prepayment plans); there were top executives from insurance companies, leaders of organized medicine, educators, economists, businessmen, and labor leaders. It is anticipated that a number of very specific recommendations will be made by this conference which will be helpful in developing a more modern medical care system under which the rapid escalation of costs can be contained or arrested.

Here are some of the recommendations offered at the conference:

(a) Medical schools should be encouraged to develop group practice treatment centers so that the new physicians will get some experience in this type of organization.

(b) Because there is trouble in licensing or chartering group practice and group practice prepayment agencies, there should be Federal legislation for the licensing or chartering of such agencies.

(c) Hill-Burton grants should be denied to hospitals which discriminate against physicians who are in group practice or group practice prepayment plans.

(d) Insurance companies should seek to help develop and invest in group practice plans and enter into joint marketing arrangements for such coverage.

(e) There should be choice of fee-for-service open panel plans and group practice plans under existing health insurance coverages.

(f) Title XVIII and Title XIX money for Medicare and Medicaid should be denied to States which refuse to make suitable arrangements with group practice plans for coverage under these Federal programs.

(g) There should be Federal subsidies for training programs to be developed in suitable medical schools and schools of public health and in existing prepayment group practice programs.

(h) Federal monies should be made available for expanding existing group practice and group practice prepayment programs and for developing new programs of this kind. These funds should be in the form of grants, loans, and loan guarantees, especially for the creation of facilities and personnel and financing for initial planning and starting-up expenses in such programs.

Senator SMATHERS. I thank both of you gentlemen for the excellent suggestions to look into this in more detail.

Dr. Gitman, you may proceed.

STATEMENT OF LEO GITMAN, M.D., DIRECTOR, DEPARTMENT OF COMMUNITY HEALTH, THE BROOKDALE HOSPITAL CENTER, BROOKLYN, N.Y.

Dr. GITMAN. In my written testimony which is in the hands of the committee the following are some of the areas of concern which were discussed.

1. Requirements for provision of high-quality health care services for the elderly in a poverty, urban area, using the community of the Brookdale Hospital Center as a model.

I pointed out that high-quality health care resulted from the application of current knowledge and developing research findings to the safeguarding of the health of the population with minimal timelag. This implies a transmission mechanism originating in the store of existing knowledge and research activity, and ending in the man in the street. This mechanism consists of two segments—delivery of health knowledge to the physician and other health professionals, and delivery of health services to the population. Both segments require reorganization and upgrading. We have "disadvantaged" physicians as well as patients.

2. The development, scope, and objectives of the Brookdale multiphasic health screening program. Among the effects we anticipate this program to have on the organization of health services in our area are the following:

(*a*) The effectiveness and efficiency of the physician should be significantly increased by the data base provided by the computer processed patient summary. In practice, this should be equivalent to increasing the supply of available physicians.

(*b*) Since referral and followup of patients who have been screened is an integral part of a multiphasic health screening program, delivery of health services will, out of necessity, be strengthened.

(*c*) The information supplied in the multiphasic health screening patient summary should upgrade the quality of medical care in the community.

(*d*) The mechanism created for the registration, referral, and followup of people in the community should bring many of the "hard to reach" into the mainstream of health care.

3. I am not alone in my conviction that medicare and medicaid are milestones in the development of health care systems which, hopefully, will furnish what we all earnestly desire—the highest quality health care for all people.

Unfortunately, medical care for the elderly is still largely episodic, fragmented, discontinuous, and far from comprehensive.

Legislation has eased the financial burden of the elderly. But major changes are needed to create systems of delivery of health services which are responsive to individual needs and furnish high quality care. This, in turn, has two requirements:

(1) A radical shift of emphasis from consideration of the patient as an inert container in which reside one or more disease processes, to looking at him as a social being.

(2) Since the hospital is the primary provider of health care to the poor older person, it must reorganize its ambulatory care program. A basic requirement of good outpatient care is having a single physician assume the role of guardian of the patient's health. This arrangement will avoid the situation where several highly trained specialists concurrently treat specific diseases, but no one treats the patient as a person.

I would conclude with a plea for a reappraisal of our approach to the entire problem of health services for the elderly. This in no way underestimates or derogates the need for meeting the existing problems.

Every effort should be made to reduce the economic burden of the elderly, develop more efficient systems for delivery of health services, increase health manpower, reevalate the role of the physician, nurse, social worker, and other health professionals, and improve the quality of health care. But all we can hope for is a holding action until we can make a significant impact on the incidence and morbidity of chronic disease.

The health needs of the elderly, far outstripping our current health resources, are increasing at such a rapid rate that we, very likely, will never catch up.

The enormous unmet health needs of the elderly derive not primarily from the fact that he is aging, but is an expression of the disabilities produced by chronic illness. Logically we should, therefore, address ourselves to the problem of chronic disease prevention.

The early detection of disease, before the individual presents symptoms, offers the most promising preventive aproach. It is for this reason that we at the Brookdale Hospital Center are developing a multiphasic health screening program. We strongly urge increased support of demonstration programs of this type.

We are fortunate in that two agencies in the U.S. Public Health Service have concerned themselves with multiphasic screening. The National Center for Chronic Disease Control is funding development of instrumentation and systems, and the Adult Health Protection and Aging Branch is supporting demonstration programs. A significant expansion of their currently modest programs would provide an ade-

quate base for a logical, basic approach to the problem of high-quality health care services for the elderly—the prevention of chronic illness.

We can ill afford the luxury of indecision and delay. It is imperative that we intensify the study of preventive health systems now.

Thank you.

(Dr. Gitman's complete statement follows:)

PREPARED STATEMENT OF LEO GITMAN, M.D., DIRECTOR, DEPARTMENT OF COMMUNITY HEALTH MULTIPHASIC HEALTH SCREENING PROGRAM, THE BROOKDALE HOSPITAL CENTER, BROOKLYN, NEW YORK

The subject of inquiry is, "Costs and Delivery of Health Services to Older Americans". Having no special competence in the economics of medical care, I will confine my remarks to the delivery of health services.

May I begin with a caution. Too many discussions of health care services are characterized by John Galbraith's "wordfact" which he defines as follows:

"The wordfact makes words a precise substitution for reality. This is an enormous convenience. It means that to say something exists is a substitute for its existence, and to say that something will happen is as good as having it happen. The saving in energy is nearly total."

A closely related species is the "wordglow". In this case, the use of words as slogans with little attempt at precision, provides the user with a glow of satisfaction. After sufficient repetition, this replaces the need for accomplishment.

A good example, perhaps, is the use of the phrase "high quality health care". No reasonable member of society would deny the desirability of high quality health care. But what is it exactly, that is found so desirable? A valid definition is crucial, because without it we cannot define our goals. I would propose a simple definition. High quality health care results from the application of current knowledge and developing research findings to safeguarding the health of the population with minimal lag time.

A crude systems analysis indicates the existence of a transmission mechanism originating in the store of existing knowledge and research activity, and ending in the man in the street. Closer scrutiny reveals two subsystems; delivery of medical knowledge to the physician and other health professionals, and delivery of health services to the population.

I submit that these subsystems must be considered jointly for it would be senseless to develop an effective mechanism for dispensing second-rate health care.

Let us first consider the lag between existing and developing knowledge and the physician. This essentially relates to continuing education. The American Medical Association, county medical societies, medical schools, chapters of the American Academy for General Practice, have, for many years, provided post-graduate courses, many of excellent quality. There is, however, serious doubt that the "one-shot" course of instruction is an effective means of improving the physician's management of patients. I firmly believe that there must be an on-going daily involvement in learning in a fostering environment. First-rate hospitals, community or university, are most likely to offer this setting.

In many instances, the general practitioner may be considered the "disadvantaged" physician. He is busy, harassed, and with little time to keep abreast with the medical literature. He must cover a wide spectrum of medical subjects, in contrast to the narrow specialization of other physicians. To make matters worse, the generation of new medical knowledge proceeds at a bewildering rate. In addition, in too many instances, he is not a member of the staff of a first-rate hospital. It is here that the new knowledge becomes part of the daily experience, where he can absorb it efficiently and effectively. He strives against tremendous odds, and finally, like other disadvantaged members of society, he throws his hands up in frustration.

SPECIAL PROBLEM IN GERIATRICS

In the case of geriatrics—the medical care of the elderly—special problems exist. The medical profession, with some exceptions, often disregards the special body of medical knowledge relating to aging. This holds true for the medical education programs of hospitals, where the post-graduate training of medical

students and the continuing education of practicing physicians takes place. There is also a lack of appreciation of the physician's role in the social system created by the doctor-patient relationship, especially when the patient is aged.

Several years ago, I studied the effectiveness of a Geriatric Coordinator in a hospital setting in remedying this situation.

A well trained physician with experience in health care for the aged, in its broadest aspects, was designated Geriatric Coordinator. His function was to stimulate consideration of age-related factors in staff conferences, bedside and informal discussions which constitute the learning experience of hospital work.

The findings of this study were as follows:

1. The level of knowledge of the physicians studied about the unique problems of and resources for dealing with the health of the aged, was low.
2. Specialized conferences and seminars on aging, per se, were not an effective means for fostering interest and increasing knowledge in this field. If aging is considered a stage in the continuum of human development, it is logical to strive for an awareness of its impact being incorporated into the warp and woof of the daily professional activity of the hospital.
3. Analysis of the clinical presentations and discussions at the departmental conferences revealed the importance of the role of the Geriatric Coordinator. Initially, many case discussions failed to take into account age-related aspects where these considerations were pertinent. When this was discussed with the Directors of Service, the performance improved considerably. Performance tended to deteriorate until jogged by further pressures by the Coordinator. It was apparent that an on-going effort was required to prevent retrogression.

At the conclusion of this study, we found a significant increase in the awareness of health resources for the aged by the physicians; an increased acceptance of the legitimacy of special concern with the health problems of the aged and of directing services to them; a milieu in which this greater concern and awareness was more acceptable.

With these considerations in mind, the following recommendations for upgrading the delivery of health knowledge to the physician are offered:

1. All general practitioners in a hospital's community become members of the staff of a hospital. It is the hospital's obligation to aid in accomplishing this. This applies to community, university, and government hospitals. This appointment should not be a superficial one. The general practitioner must be intimately involved in the daily activity of the hospital and his responsibilities should be commensurate with his training and skill as in the case of other hospital staff members.
2. A coordinator for Geriatrics be appointed to hospital staffs to work with the Director of Medical Education to stimulate and incorporate the teaching of age-related biomedical changes in patients. An important part of the program should focus on the psycho-social role of the physician in his relationship to the patient.
3. Training courses for Geriatric Coordinators should be organized.
4. Since the Director of Medical Education in hospitals is a key figure in planning and orientation, an educational effort to convince him of the need for instructional activity in the field of aging is necessary.

These recommendations can be implemented in the near future. They do not require expenditure of large sums of money. They do not require radical innovations in the current practice of medicine. What is required is the hospital's acceptance of its responsibility and the practitioner's willingness to expend the necessary effort to meet his obligations to continuing education and hospital activity.

In our consideration of the doctor-patient relationship, let us consider some of the psycho-social factors which act upon the physician. One of these is his own self-image, and as part of this, his self-esteem. The physician generally accepts the role of savior or helper which the patient assigns to him. He, therefore, bases his self-evaluation on his effectiveness in helping the patient. When the symptoms are numerous and vague, the history difficult to elicit, the number of diagnostic possibilities bewildering, and therapy ineffective, the physician's self-esteem is threatened. He becomes frustrated and disengages himself.

This disengagement or withdrawal may take many forms. One of these is loss of interest, resulting in haphazard, ineffective management. Another form of

withdrawal is symptomatic treatment. The physician no longer looks at his patient searchingly. A prescription is given for each symptom, resulting in a list of multiple, often confusing, medications.

Another form of disengagement is excessive referral to specialists. The old man presents such difficult and frustrating problems, that it is very easy to believe that he needs the services of a trained psychiatrist or other specialist.

Another possible consequence is—uncritical diagnostic evaluation—which becomes a form of withdrawal. The physician presented with an obvious diagnosis in an aged patient closes his mind, and additional important and perhaps curable disorders remain undetected.

Another danger is attributing abnormal test results or lack of therapeutic response, in some vague way, to the advanced age of the patient. If his liver function tests are abnormal, or if the medication prescribed doesn't help the patient, the physician doesn't re-examine his approaches and techniques.

Gaps in Service Delivery

Now, let us turn our attention to the gap in the transmission line between physician and patients, i.e. delivery of health services.

Here, the significant variables are the amount and nature of health care resources available in a community, and the characteristics of the population to be serviced.

For the past several years, I have been Director of the Department of Community Health of The Brookdale Hospital Center. I will use my experience in that setting as a basis for discussion.

With regard to health care resources of our community, I present some pertinent data in Table I.

We have compared the four least deprived health areas in our hospital community with the four most deprived. The population per physician in the former is 1,142, and in the latter 6,325. This is almost a six-fold difference! The age distribution of the physician is also significant. Eighty-four percent of the physicians practicing in the most deprived areas are over age 50, whereas 58% are over age 50 in the least deprived areas.

In two of the four most deprived health areas with a population of 43,000, there is a total of two physicians, one in the 66 to 70 and one in the 71 to 75 years age bracket.

The dearth of practicing physicians in the ghetto area is painfully apparent. One may question the significance of these findings with the statement that these areas are not isolated, so that people could reach health resources by public transportation. This belief disregards the fact that the elderly in this kind of community are often doubly afflicted—they are poor and they are chronically ill.

In view of the lack of physicians in the area, it is the responsibility of the Hospital to cooperate with the City and other agencies in efforts to provide adequate medical services.

The total population of the Hospital community is approximately 500,000. It is obviously impossible to service this number directly by The Brookdale Hospital Center. Several years ago, we proposed a regionalization of health care services in our Hospital area. According to this plan, The Brookdale Hospital Center would be the back-up resource for the Department of Health District Health Clinics and neighborhood health centers which would be strategically sited in the community to provide complete coverage for the area in cooperation with existing resources. This concept coincides with the current master plan of the Health Services Administration and Department of Health of New York City, with whom we are working closely in establishing this network in our core area.

This regionalization should ease the problem of travel distance to health service resources and since the satelite units will be situated in the community, the sociological separation between provider and user of health services will also be narrowed. Although this applies to all age groups, it is of special importance to the aged.

Up to this point, I have discussed the delivery of medical knowledge to the physician and the facilities program for the delivery of health services.

What *kind* of health services are needed? Two years ago, we critically reviewed our Out-patient Service practices, with special emphasis on the elderly patient.

Some of the pertinent findings with regard to patients, age 65 and older, are

presented in Table II. It was found that one out of seven patients had attended the Out-patient Service for five or more years; more than half were admitted as patients, and an equal proportion utilized the Emergency Room. One out of three utilized all three facilities—Out-patient Service, Emergency Room, and In-patient Services—of the Hospital. These data appear to indicate that the aged poor utilized the Hospital as their primary and chief source of medical care.

Another significant finding was that one out of four attended four or more separate specialty clinics in the Out-patient Service. This might, at first glance, appear to indicate good medical care since the patient is being seen by specialists. Unfortunately, this is not true. Concurrent attendance of numerous clinics usually indicated fragmented uncoordinated care. The patient's failing heart, arthritic joints, diabetes, and high blood pressure were being treated—but no one was concerned with the patient as a person.

On the basis of this study, we formulated an ambulatory care program, designed to provide a doctor-patient relationship. Hitherto, as in most Out-patient Services in this country, the patient reported to a room. The physician assigned to that room for that session was the patient's doctor for that visit. The next visit would be to the same room, but, very likely, the patient would be seen by another physician, unfamiliar with his condition, who would spend precious time trying to reconstruct the medical situation from a chart difficult to decipher.

At this point, I must note that the considerations and recommendations made above leave the basic problem untouched. Just as the building of more roads doesn't appear to catch up with the increasing number of motor vehicles in circulation, so will the construction of health care facilities and services be unable to adequately meet the problem of inadequate health care for the elderly. The needs of the elderly, far outstripping our current health resources, are increasing at such a rapid rate that we, very likely, will never catch up. These needs derive not primarily from aging, but are an expression of the disabilities produced by chronic illness.

Our concern should be with the "well" person with no significant health complaints. We should attempt to detect disease in its earliest stages, so that the subsequent course of the disease could be halted or altered to minimize chronic illness and disability. Only then, would it be possible to get ahead of the game.

Brookdale Multiphasic Screening Project

At The Brookdale Hospital Center we are developing a Multiphasic Health Screening Program designed to evaluate its effectiveness as a chronic illness preventive. This program is partially supported by the Adult Health Protection and Aging Branch, Bureau of Health Services, U.S. Public Health Service.

I would add, parenthetically, that the activity of this Branch and National Center for Chronic Disease Control, is making a significant contribution. NCCD's support of development of automatic disease detection equipment and systems, coupled with the Adult Health Protection and Aging Branch's support of programs which would utilize these techniques, serve as a potent stimulus to further development.

The Brookdale Multiphasic Health Screening Program is based on the use of automated testing equipment and the Hospital's fully automated laboratory and computer facility. It is designed to provide, with careful quality control, screening tests results in large numbers of apparently "healthy" adults, age 40 and over, in an efficient, effective manner.

The program is part of a health program aimed at detecting and treating disease in its earliest stages. In the present state of medical science, this concept offers the most promising approach to the prevention of chronic illness.

During the screening process, the participant passes through a number of test stations, including the following: medical history questionnaire; standard scalar electrocardiogram and vectorcardiogram (Frank), blood pressure, Papanicolaou smear for cervical cancer, height, weight, chest x-ray, visual acuity, tonometry, dental examination including exfoliative cytology and survey dental x-ray, audiometry, spirometry, retinal photography, and laboratory tests consisting of: RBC, WBC, hematocrit, mean corpuscular volume, hemoglobin and hemiglobin concentration, WBC differential count, urinalysis; blood chemistries: (1 hour post-glucose challenge), glucose, urea nitrogen, total protein, albumin/globulin, alkaline phosphatase, bilirubin, SGOT, LDH, calcium, phosphorus, uric acid,

cholesterol, sodium, potassium, chloride, CO_2 content, VDRL, blood grouping, and PBI.

The processing time is approximately 2½ hours.

The test results are processed by the Hospital's computer facility which prints out a complete summary for each participant. Rigorous precautions to maintain professional confidentiality will be taken. Since the Multiphasic Health Screening is only a part of a periodic health check-up, this summary is sent to the physician and the dentist of the participant's choice, who will then proceed in the traditional manner to examine, investigate further, and prescribe treatment, if indicated. The patient is advised that he will receive information regarding the results of his tests when he visits his physician and dentist. The Medical Society of the County of Kings and the Second District Dental Society are cooperating with us for referral of those persons who may not have their own doctor or dentist.

The screening process is primarily an alerting, rather than a diagnostic mechanism. Significant responses in the medical questionnaire and abnormal test results will indicate the areas requiring definitive diagnostic effort, e.g.: findings of anemia require the physician to establish the cause, with perhaps the questionnaire responses furnishing clues. The physician's role in the provision of medical care is, therefore, strengthened, not attenuated.

Hopefully, this Multiphasic Health Screening Program, coupled with the improved ambulatory care program, will have several important effects on the delivery of health care services in our community.

1. The effectiveness and efficiency of the physician should be significantly increased by the data base provided by the computer processed patient summary. In practice, this should be equivalent to increasing the supply of available physicians.
2. Since referral and follow-up of patients who have been screened is an integral part of a multiphasic health screening program, delivery of health services will, out of necessity, be strengthened.
3. The information supplied in the multiphasic health screening patient summary should upgrade the quality of medical care in the community.
4. The mechanism created for the registration, referral and follow-up of people in the community should bring many of the "hard-to-reach" into the mainstream of health care.

I am not alone in my conviction that Medicare constitutes a milestone of historic significance in the history of medical care in the United States. But this should not blind us to its inadequacies. The most glaring example is the law's almost total disregard for preventive medicine. This is of fundamental importance, for only by preventive medicine, can we hope, in the long run, to turn the tide of the effect of chronic disease in the aged.

A second matter of concern is that the law concerns itself with the payment of medical costs and pays little attention to the quality of the care this money is to purchase. That is to say—quality control. The funds made available by Medicare should not be used merely to pay for services previously rendered at reduced costs or gratis, without improving the quality of these services.

If the goal of Medicare and Medicaid is to improve the health service practices in this country, especially in urban areas, I must confess to serious doubts. Medical care for the elderly is still largely episodic, fragmented, discontinuous, and far from comprehensive. Legislation has eased the financial burden of the elderly. But major changes are required to create systems of delivery of health services which are responsive to individual needs and furnish high quality care. This, in turn, has two requirements:

1. A radical shift of emphasis from consideration of the patient as an inert container in which resides one or more disease processes, to look at him as a social being.
2. Since the hospital is the primary provider of health care to the poor older person, it must reorganize its ambulatory care program. A basic requirement of good out-patient care is having a single physician assume the role of guardian of the patient's health. This arrangement will avoid the situation where several highly trained specialists concurrently treat specific diseases, but no one treats the patient as a person.

I would strongly urge amendments to the Medicare legislation which would relate to these considerations.

I conclude with a plea for a logical, basic approach to the problem of high quality health care services for the elderly—the prevention of chronic illness.

TABLE I

Health areas	Population		Physicians			Population per M.D.
	Number over 40	Total	Number	Over age 50	Under age 50	
4 least deprived health areas	50,707	103,922	91	60	31	1,142
Percent				58		
4 most deprived health areas	24,459	82,220	13	11	2	6,325
Percent				84		

TABLE II. SURVEY OF OUT-PATIENT SERVICE ACTIVITY THE BROOKDALE HOSPITAL CENTER

SOME FACTS ON PATIENTS AGE 65 AND OLDER

1. Constitute approximately 20% of patients attending Out-patient Service.
2. Eighty percent of Out-patient Service population resides in Hospital core area.
3. Duration of Out-patient Service attendance: 5 years or more—13%.
4. Number of specialty clinics attended concurrently: 4 or more clinics—25%.
5. Number attending Emergency Room: 58%.
6. Number admitted to In-patient Service: 53%.
7. Number served by Out-patient Service, Emergency Room, and In-patient Service: 36%.

(The chairman addressed the following questions to Dr. Gitman in a letter written after the hearings:)

1. Your statement said that the multiphasic screening program at Brookdale would increase the effectiveness and efficiency of the physicians in your area. May we have details on the number of physicians in your service area and the number of individuals they serve, as well as your estimate of the amount of added service they could give when the screening program becomes operational?

2. Much was said at the hearing about the desirability on neighborhood health centers. What do you think would be the relationship of your screening program to such centers?

3. May we have additional details on the facilities to be employed in your screening program, the numbers of people to be served, and what special provisions you are making for the elderly?

(The following reply was received:)

1. Number of physicians and population they serve in the service area of The Brookdale Hospital Center:

The enclosed table presents this information according to health areas. The paucity of physicians is painfully apparent. It should be noted that the highest ratios of population per physician are found in poverty areas with the most severe degree of negative demographic characteristics.

Hopefully, Medicare and Medicaid reimbursements, the availability of multiphasic health screening data on patients, the involvement of The Brookdale Hospital Center in health planning and services in the community and providing sophisticated back-up resources, will attract physicians into the community. In the immediate future, however, our Hospital will have to fill the void.

A significant development is the approval, in principle, of the information of neighborhood family care centers in poverty areas by the Medical Society of the County of Kings.

2. Estimate of the added service physicians could give when multiphasic health screening becomes operational:

The delivery of health care depends upon the number of physicians and their individual effectiveness and efficiency. Effectiveness is an expression of the quality of care, i.e.: preventive, diagnostic, therapeutic, and rehabilitative; efficiency is related to the amount of work performed per unit time.

Multiphasic health screening should increase both effectiveness and efficiency. The computer printed patient summary provides the physician with an extensive data base generated by sophisticated automated accurate techniques. This information would otherwise not be available, especially to the

general practitioner. This information enhances the physician's capabilities for diagnosis and evaluation for medical management, i.e.: effectiveness. This improved quality of performance can be achieved with no increase in time spent with the patient, i.e.: efficiency. That is to say—a busy physician spending 15 minutes with the patient can be far more effective and efficient with the multiphasic health screening data base consisting of 300 medical history questions, 16 groups of tests, and over 50 specific measurements, than if he were to start from scratch.

3. Relationships of our screening program to neighborhood health centers:

As you know, we firmly support the concept of neighborhood health centers as extensions of the Hospital into the community for delivery of comprehensive health care. Since prevention is an integral part of high quality care, we have urged the incorporation of multitest screening facilities in each neighborhood center, with The Brookdale Hospital Center providing the automated laboratory and computer services.

The Department of Health, Health Services Administration of New York City, has agreed to incorporate a multitest health screening unit in a neighborhood health center to be built in our hospital service area. Since the centers in our area would be staffed by The Brookdale Hospital Center, the integration of patient records in the central hospital patient record file becomes feasible. Thus, preventive medicine would be integrated in a high quality health care program that had continuity, was accessible and acceptable, and would have the resources of The Brookdale Hospital Center to service it.

4. The number of people to be served by the screening program and special provisions made for the elderly:

The screening program will start with 10,000 to 15,000 the first year of operation, and beginning with the second year, 20,000 to 25,000 will be screened. By the third year, satellite multitest stations are expected to tie in with The Brookdale Hospital Center program for laboratory and computer services. Each of these, in turn, would serve 20,000 to 25,000 individuals per year. In the subsequent three to five years, we expect to have 10 satellites which will service 250 to 300 thousand persons annually.

Specific motivational programs for the elderly are planned. Transportation from senior citizen centers and housing developments will be arranged. The patient flow in the screening process allows for differences of rate of progression of individuals. Initially, this will be achieved by admitting patients into the process in platoons of four rather than single individuals at rigid intervals. After experience has been gained, we plan to change the computer appointment program to achieve a balanced proportion of younger and older patients in each platoon interval. This will provide even more leeway for elderly individuals. The volunteer and program staff will be trained to provide quiet assurance and helpfulness to minimize anxiety and possible depersonalization effect of the screening procedure.

DISTRIBUTION OF PRACTICING PHYSICIANS IN THE CORE SERVICE AREA OF THE BROOKDALE HOSPITAL CENTER CORE AREA

Health areas	Total number of M.D.'s	Total number of groups	Total population	Population per M.D.	Population per group
48:00	51	18	30,356	595	1,686
49:00	75	35	32,223	430	921
50:10	21	18	18,739	892	1,041
50:20	29	17	33,746	1,164	1,985
55:10	28	16	31,366	1,120	1,960
55:20	15	11	31,688	2,113	2,881
56:00	4	4	18,891	4,723	4,723
57:00	6	5	20,288	3,381	4,058
58:10	17	7	24,299	1,429	3,471
58:20	3	2	16,624	5,541	8,312
59:00	1	1	24,493	24,493	24,493
60:00	1	1	18,548	18,548	18,548
61:00	10	8	19,263	1,926	2,408
62:00	5	2	23,323	4,665	11,662
63:00	12	10	19,964	1,664	1,997
64:20	10	9	27,447	2,745	3,050
75:10	8	7	17,901	2,238	2,557
75:20	28	21	43,280	1,546	2,061
Total (18)	324	192	452,439	1,396	2,356

Senator SMATHERS. Now, ladies and gentlemen, before I adjourn this hearing I wanted to take the opportunity once again to thank Miss Landau and Dr. Wise and all the people and the staff of this William Hodson Community Center. We have had a most hospitable welcome here today and you were cooperative in every way possible.

I furthermore want to thank my staff and the staff of the Committee on Aging of the United States Senate and compliment Bill Oriol who is the staff director for the fine constructive work which he has done in getting all the witnesses together and making it possible for us to have this exchange of views.

In that connection I want to thank Mr. John Guy Miller who is the minority council representing the Republican membership and has been with us today.

I want to compliment and thank Mr. Bill Norman, who is the counsel for the subcommittee and who is here with us today, and Pat Slinkard and her staff for all the fine work which has been done.

As has been said over and over again by all these witnesses, we have made giant strides forward but much, much more needs to be done. I am certain that as a result of the fine ideas which have been expressed to us today and the many suggestions which have been made that we will make substantial improvement. Certainly we can never stop working until the time has come when all elderly people have available to them, if they want it, the best that is possible for this Nation to provide in the form of good health care.

The meeting stands adjourned.

(Whereupon, at 5 p.m., the subcommittee adjourned.)

APPENDIXES

APPENDIX 1

ADDITIONAL INFORMATION OR EXHIBITS FROM WITNESSES

ITEM 1: FLOOR STATEMENT BY SENATOR ROBERT F. KENNEDY ON MEDICAID AMENDMENTS

Mr. President, I introduce, for appropriate reference, two amendments to H.R. 12080, the omnibus social security welfare bill now pending in the Senate Finance Committee.

These amendments relate to Title XIX—Medicaid. Their purpose is to lower the enormous costs of that beneficial program without injuring the millions of Americans who are deservedly aided by it. They will help to alleviate two of the most serious problems that have arisen with Medicaid, particularly in my State of New York.

The first contemplates variations in the income levels of eligibility within a State based on differences in shelter costs within a State. Studies have shown that shelter costs are the most significant variable in the cost of living as between urban and rural areas. The cost of rent and home purchase in rural areas is far less than in the cities. An income of $5,000 a year therefore buys far more in rural areas than it does in the city. As a result, there is no real need that eligibility levels for Medicaid be as high in the rural areas of New York State as they are in its large cities, and my amendment would require the States to take variations in shelter costs into account when they determine eligibility levels. I believe this is an important and constructive step forward, and would help us significantly in the State of New York.

This amendment would alleviate what has become a near-crisis situation in New York State. In some of our rural counties 75 to 80 percent of the population is eligible for Medicaid under the income eligibility levels which the State established. In these counties, welfare costs have skyrocketed over the past eighteen months. Increases of 50% and 60% in the cost of welfare are common, and 90% or more of the increases are due to the cost of Medicaid. One county executive wrote to me that welfare costs in his county are up almost 60%—over $8 million—in just one year. He pointed out that this will cause local taxes to double in short order, with the prospect ahead in the near future of a tax rate triple the current level. Many counties have been forced to borrow to meet the obligations which Medicaid has imposed.

It is no accident that the counties which have faced these difficulties are, by and large, counties where living costs, and particularly shelter costs, are lower than they are in some of the most heavily urban areas. The fact is consequently, that in these areas Medicaid is available to some who simply do not need it. Not surprisingly, these are the areas in which the greatest opposition to the program has been expressed. Under my amendment, the State would objectively determine differences in shelter costs around the State, and would accordingly establish differences in eligibility levels. The result would be decreases of as much as 20% in eligibility levels in some of the counties which are the hardest pressed at the present time. A further result would be that Medicaid would come closer to being a program which in fact serves only those who need it.

The second amendment would allow far more stringent regulation of the costs of hospital care and physician services than exists at the present time. Medical

costs have risen greatly in the past year and a half, and it is no accident that this has occurred since Medicare and Medicaid have been in effect. Many of these costs are unavoidable, of course, as nurses and other personnel finally begin to receive a living wage for their work. And the costs of materials and supplies have risen. But in some areas of our country, unfortunately, there are some physicians who and some institutions which have literally reaped bonanzas from these programs. A newspaper report recently, for example, indicated that in California 1200 physicians have received $83 million in the last eighteen months in reimbursement under Medi-Cal, that State's Title XIX program, an average of $70,000 for each physician.

In New York State, the physicians' fees paid under Medicaid have increased substantially over the past year. Fees for office visits to general practitioners and specialists have more than doubled. If these fees, as well as the reimbursement to hospitals and nursing homes, were regulated under my amendment, the fiscal pinch which many counties in New York have felt as a result of Medicaid would be substantially alleviated.

The amendment would operate as follows: for in-patient care, it would limit payments to hospitals and nursing homes to the amount paid for comparable services by either the Blue Cross Plan in the area or Title XVIII, whichever is less. At the same time, it would provide incentive payments for the efficient operation of hospitals and nursing homes based upon their demonstrated ability to develop new management procedures and discharge patients promptly. For out-patient care, the amendment directs that an out-patient visit be defined and that it must include seeing a physician, and it limits payments to a hospital for an out-patient visit to a ceiling of 18% of the per diem payment for in-patient care. For payments for the services of physicians and other professionals, the amendment directs that fee schedules shall be based upon the average level of fees charged in the county or metropolitan area over the ten years previous to the adoption of the plan. The amendment would allow the development of special reimbursement methods for group practice plans.

These are by no means the only problems which beset Medicaid. Medicaid was a program with great promise. Its purpose was to make medical care available to millions of Americans for whom routine medical attention was previously an unattainable luxury and catastrophic illness a bankrupting disaster. Yet in New York State, and here in Congress, it is apparent that public confidence in the program has been badly shaken. I believe that adoption of the two amendments I have proposed today would help to restore that shaken confidence, but I think other steps need to be taken as well. I therefore call on Governor Rockefeller to establish a blue-ribbon commission composed of medical experts, fiscal experts, government officials, consumers of the medical care which medicaid provides, and other relevant persons, to look into all of the issues which have been raised and to make recommendations for the future. The Commission could investigate all of the components of the cost of Medicaid—the extent to which the surprisingly high cost of the program is a result of abuse by individual physicians and other professionals and by inefficient hospitals and nursing homes which have had no incentive to reduce management and administrative costs, and the justification for the suddenly increased fee schedules for services of physicians and other professionals that are now in effect around the State. The Commission could look into the fiscal burdens on local government around the State, and recommend steps to ease those burdens. Governor Rockefeller has already stated that he will ask the Legislature to act to have the State take over some or all of the local share of the costs, and I support that proposal. The Commission could also look into the quality of care which is being provided under Medicaid around the State, and make recommendations for new laws and new procedures to assure that the quality of care is maintained at the highest level possible. The Commission, in summary, would determine just what the taxpayer's dollar is buying with Medicaid, and could take us a long way toward understanding what new forms of delivering health services must be developed and how we are going to develop them if the provision of health care to those of our citizens who need it is not going to bankrupt us.

Proposed Cutback in Medicaid

There is one other matter of importance at the Federal level. The House of Representatives imposed a limitation on Federal participation in programs under Title XIX which is wholly unreasonable and unworkable. It will be an unwar-

ranted intrusion in New York State, but it will be nothing short of disastrous elsewhere. The 150% ceiling which the Administration originally proposed earlier this year was based on each State's public assistance definition of minimum need. The 133% provision in the House bill is based on the amount which the State actually pays to its public assistance recipients, which in many cases is a vastly smaller amount than its definition of minimum need. The original intention of Title XIX was that medical indigency be defined at a level substantially in excess of a state's public assistance definition of minimum need. The House bill will in many states have the opposite effect, and is therefore totally unrealistic.

For example, Mississippi, according to HEW figures, was paying 22.8% of minimum need to its ADC children in January of this year. When the 133⅓% limitation in the House bill goes into effect, the ceiling for medical assistance in Mississippi will be approximately 30% of its own definition of minimum need. The State of Ohio is another good example. In January 1966 its definition of minimum need was $224 a month for a family of four. However, the ADC payments were actually $170 a month for a family of that size. When the 133⅓% limitation goes into effect, the ceiling on medical assistance for a family of four in Ohio will, therefore, be approximately $227 a month—an unacceptably low figure.

What is really involved even in the 150% limitation originally proposed is a failure of insight about the connection between ill-health and dependency, a failure to realize that the provision of adequate health care to the poor depends upon an infusion of funds of the magnitude which Title XIX as originally enacted was intended to supply. Thus, if we cut into Title XIX, we cut into the possibilities of better health care for the poor.

Nevertheless, I think we must realistically face up to the fact that some ceiling is likely to be imposed. If the bill as it emerges from the Senate Finance Committee contains a ceiling lower than what the Administration proposed, I intended to join Senator Javits in seeking on the Senate floor to raise the ceiling to the 150% level. That is the least we can do.

Medicaid, as I have said, was a program of great promise. It was a new hope for millions of Americans to receive health services never before available to them. That hope has now been tarnished. I believe, however, that if the amendments I propose are enacted, we will have taken the first steps toward instituting the kind of regulation that can make Medicaid a viable program for the future.

I ask unanimous consent that the amendments be printed in the Record at this point in my remarks.

ITEM 2: ADDITIONAL STATEMENTS BY JAMES G. HAUGHTON,* FIRST DEPUTY ADMINISTRATOR, HEALTH SERVICES ADMINISTRATION, CITY OF NEW YORK

EXHIBIT A. THE FUTURE OF PUBLIC GENERAL HOSPITALS—AN ADDRESS DELIVERED AT THE 95TH ANNUAL MEETING OF THE AMERICAN PUBLIC HEALTH ASSOCIATION, OCTOBER 26, 1967, MIAMI BEACH, FLORIDA

"There is really no reason for city-run hospitals anymore. The 'charity' patient for whom they were set up originally no longer exists. Medicare and Medicaid have made everyone a 'private' patient." So wrote Dr. Martin Cherkasky, Director of Montefiore Hospital and Medical Center in New York City, in the magazine section of the New York Times on October 8, 1967.[1] Dr. Cherkasky was, of course, making reference to the New York City municipal hospital system and to the fact that New York State has the most liberal Medicaid program in the the nation. What he overlooked was that not only New Yorkers read the New York Times and, furthermore, that less than 30 States have Medicaid programs. But more important than both of those omissions was his minimizing the very selective admission policies of most voluntary hospitals—particularly the teaching hospitals.

The discussion of the future of public hospitals has predictably had as its focus the future of medical education. This, of course, because the "charity" hospital and the "charity" ward of the voluntary hospital have traditionally been the locus for post-academic medical training. It is difficult, therefore, to discuss the public hospital without simultaneously discussing the "charity" ward of the

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*Additional statements by Dr. Haughton appears on p. 377.
[1] Article appears on p. 598.

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voluntary hospital because some of the issues to be discussed have relevance to both.

The professions have taught the public that there is a difference in the care one receives in a "charity" service, be it public or voluntary. The public has been taught that the care on a "private" or "semi-private" service is better, that on the public ("charity") service he is perceived and treated, not as a patient, but as a teaching instrument to be probed, analyzed and studied ad nauseum and furthermore, to be the subject of research and experimentation. He has also been taught that upon admission to such a service he loses contact with his personal physician no matter how competent.

This education of the patient has been reinforced by the fact that Medicare provides "semi-private" care and defines it to exclude ward service. While in social terms I would have been more proud of my profession had the discussion been focused on ways of eliminating the dual system and quality of services as between poor and affluent patients, I am not overly disturbed by the concern over the future of medical education if in the process of resolving that problem the dual system is abolished and the patient and his needs become the central issue.

Across the nation there is mounting evidence that the poor, released from the shackles of charity medicine, are seeking their care in the semi-private facilities of voluntary and proprietary hospitals rather than in the "charity" facilities of either the public or voluntary hospital even when this means weeks of waiting for electric services. In our own N.Y.C. municipal system we are predicting a 30% annual decrease in patient days over the next five years.

Clearly, the double standard is no longer acceptable to the public and should not be acceptable to us as health professionals. The real question is how to accomplish the change. The course adopted by the public is obviously not the answer since in many communities the public hospital is an important medical resource and the voluntary system could not carry the full load. In the voluntary system a part of the solution is relatively simple, the wards can be converted to semi-private facilities. But will this change in physical plant really accomplish the substantive social change? I think not.

In the public hospital the whole problem is more difficult. The poor maintenance and obsolescence will be expensive to correct and the image of inadequate "charity" care is more deeply etched in the minds of the public.

It seems to me the voluntary teaching hospitals must begin by accepting as the primary criterion for hospital admission the need of the patient for hospital care. The premise that something can be learned from every patient is not as far-fetched a notion as some medical educators seem to think. The patient must be perceived not as a bearer of disease to be studied, but as a human being with medical needs to be met expertly, kindly, gently and with dignity. If this cannot be achieved and accepted in the voluntary sector, the public hospital will always suffer because it will always be a residual system reserved for the "undesirable" patient.

Future Role of Public Hospitals

The public hospital cannot continue to be a resource exclusively for the poor because it will then inevitably be a poor hospital. Recent health legislation has created the financial resources which if properly used can transform the physical facilities of public hospitals into resources which are acceptable to all segments of the population. The community should be encouraged to take an active interest in its public hospital and to participate meaningfully in planning and in the formulation of operating policy. This has already begun in some parts of the country where non-profit corporations have been formed to administer public hospitals and in others where lay boards have been formed to participate in policy-making.

The competent private physician should be encouraged to use the facilities of the public hospital and to admit his private patients regardless of their method of payment. When such full community involvement in the life of the public hospital is achieved, it will be less difficult to muster adequate financial support for these hospitals and the aura of chronic underfinancing will be dissipated.

In many parts of the country the major issue associated with the problems of the public hospital is the rigidity of the civil service system with its inflexible job classifications and low salaries. This has made it virtually impossible to utilize new types of health care personnel and to attract competent adminis-

trators and other professional personnel. Overcoming such rigidities is a responsibility of the community, and leaders in the health industry must take the responsibility for mustering the political and community support necessary to break through these barriers.

In all hospitals, but particularly in the public hospitals, teaching and service goals must be balanced and teaching objectives must not transcend the service objectives. This balance of objectives is clearly possible for we know that some of the most outstanding teaching institutions in the country are completely private, and equal attention is given to the necessary technical competence and training of personnel and to the rendering of considerate and acceptable service.

It is true that there are definite problems when a teaching institution has a large service commitment, but it is possible for such a hospital to take the leadership in organizing neighborhood satellite facilities and mobilizing local professionals to staff them under the supervision of the teaching facility with the participation of house staff in a meaningful educational experience. For in the final analysis, the public hospital, if it is to attract and maintain the support of the community, must accept a commitment to provide basic care for the population.

The question of whether all public hospitals should be turned over to voluntary operation is in many instances an academic one since frequently there are no voluntary institutions available or willing to take on the responsibility. What seems more to the point is that we commit ourselves to taking whatever steps are necessary to eliminate the differences in quality between care for the poor and care for others, that we foster the rational organization of resources in order to keep the cost of care within our reach and that we set as our goal dignified, personalized, competent health care for those who need it.

EXHIBIT B. GOVERNMENT'S ROLE IN HEALTH CARE, PAST, PRESENT, AND FUTURE—AN ADDRESS DELIVERED AT THE 72ND ANNUAL CONVENTION AND SCIENTIFIC ASSEMBLY OF THE NATIONAL MEDICAL ASSOCIATION, AUGUST 9, 1967, ST. LOUIS, MISSOURI

By James G. Haughton, M.D., M.P.H., F.A.P.H.A.

The dictionary of the Encyclopedia Brittanica defines the word "pedantic" as "making an ostentatious display of knowledge". Today I am accepting the risk of being accused of pedantry because I have frequently been appalled by the ignorance which is displayed by my fellow physicians about important activities of government, important legislation before State and Federal legislative bodies and important points of view held by politicians all concerning the field of health care and all bearing important implications for the future of medical practice in the United States.

The role of government in health care today is pervasive and will continue to be so. To understand where we are and where we are headed it may help to look back over the route we have come, for as we review the past we may gain insights which help us understand the present and predict what it portends for the future.

As I begin my research in preparing this paper I reviewed the history of the United States Public Health Service and several other Federal agencies. It became obvious that the history of the Public Health Service is in fact the story of the evolution of Federal participation in health care over the past 170 years.

The Public Health Service began when in 1798 President John Adams signed a bill authorizing medical care for merchant seamen and establishing the U.S. Marine Hospital Service. It was established in recognition of the responsibility of the Federal government for the well being of its seamen since the merchant fleet had been the Nation's economic lifeline and a major element of its naval defense. Much of what has happened since has been a reflection of an expanding Federal recognition of responsibility for the health of the populace.

As early as 1799 a pattern of Federal-State cooperation began when Congress authorized Federal officers to cooperate with State authorities in the enforcement of their quarantine laws. In the ensuing years an expanding pattern of Federal-State-Local partnership has evolved which has manifested itself in a variety of programs which have done much to raise the level of health in the nation.

In the early years physicians of the Marine Hospitals were authorized to help communities curb severe epidemics of cholera and yellow fever. As the popula-

tion increased and cities and industries expanded the problems of epidemic control increased, and our ports became the main point of entry of epidemic diseases. After the establishment of the Commissioned Corps of the Public Health Service in 1899 the Congress, in 1893, gave the Service full responsibility for foreign and interstate quarantine emphasizing cooperative relationships with State health departments.

In the 1870's the science of bacteriology was born and scientific advances made in Europe and this country in the latter part of the 19th Century began to demonstrate the value of a central organization for research, epidemiological studies and practical assistance in epidemic control. In 1887 a Hygienic Laboratory was established at the Staten Island Marine Hospital to apply the new bacteriologic principles to the study of disease in this country. It quickly proved its worth and was soon transferred to Washington where it became the forerunner of today's National Institutes of Health.

As the production and interstate sale of biologic products for the prevention and treatment of infectious diseases expanded the Congress gave responsibility for their licensing and regulation to the Public Health Service under the Biologics Control Act of 1902.

An important milestone in this evolution was the passage of the Social Security Act of 1935 which among its other provisions authorized annual grants to the States for health purposes. In effect, the Federal Government undertook a partnership with the States to protect and promote the health of the people and this resulted in the establishment of a number of Federal-State programs against specific diseases such as venereal disease and tuberculosis. Prior to World War II major emphasis was given to the strengthening of State and local health agencies and to the promotion of maternal and child health and the control of communicable diseases.

As the population began to age and the leading causes of death began to shift from the infectious diseases to chronic diseases a major national research effort began aimed at the chronic and long term illnesses. This effort was signaled by the passage of the National Cancer Act in 1937 creating the National Cancer Institute dedicated to cancer research and the training of scientists. This was followed by the National Institute of Mental Health in 1946, the National Heart Institute in 1948, the Institutes of Arthritis and Metabolic Diseases and of Neurological Diseases and Blindness in 1950 and the National Institute of Allergy and Infectious Diseases in 1955. These institutes have all made major contributions to our knowledge of the chronic diseases and to the training of scientists dedicated to continuing research in this area.

At the end of World War II a serious problem faced the nation—a shortage of hospital and related medical facilities, and in 1946 the Congress expressed the will of the people by enacting the National Hospital Survey and Construction Programs, otherwise known as the Hill-Burton Program. This legislation authorized Federal financing to aid the States in the construction of hospitals and health centers and has since been broadened to provide grants for the construction of nursing homes and rehabilitation centers.

To bridge the gap between knowledge and service the Community Health Services and Facilities Act of 1961 authorized support of community studies and demonstrations to develop new and improved ambulatory services especially for the chronically ill and aged. This concern for the application of health knowledge was further demonstrated in The Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, and during this same period the Vaccination Assistance Act was passed authorizing the Public Health Service to assist States and communities in carrying out immunization programs aimed at the eradication of poliomyelitis, tetanus, diphtheria and pertussis.

Since the end of World War II the Congress has become increasingly alarmed about the hazards of the modern environment and has expressed this concern through supportive legislation. The Water Pollution Control Act of 1948, legislation in 1956 authorizing grants for the construction of waste treatment facilities, the Air Pollution Act of 1955, the creation of the Division of Radiological Health in 1958—all these were expressions of the growing concern of government regarding health hazards created by our industrial development and led to the authorization by the Congress in 1964 of funds to plan a new Environmental Health Center as a focal point for research, training and control programs in environmental health.

Health manpower training and development is a more recent area of concern in government, but its recent origin has not in any way dampened the magnitude

and scope of the effort. As early as 1956 the Public Health Service was authorized to provide traineeships for professional public health personnel. I, myself, received my Public Health training through a Public Health Service fellowship. In that same year a nurse traineeship program was begun to provide administrative, teaching and supervisory nursing personnel. Later (1963) the Health Professions Educational Assistance Act was passed and provided Federal grants to assist in the construction of all health professions schools, as well as providing a loan program for medical, dental and osteopathic students. The Nurse Training Act of 1964 not only authorized Federal assistance for the construction or rehabilitation of nursing schools, but also established a loan program for student nurses and extended the public health traineeship program to include nurses.

The collection of Vital Statistics is another area in which the Public Health Service has provided leadership. The transfer, in 1946, of the National Office of Vital Statistics from the Census Bureau to the Service marked the beginning of a new era in the collection, analysis and dissemination of health data, and when in 1956 the Congress authorized the National Health Survey, this set the stage for the later development (1960) of the National Center for Health Statistics. (1)

I am certain there are those who will hasten to remind me that most of what I have so far described are the traditionally accepted roles of government in the field of "Public Health": quarantine and epidemic control, food and drug inspection and regulation, venereal disease and tuberculosis control, research, health professions training, construction of health education and health care facilities, and environmental health activities.

The fact is that although the medical services of the Public Health Service have been provided only to special categories of persons, they have amounted to a considerable imput into the national medical care effort. Other agencies of government have provided even greater quantities of care. The medical services of the military are well known to all of you and include the Medicare program for military dependents not living near a military facility. The Veterans Administration has a long history of magnificent medical services to eligible veterans.

Concern About Costs

Since 1948 there has been growing concern among the public and their elected representatives about the costs of medical services and the inability of certain segments of the population to pay for them. This concern has been expressed in a series of legislative proposals which culminated, in 1965, in the passage of the medical aspects of P.L. 89-97, better known as Medicare and Medicaid. These legislative enactments have addressed themselves to the medical needs of certain well defined population groups. It is worthy of note that all the recent health legislation—P.L. 89-97, P.L. 89-239 and P.L. 89-749—pledge in very brave words not to interfere with existing patterns of medical practice. The conspicuous exception is the OEO 211 neighborhood health center groups program which deliberately intends to foster new ways of delivering comprehensive health care to disadvantaged populations. The clear implication is that the medical and related health professions have failed to create and provide health services responsive to the needs of these communities.

Only one year after the inception of our federal programs for the financing of health care it has become obvious that if government is to assume the responsibility for this financing it must also become concerned about the prices of medical care. The recent report to the President followed by a two day conference on Medical Care Prices in Washington is a reflection of this concern. The Secretary of H.E.W. in addressing the health experts gathered at that meeting challenged them to re-examine the efficiency, productivity and even the logic of our present health care systems. (3)

This governmental concern and involvement may be translated into dollars if one reviews our health expenditures for a recent year. In 1965 the nation expended $40.8 billion or 6% of the gross national product for the purchase of health services and supplies, the support of health research and the construction of health facilities. 91.5% of the total was spent for health care and supplies.

Of the $40.8 billion total $30.5 billion represented private expenditure and $10.2 billion were public funds. The distribution of the health dollar among the various elements of expenditure differs widely between public and private spending. For example 40 cents of the private dollar is spent for the services of private practitioners but only 6 cents of the public dollar. Less than 5 cents

of the private dollar is spent on research and construction, but 13 cents of the public dollar is spent on research and 6.5 cents on construction.

One bit of information which to me speaks volumes is that health insurance payments met less than ⅓ of the private health bill. During the legislative conflict which culminated in the passage of the Medicare law we were frequently reminded that more than 80% of the American public are protected by voluntary health insurance. This tid bit of intelligence was supposed to convince us all that we did not need the federal legislation, but I, like the Congress, have deep questions about the effectiveness of a system which covers more than 80% of the population but pays less than a third of the bill. (4)

In view of the past and the present what shall our national health goals for the future be and what shall be the role of government in the achievement of these goals? As a matter of national policy it is already the stated goal that optimal health services shall be available to every American Community. But what is the definition of "optimal health services"? *The Task Force on Comprehensive Personal Health Services of the National Commission on Community Health Services has defined it* in these words:

"It must be comprehensive and it must be personal. It starts in the relationship of a personal physician to his patient. It must support and supplement the patient-physician relationship with a team drawn from all the health professions. As a consequence of being personal and comprehensive, it must cover the full range of medical functions, beginning with health maintenance and preventive care, taking in diagnosis and treatment of acute disorders, and including rehabilitation. It must be available to everyone. It must be available at all times and in all places. It must recognize and cope with the special health needs of people at all stages of life, from infancy to old age.: (5)

Does this seem a grandiose goal? It does to me, but I believe it is an achieveable goal. It can only be achieved, however, as we begin to look at health services in proper perspective. *As health professionals both in the public and private sectors we frequently behave as if health services are the only factor which affect the health of a community.* As long as we take this limited and narrow point of view we shall never achieve the national goal of optimum services for all who need it because too many will need it.

In planning for improving the level of health of any community we must begin with a recognition that health is inseparable from all aspects of living. Again the Task Force on Comprehensive Personal Health Services has perhaps said it better than I could:

"The health of the individual is not only dependent upon services specifically aimed at personal health care, but also dependent upon the quality of the relationship of the individual with his environment—his sustenance needs, his shelter, his ability to communicate and his enjoyment of a creative as well as a productive life. Basic to this concept is the viewpoint that * * * the opportunity for employment and job security is as essential to health as a hospital bed for acute * * * care; and, that poverty in all its insidious complexities acts like a virus in affecting the health of the total community." (6)

These are brave words. How are they to be implemented? Can the private practitioner address himself in depth to the employment, housing and sustenance needs of his patients? Obviously not. Can any one physician pretend to provide all the health care a given patient with a complex ailment may need? Of course not. Certainly he can make appropriate referrals, but what if the patient is not eligible for Medicare, or Title XIX, or if your State has not yet implemented Title XIX; or if the patient has health insurance with serious gaps in coverage? How does the private practitioner deliver comprehensive personal health care in these circumstances? Obviously he does not.

A Framework for Leadership

There is an answer, and the answer lies in the various roles which government must assume in health matters in the future. Recent health legislation has begun to show the way. *P.L. 89–749, also known as the Hill-Staggers law, is intended to create the framework within which government can provide the leadership in the comprehensive planning which will be necessary to deal with health problems within the context of the total life situation of a community.* This law provides for the appointment of State and local interdepartmental comprehensive health planning agencies. These agencies should plan for the mobilization and equitable

distribution of all the health resources of a community or region. It should plan for the channeling of the irrationally fragmented and categorized federal funding into rationally designed health programs.

Government must identify gaps in service and provide the leadership and the funds whereby voluntary agencies may fill the gaps. Undoubtedly, present federal programs for the financing of health care will be expanded to provide for other segments of the population. In the implementation of these programs official health and welfare agencies must be accountable for the quality, cost and utilization of the services they purchase. The requirement for utilization review of hospital care and extended care in the Medicare program, *the requirement of continuing post-graduate medical education as a criterion for physician participation in New York State's Medicaid program, the responsibility for medical audit of institutional health care conferred upon the State Health Department by New York State's Folsom Law, the authority of the* New York City Health Services Administration *to revoke the license* of a private proprietary hospital if an unqualified physician is permitted to perform major surgery, (7) all these are examples of government's responsibility to be accountable to the people.

But this responsibility for comprehensive planning must go further. It must include an assessment of present and future health manpower needs not only by analyzing the need for traditional categories of health workers, but by taking the leadership and providing the funds to stimulate the analysis of present and future health functions to determine whether the devision of labor may not be as effective in increasing productivity in the health field as it has been in industry. The medical corpsman and a variety of technicians have proven their value on the field of battle and on the capital ships of the Navy. Are not their skills transferrable to the civilian medical market place? Are not some of the functions now performed by doctors susceptible of performance by nurses or a variety of doctor's assistants? These are questions that must be answered if we are to resolve our manpower dilemma.

I have raised these questions before and have immediately been reminded by *my colleagues of the doctor's malpractice liability.* Perhaps it will be necessary to change the laws which define the functions and liability of both nurses and doctors in order that imaginative use may be made of our human resources. Clearly, these decisions cannot be left to the professions for it was only about a decade and a half ago that we were assured by the medical profession that there was no shortage of physicians and that such a shortage was not likely to develop. Now, in 1967, we are told belatedly by the A.M.A. that there is indeed a severe shortage of doctors. We have all heard the old "saw" that war is too important to be left to the generals. *I suggest now that health planning is much too important to be left* to organized medicine. Even voluntary health agencies are too parochial and chauvinistic in their interests to address themselves to the broad scope of planning which will be necessary to solve our problems.

We must also explore new methods for the delivery and financing of health care for in today's context the private, solo-practice model seems *not to be viable, and the fee-for-service system of payment has already caused serious financial difficulty in one large State's Title XIX program.*

I am not suggesting that government planners should impose upon the professions new methods of practice, new delivery systems, new categories of health workers or new methods of financing health care. Nor am I suggesting what is often referred to as the socialization of medicine. *I am, on behalf of government at all levels, extending a hand to organized medicine and inviting and challenging you to join us in finding solutions to our mutual problems.*

In the past government has proposed and the A.M.A. and others have opposed. I was pleased to note that this organization was one of those few medical bodies which supported the Medicare legislation. Medicare is not perfect, but it is attempting to meet the needs of a segment of the population which clearly needs help. The American public has made it clear that it wants change. The status quo with its dual standards of health care is no longer acceptable. It is foolhardy for our profession to stand against the mainstream of public opinion. The Secretary of H.E.W. in addressing the conference on Medical Care Prices on Jne 28, 1967 said it very well indeed: "We cannot go on as we have in the past. New patterns will be necessary. * * * Those who entertain some apprehensions as to what the new patterns will be had better plunge in and experiment with their own preferred solutions. Standing back and condemning the solutions that other devise will not stem the tide of change * * *. Responsibility

for devising solutions must be widely shared among all groups involved in the delivery of health care to the American people. Such a widely accepted sense of responsibility is the best insurance against the Government having to shoulder more than its share of corrective measures." (3) This is the challenge which is offered, and organized medicine's role in planning health care in the future will be determined by the extent to which this challenge is accepted.

Finally, the various roles of government which have been described can only be meaningful to the extent that government guarantees to all, regardless of race or color, equal access to health care, equal opportunity for professional education, equal access to health facilities by both patients and physicians and other health workers and equal opportunity to participate in the formulation of health policy. Without these guarantees all recent and future health legislation will be but empty promises to a large segment of the population. The functions of the Federal Offices of Equal Health Opportunity have recently been transferred to the office of the Secretary of H.E.W. This step has been hailed by some who have made no secret of their opposition to Title VI of the Civil Rights Act. We can only hope and be militantly watchful to make sure that this action does not portend a relaxing of the government's resolve to assure to all the people the blessings of optimal, unsegregated health care.

There is much work before us. We must experiment, we must be imaginative and we must not hesitate to explore the unknown for in this exploration lies the path to new knowledge, to new methods and to a bright future for the health professions and for the level of health of the American people.

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EXHIBIT C. UNRESOLVED ISSUES IN MEDICARE AND MEDICAID—AN ADDRESS DELIVERED AT A SPECIAL SESSION OF THE 95TH ANNUAL MEETING OF THE APHA, OCTOBER 24, 1967, AT THE FOUNTAINBLEU HOTEL, MIAMI BEACH, FLORIDA

MEDICARE VERSUS MEDICAID: THE NATION'S DILEMMA

The year 1965 will be a landmark in the annals of medical care legislation. The passage of Public Law 89–97 brought to public view the Congress' ambivalence regarding the financing of health care, for in one enactment the Congress simultaneously created a contributor health insurance plan with a voluntary component and expanded an existing welfare medical care program. Now, two years later, the House Ways and Means Committee of the Congress has reported out a bill (H.R. 12080) which proposes to expand Medicare benefits but simultaneously to limit Federal responsibility for reimbursement under Title XIX.

It seems, therefore, that the time has come for the nation to make a decision as to which road it shall follow in financing health care—Health Insurance or Medical Welfare. In order to focus on the relevant issues it may be well to analyzes the programs and to identify their strengths and weaknesses.

MEDICARE

Strengths

The major socially significant aspect of the Medicare program is the absence of the "needs test" and the fact that the hospital insurance (Part A) is provided through a *compulsory* contributory system. The encouragement of alternatives to in-hospital care, i.e., extended care, home health care, out-patient

diagnostic services, is an important step toward stimulating fiscal responsibility among doctors and hospital managers alike while providing a framework for providing care under socially acceptable circumstances. The requirement for utilization review is also intended to discourage inappropriate utilization of costly resources without interfering with the physician's prerogative to provide the kind and quantity of care which in his best professional judgment is required by the patient.

These positive aspects should be transferred in toto into any government sponsored health insurance plan which may evolve in the future.

Weaknesses

Deductibles and co-insurance features in health insurance plans are unacceptable and regressive because they require the insured to pay twice: When he pays his premium and when he receives service. Those who support these provisions argue that they discourage inappropriate utilization and therefore control costs. I submit that this argument is specious in that these features are more likely to discourage *appropriate* utilization of services by persons who need care but cannot pay the deductibles. These persons are likely to require more care at a greater cost in the long run and thereby become a heavier financial burden to the community.

The prohibition of routine physical examinations is particularly shortsighted in a program for this age group since this is the population at greatest risk from serious disabling diseases which are often susceptible to early detection and treatment and which are often "silent" in their early stages. To address ourselves to this population only after symptoms appear is contrary to good public health and preventive practice. A similar statement can be made about the absence of podiatry since some of the most disabling conditions in an aging population are podiatric in nature and, though sometimes not related to systemic disease, often reduce or prevent ambulation and therefore create dependency. Current proposals for the inclusion of podiatry are inadequate since they proscribe "routine" foot care. "Routine" foot care in patients with diabetes or peripheral vascular disease can be crucial to the health and well-being of the patient.

The exclusion of self-administered drugs is another serious deficiency in the Medicare program. Many persons over 65 suffer from one or more chronic diseases which require one or more items of medication for their adequate control. Such drug expenditures can be a serious financial burden to persons living on small pensions and can make the difference between independence and the need for public assistance.

Dental care is perhaps a less acute problem among the aging even though I am sure there are many who could benefit from such care but, given the high cost of dentistry, younger populations to serve, and our finite resources, this is perhaps a pardonable exclusion.

To our dismay we find that Medicare has, in some instances, increased the cost of care to the elderly. In New York City, patients who previously paid $1.00 or $2.00 for a clinic visit, are now required to pay 20% of a $20 per visit clinic fee or $4.00 and 20% of the doctor's fee of $8.00 when, previously, the same doctor provided his services in the clinic without compensation. A $1.00 or $2.00 pre-Medicare visit is therefore costing the patient $5.60.

Physicians in private practice have taken the position that because Medicare is available they can now charge their full fee to the elderly patient since he is only required to pay 20% of the fee. The fact is, however, that in some cases 20% of the doctor's prevailing fee is more than he charged an over-65 patient of limited resources before Medicare. Furthermore, Medicare provides the patient no protection against the physician who refuses to accept an assignment and who can therefore charge whatever he pleases, although the patients' reimbursement from government will be based on what the fiscal intermediary considers to be the doctor's prevailing fee.

The law, furthermore, starts out by promising not to interfere with present patterns of practice but, then, immediately proceeds to exclude hospital-employed physicians' services from Part A thereby interfering with what has been a traditional relationship between hospitals and their radiologists, pathologists and other specialists.

Part B is a further problem because it is inimical to the proper organizations of resources. There is no incentive to organization and economy in a plan which sanctifies the solo practice fee-for-service approach to the delivery of health care.

There are, of course, those who defend some of these weaknesses by pointing out that Public Law 89–97 provides that Title XIX may be used as a supplement to Medicare to pay the deductibles and coinsurance and to provide the uncovered services, but this is not the best solution since Title XIX has its own weaknesses.

TITLE XIX

Strengths:

This is not to say that there are no positives in Title XIX, but the negatives may well outweigh them. Title XIX, because its implementation is dependent upon State enactments within very broad Federal guidelines, is very permissive. This is at once a weakness and a strength because it permits liberal, progressive States to enact and implement programs of broad scope both in terms of services provided and population served, but at the same time permits less progressive States to provide less. As a result, the geographic mobility of the needy population is diminished by the need to live in States which provide liberal programs, and their constitutionally granted right to freedom of movement is therefore meaningfully curtailed. Residents of the poorest States may also suffer a serious disadvantage since even the 17% matching which these States must provide may be beyond their means although the will to participate exists. But this very permissiveness has some advantages.

Health services result from a combination of three determinants:

1. method of financing;
2. organization of services; and
3. patterns of practice.

These three determine the health services system of a community. There has been in the past, an assumption that if the method of financing changes, the other two variables will change and the system will, therefore, also change. This assumption has not been borne out by the British experience where, although the method of financing was changed in 1948, there has been little or no change in either the organization of services or the pattern of practice.

The permissiveness of the Federal Title XIX legislation will permit us, if State enactments are properly drawn, to experiment with new organizational patterns. For example group practice, while not really new, can be expanded, changed and strengthened. New kinds of hospital-based programs can be attempted and tested, and other organizational patterns not yet conceived can be designed and proven.

Patterns of practice can be changed by local regulation where indicated so that services may be provided by the most appropriate persons and in the most appropriate settings. For example, in New York City, local regulation has already determined who may perform major surgery, who may perform certain x-ray procedures, which laboratory procedures a physician may perform in his office and which hospitals may be reimbursed for certain kinds of services.

These powers, properly exercised, can contribute to the improvement of the quality of health services and to the appropriate allocation and utilization of human and financial resources.

Perhaps the most evident advantage of Title XIX is its potential for removing the financial barriers to health care for a portion of the population, but even this potential is limited by the unwillingness of some States and, now the Congress, to permit the establishment of realistic standards of financial eligibility.

Weaknesses

Having already pointed out the ways in which the permissiveness of this portion of Public Law 89–97 can be a disadvantage, I can now deal with the most important weakness in the law. Title XIX is a Public Welfare law, and all of our welfare laws have their roots in the philosophy of the English Poor Law which is that only the *worthy* poor should be helped. All eligibility, therefore, is based on proven need. This approach is particularly onerous to *medically needy* persons who are presumably independent where sustenance is concerned. Such persons are militantly proud of their independence and resist any regulations which threaten it. This is especially true of persons over 65 who have been independent all their lives and are especially proud of their continuing independence during their declining years and therefore refuse, as stated by Dr. Alonzo Yerby, to "barter their dignity for their health care".

This refusal to submit to a "needs test" and accept the "Welfare" label has led to the rejection of Title XIX benefits by thousands of presumably eligible New Yorkers.

But there is an even more serious failing in the Title XIX program which penalizes the potential over-65 beneficiary. Because it is a "welfare" law, all State-enabling legislation will undoubtedly carry regulations with regard to the treatment of liquid assets. Those who have moderate savings will no doubt be required to exhaust at least a portion of them in order to "achieve" eligibility—this at a time in life when it will not be possible for them to replenish these savings. Since many of these persons use their savings to supplement meager pensions and/or Social Security benefits, these regulations merely serve to hasten their pauperization and to make them recipients of Old Age Assistance. Title XIX therefore is not necessarily an acceptable answer to the deductibles, coinsurance and exclusions of Title XVIII.

Having explored the strengths and weaknesses of both programs, what can we recommend for the future? To answer that question we must first determine what is to be the national philosophy regarding health care in the future. Is optimum health care to be a *right* or is to be a privilege? Much of what has been heard from the Executive branch of government in Washington in recent months suggests a commitment to the philosophy of health care as a right, but nothing in the present law nor in the recent activities of the Legislative branch suggests such commitment. Until this dichotomy in National philosophy is resolved, we must, therefore, assume that for some time to come health care will be financed through a variety of approaches.

This suggests that the next order of business is to improve both Titles XVIII and XIX. In Title XVII the deductibles and coinsurance features must be removed because I believe experience will show that they are not the money-savers they are purported to be. The scope of services must be broadened to provide podiatry care, drugs, preventive care, and at least some acute dental care if not the total scope of reparative and prosthetic care. Apparently the Congress intends to provide Title XIX benefits only to the very lowest financial stratum of the population on the assumption that those above that level are capable of meeting the cost of their own health care. This is, of course, a fallacious assumption and two steps are therefore necessary:

1. The Federal Title XIX law must be strengthened by mandating a broad scope of benefits for those who are eligible, by placing a floor on eligibility standards, and by providing whatever financial assistance is required by poorer States to underwrite these changes in the law.
2. Title XVIII must be broadened to include all those who are not eligible for Title XIX, and the supplementary medical insurance must be mandatory not voluntary.

Those eligible for Title XIX benefits would contribute to the Social Security system only to the extent necessary to provide them with pension and disability insurance benefits. All others, including the self-employed, would make full contributions.

Concomitant with these steps must be an effort to reorganize the delivery of health services so that maximum productivity be achieved. Clearly present patterns of practice and present organization of services are wasteful of both human and financial resources and should not be supported even if the resources were available. Until steps aimed at these goals are taken, no method of financing, no matter how sophisticated, will support the cost of optimal health care for the Nation.

This is the challenge of the next decade and if we, as health professionals and as medical administrators, are not prepared to accept it, and, if we are not prepared to fight the requisite political battles and accept the consequences, now is the time to "get out of the kitchen."

ITEM 3: "WITNESS FOR MEDICAID," A REPORT ON AN INFORMAL HEARING CONDUCTED BY UNITED NEIGHBORHOOD HOUSES, N.Y.C., APRIL 14, 1967 *

* See testimony by Miss Helen Harris, p. 444.

WITNESS for MEDICAID

UNITED NEIGHBORHOOD HOUSES

Foreword

This impressive and moving document is the first published report on what the people for whom the Medicaid program was enacted have to say about this program.

It is one thing to write and talk about the urban crisis—and to write and talk about the indignities of poor relief status as a condition for receiving tax-financed health care—but it is quite another matter to have the poor in our own neighborhoods share with us their excitement at being first class citizens when they open the door to the health service of their own choice.

We have a long way to go before the Medicaid program is all that we hope for it. We have yet to begin the task of restructuring our health services so they will be more responsive to neighborhood decisions—and more comprehensive in response to neighborhood needs. But what this document does tell us is that the day has now come when health care must be a right, universally available to all people, on the same basis. Health need, and health need alone, must determine the right to health care.

We can no longer segregate those who seek health services by the source of payment for the care they will receive. The meaning of what the Witnesses for Medicaid have to say is quite clear: the dignity and enhancement of self-respect essential for full participation in our democratic society mean abolishment forever of our two-class system of health care. The very least we can do is to assure all people "private" status in the most personal of all services.

It is against this social policy commitment that we must measure the effectiveness, and ineffectiveness, of today's Medicaid program. The gaps and deficiencies are many. Some of these deficits will be corrected only by legislation—others require better administration of existing laws. Most important of all, perhaps, is that the people for whom the programs are designed must share in the decision-making process.

Medicaid is the beginning of a series of changes which must be revolutionary. They must remove the welfare stigma too often associated with all of the tax-supported services—a welfare stigma too long characterized by our health care system. Eligibility criteria and application procedures are unsatisfactory and unrealistic in today's democracy. Weaknesses in administrative and fiscal procedures, many of which are revealed in this testimony, can and must be corrected without further delay. We must get on with the job of bringing to all people in all neighborhoods the comprehensive health center concept of services.

This first effort of "Witness for Medicaid" must be repeated throughout New York City—repeated throughout all our urban communities. It must be repeated often. These voices are one way of preserving the small gains that have been made—and of building on these gains. It is these voices which will bring the public participation needed to strengthen the laws and to make public officials aware of their responsibility to improve the quality of both the administrative procedures and the health services provided.

United Neighborhood Houses has once again demonstrated that the strength of democracy rests with the people—and where health is concerned it is at the point where program meets people that the final test of program and social effectiveness must be made.

Harry Becker
Executive Secretary
Committee on Special Studies
New York Academy of Medicine

What Is Medicaid?

Medicaid is a New York State health care program for the medically indigent of all ages which currently covers all medical bills for hospitals, doctors, dentists, nurses, druggists and others who provide needed medical care and services. This includes preventive care as well as treatment of an illness.

Participants in Medicaid are free to choose where they want to go for medical care—to any hospital (public, voluntary or private), or any doctor, dentist or other practitioner who participates in the program. The practitioner, instead of charging the patient, bills the city.

The program is financed under Title XIX of the federal Social Security Act and State enabling legislation.

Why a "Witness for Medicaid" Hearing?

"Witness for Medicaid," an informal hearing held by United Neighborhood Houses on April 14, 1967, was conceived as a means of dramatically informing New York City's Congressmen and the City and State administrators of Medicaid on what Medicaid means to those who use it. UNH's frank hope was that the testimony would help persuade Congress not to reduce the scope of Medicaid and suggest to Medicaid's administrators ways of improving the operations of the program.

United Neighborhood Houses views Medicaid as an enormous forward step in freeing low and moderate income persons from the economic hazards of illness, while providing them with high quality medical care. UNH strongly supported the enactment of the Medicaid program in New York State and has fought against subsequent efforts to dilute it.

Two threats to Medicaid prompted the April 14th hearing: *First,* Congress was reported considering limiting federal reimbursements. Second, Administrative roadblocks were discouraging medical practitioners, as well as persons eligible for the benefits, from participating in Medicaid.

The hearing was chaired by Congressman Jacob H. Gilbert (22nd C.D.) and by Mr. Theodore Pearson of the UNH board. Two other Congressmen attended—William Fitts Ryan (20th C.D.) and Leonard Farbstein (19th C.D.). Two others sent aides—Stephen Berger, representing Jonathan B. Bingham (23rd C.D.), and Ira Rubin, representing Edna F. Kelly (12th C.D.).

The City and State agencies responsible for administering Medicaid were represented by Joseph H. Louchheim, Deputy Commissioner, New York State Department of Social Welfare; John Mullaney, Medical Assistance Administrator, New York City Department of Welfare and Dr. Howard Brown, Administrator of Health Services, New York City.

The witnesses were, for the most part, ordinary people enrolled in Medicaid who were known to UNH's member settlement houses. Some were Welfare recipients; others were not. Among the witnesses also were neighborhood workers who had been engaged in enrolling people in Medicaid and in helping them make use of its services, two hospital spokesmen, a dentist and a sprinkling of other interested parties.

The testimony which follows is verbatim. The only editing consisted of arranging it by topic and eliminating excessive repetition. To those who want to know directly from those who are experiencing it, what Medicaid is all about, here is the living testimony.

What's Right

"Out of the clear blue sky you have to figure $10 for a penicillin injection . . ."

MRS. BERTHA JACKSON: (Parent, Church of All Nations Neighborhood House)

I'm happy to be here to be a witness for Medicaid. Because we're a family--we have two small children--and before Medicaid we had so many bills, constantly, one right after the other. When you have small children you know what happens. Out of the clear blue sky you have to figure $10 for a penicillin injection and then you have to figure out three stitches, for example, that's $10. And that's something that is not on a regular weekly budget. Unless you have a lot of money or are an upper middle class family, well, it's really hard. You have to always keep figuring where is the money going to come from to pay for these unexpected bills, which is really what it amounts to.

Just before we were able to get our Medicaid cards, which was September, my husband had an operation which was $125 and then I had to go to the dentist and he told us that it would cost us $250 for some work that I had to have done on my teeth. And that was just...well that was just the end, because that was the end of the bank account that we had and, well, we just were at the end of the road, the bottom of the barrel.

We started looking around trying to figure out, "What are we going to do now?" We just were really finished--flat out. So we got our Medicaid card and right after that, I had to go to the hospital for three weeks and it took care of a three week stay in the hospital. Since that time, I've had other medical attention which involved an IBT x-ray, which would have run us $65, and my little boy had to have some extensive dental work done on his teeth which is going to be taken care of. Also, the work that will be done on my teeth will be taken care of, too.

So I want to say that this is a wonderful program and it's just marvelous to think that people even exist today that are really interested in the average poor person, or someone that is below middle class.

"I think it's the best thing we ever had."

MRS. ADA CABEZUDO: (Head Start Parent, James Weldon Johnson Community Center)

When I got my Medicaid card I didn't even know what it was all about. I was two months sick and almost paralyzed. I was going to a City hospital and it took me a long time to get my medicines.

When I got my Medicaid card I had to call my (Welfare) investigator and find out what it was about and he told me that I could go to my private doctors, or any private hospital. So I went to one of the better hospitals that we have in New York and, thanks to Medicaid, I am walking. I have my braces that without Medicaid I wouldn't be able to pay for. I think it's the best thing we ever had.

With Medicaid

MRS. NANCY DELAUROT: (Parent, Child Development Program, Colony House).

When I first heard about Medicaid, I said to myself this is too good to be true. The most wonderful thing for me was to be able to go to a dentist for the first time in years.

"For the first time . . . a family doctor."

MRS. MARILYN FARMER: (Community Aide, Forest Neighborhood House)

For the first time, many of these patients have had what we generally call, a family doctor...They've had one doctor.

Previously, when they called the Department of Welfare for a doctor, they got one this week, one the next week. And treatment was not always the best that it could be because the doctor wasn't aware of their problems.

"It has lifted our out-patient department out of the nineteenth century."

RICHARD LORRANCE: (Manager, Out-Patient Services, Long Island College Hospital)

While there are some difficulties with Medicaid applications--they are very complicated and the processing takes a good deal of time--the more positive aspects of Medicaid in terms of their effect on the hospitals are very gratifying.

For example, at our hospital, it has lifted our out-patient department out of the nineteenth century into a twentieth century type of clinic. We have developed an appointment system. We've done away with the three and four hour waits that people had to suffer through. We have developed a preventive medicine program, so that the doctors are concerned with the whole patient and not with the patient who comes with one specific illness in one specific part of his body.

More important, however, to me is the fact that the hospital has moved out of its removal from the community and become part of the total community life.

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"... a person is able to choose ..."

SISTER MARIA JOSEFINA: (Student, Fordham University School of Social Work, La Casa, South Brooklyn Neighborhood Houses)

This is a magnificent thing to watch--that a person is able to choose whether he wants to go to a group service, a medical service, or a comprehensive program in a hospital, or a private doctor. This is a tremendous thing to say for any country.

MRS. EVELYN CUMMINGS: (Parent, Child Development Program, Lenox Hill Neighborhood Assn.)

After I got my Medicaid card we joined HIP and it's very nice. I have my own family doctor; my kids have their own pediatrician and I've started going to the dentist. It's very easy to do. It's sort of one center; you have everything done there. They have specialists also.

MRS. BRUNILDA VASQUEZ: (Community Worker, Action-for-Progress, University Settlement)

Before Medicaid, I went to the Department of Welfare dentists for dentures and had to wait about five months. Three times I kept my appointment which required two hours of travelling time and was told that my dentist didn't come that day. Finally, when I did get them, my dentures didn't fit and, you can see, I don't have any teeth. I went back to the dentist a couple of times and he told me not to come anymore, that it was all in my mind. Now, under Medicaid, I go to a private dentist who has promised to let me come back all the times I want to, until my dentures fit.

MRS. IDA VADAN: (Parent, Head Start, Grand Street Settlement)

Before I was in Medicaid I used to go to the City clinic. You get there about 9 o'clock in the morning. You stay there 'til twelve-two o'clock in the afternoon. They give you the run around for this and that. They have you coming back every day of the week for something...Since I've used Medicaid, I haven't had the problem to go running back to the clinic when you can use a private doctor of your own at any time. I think it's very important that we keep it just like it is.

"Will the doctor . . . treat me . . . as if I was paying?"

MRS. MARIA GUZMAN: (Clerk, Urban Opportunities Center, Goddard-Riverside Community Center)

The first time I heard of Medicaid, I said well, I was in need of it. I applied and I got my card right away. The question that I had was: Will the doctor--a private doctor--treat me the same as any other patient, as if I was paying? I had that on my mind.

Finally, I was sick around three weeks ago and I went to a private doctor and the nurse was very nice about it. She came over and she asked me for the card without making a fuss about it or anything. She got all the information and the doctor treated me as everybody else that was paying and gave me a prescription with all the information on it. Then I went into the drugstore and I didn't have to show my card or anything. I had everything ready and I felt very good about it, very happy about it. My baby was treated, even my husband now, and I'm very happy with Medicaid.

"My Social Security is very small."

MRS. TILLIE NEWMAN: (Member, Good Companions, Henry Street Settlement)

I'm a widow and I live alone and I'm a sick person...I used to have a private doctor for twenty-four years and he died. When I called him, he used to come immediately. Now I haven't got a private doctor and I go to the Gouverneur Clinic.

But when I get sick...this winter I had a very bad winter. I was four weeks in the house with a very bad cold. I have a low resistance. And I couldn't get any doctor. I can't afford to call a private doctor. It would cost me fourteen, fifteen dollars. I wouldn't have what to eat then. My Social Security is very small.

So somebody told me about a doctor and I call him up and I ask him whether he accepts Medicaid and Medicare. He said, "Yes." He came to my house two hours later. He examined me, was very nice, gave me a prescription. I didn't pay him a cent.

I called up a pharmacy which I know. I ask him whether he accepts Medicare or Medicaid. He said, "Yes." I sent my friend. She brought the medicine. I think Medicaid is very, very necessary for poor people, for old people and for young people.

"I feel much better behind Medicaid, because she gets this attention."

MRS. DORIS HARRISON: (Parent, Child Development Program, Manhattanville Community Centers)

I use Medicaid for my two-and-a-half year old daughter. She has a murmur of the heart and she has sickle-cell anemia. Before I was attending the hospital, which is Knickerbocker, which is two blocks from my home.

I used to have to go there and sit and wait for hours before I got attention. I feel much better behind Medicaid, because she gets this attention and I feel better because I didn't have the money to pay for it and with my card I just go and present it and they take care of me right away. When the doctor walks in... she's there. She'll look at me. She says, "Okay, Mrs. Harrison, come right in." That makes me feel like I've got a million dollars in my pocket.

"... because I got now a tooth, a new tooth."

MRS. RITA VARGAS: (Community Aide, La Casa, South Brooklyn Neighborhood Houses)

I don't know...my English is a little poor...I feel so happy and help the people who receive now Medicaid. I fill out about ten or eleven applications a day, especially the group of mothers--I am the chairman. All mothers are now happy because all mothers got now the new tooth, the new glasses--especially me. About ten years ago I still waiting my new tooth, now in a couple of days I got it! What you think about it--I'm happy...Now I can eat anything when I need it because I got now a tooth, a new tooth.

Well, my children, too, I got the little ones at school. The investigator give me the appointment to their eye glasses. She say, "There is too much people. I can't give you now." Now my children is got glasses now. My daughter, too.

I got a lot of people which come to my house in the night and fill out a lot of Medicaid applications. Thank God! Now the old poor people is happy, is having now Medicaid, is going any place he likes, he is going any place he wants, is not ashamed of himself. He goes and shows his card from Medicaid and has everything.

MRS. ANNETTE LEONARD: (Parent, Head Start, East Side House)

I now have bridges which I would have never been able to afford without the help of Medicaid.

FULGENCIO HERNANDEZ: (Member, Good Companions, Henry Street Settlement)

I live on Social Security and it's very tight. I gotta support my wife. So when I hear about Medicaid, we registered and as soon as we get the card, we went to a doctor for her glasses. In two weeks and two days she got her glasses. She is very happy and then everything is OK in my house.

EDWARD SHEA: (Senior Citizen, Forest Neighborhood House)

I only needed glasses...I got them in seven days, where I would have had to maybe wait months through Welfare.

MRS. CARMEN APONTE: (Parent, Head Start, Union Settlement)

I had a note from the school which said I had to take my daughter to the dentist. I wasn't able to make it because I didn't have any money to pay the dentist. But with my Medicaid card, thanks to that, I took my child to a dentist and I returned the completion note back.

"... the excitement that we professionals have ..."

MRS. LEONA THOMPSON: (Director of Social Services, Knickerbocker Hospital)

As a professional who's worked in the field of health and social services since the 1930's and has seen thousands through the years--ill getting poorer and poor getting sicker--I want to stress the excitement that we professionals have in seeing the potential that Medicaid gives.

Now, we have a special program...that even goes beyond guaranteeing and up-raising all services given. We finally find that our hospital and the community together have a joint responsibility. When appointments are not kept, when scheduling is made, it is done both by the parent representatives and the hospital. There is a mutual follow-up.

This has changed the attitude not only of the recipient of the service, but it has also changed the attitude--which I think is equally important--of the one who <u>gives</u> the service. He is no longer doing a charitable act. He is no longer just being a room clerk. Being part of planning this program, he feels he's part of planning for the health of the community and himself, because if I know the wages of most hospital workers, they're eligible for Medicaid too.

The "Welfare" Label: "There is a

EDWARD SHEA: (Senior citizen, Forest Neighborhood House)

I receive Social Security, but I have to have Welfare supplementation... I have a friend...She's ninety-five years old and she lives on less than $80 a month. But she won't approach Medicaid because she thinks Welfare means charity. And there is a stigma there.

MRS. BERTHA JACKSON: (Parent, Church of All Nations Neighborhood House)

One thing that did happen the first visit that I went to the dentist. He said, "Oh, are you on Welfare now?" when I showed him the Medicaid card. And I said, "Well, no, that doesn't mean that we're on Welfare. It just happens that that's what it says on the top of the card--Department of Welfare."

MRS. EVELYN MARIETTA: (Aide, Child Development Program, Manhattanville Community Centers)

Now the only trouble that we find is that some of the parents claim that when

A debate and

CONGRESSMAN RYAN: As long as all the city officials are here, I'd like to make a suggestion...I've just examined the Medicaid card of Mrs. Cummings, who is not a Welfare recipient--and it doesn't matter whether she is or she isn't. But the card says "The City of New York, Dept. of Welfare, Medical Assistance Identification Card." My simple recommendation would be that this card be revised and the words "Department of Welfare" removed. (Applause) It could be identified by some simple identification code and eliminate any reaction such as a previous witness had when the dentist said, "Are you on Welfare?" I should think that would be a very simple thing to carry out.

DR. BROWN: I agree completely that we should remove anything from this program that marks it as a Welfare program. I believe, Mr. Louchheim, it is required by State law to have the Welfare identification on the card. Is that correct?

CONGRESSMAN RYAN: I would doubt that very much.

DR. BROWN: It's certainly not a ruling of the Health Services Administration.

COMMR. LOUCHHEIM: I wouldn't want to answer this from the standpoint of the law because I have a doubt. But I tend to agree with Congressman Ryan that it is not a requirement. It is definitely a requirement of the Federal law, Title XIX, that there be a single State agency which is responsible for the Medicaid Program. And that single State agency must be the same agency which does administer old age assistance, aid to dependent children, aid to the foreign and aid to the insane and, therefore, it must be the Department of Welfare. Whether or not the identification card has to have the Department of Welfare's name on it, I wouldn't say that it didn't have to. But I tend to think it wouldn't be necessary.

CONGRESSMAN RYAN: I would certainly appreciate your looking into it and if you could make the administrative change which I think is all that is required,

stigma there."

they go home and they have to talk it over with their husbands about filling out the Medicaid forms, the husbands reject it because they don't want Welfare.

ARTHUR COHN: (Executive Director, Grand Street Settlement)

Now, some of us may say, there is no stigma attached, but I think, to use the jargon in the social welfare field, feelings are facts. And if people feel that there is something stigmatic about going in to a Welfare Department office, we must take this into account. We have had numerous people who have said, "You won't get me near there, because I don't want charity."

MARILYN FARMER: (Community Aide, Forest Neighborhood House)

Welfare has not a very nice connotation to most of these people. If your program could be changed...or even if the name of the Department of Welfare could be taken off the card...I don't know, but I think something should be done in this field.

...a solution?

I think that it would be helpful to the program.

DR. BROWN: I just want to point out, Mr. Ryan, that that side of it isn't under the Health Services Administration; it is administered by the Department of Welfare.

CONGRESSMAN RYAN: It's a health program and I'm sure, Dr. Brown, that you have great influence on the policy of the City of New York in this area. A recommendation from you will carry great weight.

DR. BROWN: I want to persist in this because it's an important point. We're having great administrative difficulty because this program is administered by two departments. Under the Federal law, it is not possible to put it in, wholly, in our department...

CONGRESSMAN RYAN: I'm not arguing that. I'm not arguing where it's put. I'm arguing the identification of the person who is carrying the card should not have to display the fact that it says, "Department of Welfare." It could be coded so that could be removed.

DR. BROWN: I agree with you quite completely and if I were able to order it removed, I would.

CONGRESSMAN RYAN: I hope you will recommend it. I realize you cannot direct it.

MR. MULLANEY: This is my baptism of fire. I was appointed just two weeks ago. But I will say this. I will report back to Commissioner Ginsberg your thinking, Congressman, and apparently the thinking of the panel. And, if it is at all possible to make that change I'm sure he'll see to it. (Applause)

CONGRESSMAN GILBERT: This is a very good example of why it was a good plan for United Neighborhood Houses to have this meeting.

What Else

Faster Payment to Doctors

ARTHUR COHN: (Executive Director, Grand Street Settlement)

I don't have to tell you that not every doctor and not every dentist in the city is registered in this program. And the delays, the long delays in reimbursement are discouraging a great many from coming in. Furthermore, many of those who are in and who have not been reimbursed are refusing to take additional patients.

DORIS HARRISON: (Parent, Child Development Program, Manhattanville Community Centers)

I hope you all will pay these doctors so I can keep my little child's health going on.

MRS. ANNETTE LEONARD: (Head Start Parent, East Side House)

I would like to ask the legislators to try and arrange it so that the doctors, the pharmacists and the dentists will be able to get their money more promptly. So that whenever we call for a doctor or a dentist, or go to the pharmacist, we will not be refused because they have not received their money.

DR. R. FISHER: (Dentist, East Harlem)

No one, no business, no individual, no public administrator could possibly go on...can go on performing his daily duties if he was told he's not getting paid for seven months. This is the position that the health practitioners in the City of New York are in.

MR. MULLANEY: (Medicaid Administrator, New York City)

I'm certain that I speak for the State and City when I say that we are most appreciative of the fact that the medical profession has gone on with us through this difficult period of tooling up. I would like to point out the fact that as far as Medicare was concerned, there was a year in which there was an opportunity to experiment, make up forms, to determine procedure and do what the baseball people say--have spring training. In Medicaid, we had none of those opportunities; we had to start immediately. Dr. Fisher should be glad to know that there has been a contract made with the Systems Development Corporation by our Department of Welfare to speed up and automate the payment of bills. It is definitely contemplated that on or before September the 1st, all bills will be paid in full within sixty days.

Needs Doing

Intensive Publicity

MRS. PATRICIA KORTON: (WMCA People's Lobby)

I am co-chairman of WMCA's People's Lobby, which since the end of January has been answering questions on Medicaid...What we find is that people have no idea (a) that the program exists and (b) that it applies to them--especially people in the $6,000-$8,000 income bracket. There has been so very little publicity on the thing.

DOROTHY HARRISON: (Parent, Bloomingdale Family Program)

A friend of mine's child was hospitalized and she's worrying about the bill she has to pay and I asked her had she heard of Medicaid. She didn't know anything about Medicaid. So I think it would be a very good idea if they would try to get literature in the factories about Medicaid.

MRS. BARBARA HILL: (Registered Nurse, Head Start, Union Settlement)

When Medicaid first started, I conducted a few meetings and informed our families in Head Start, plus the families in the community, on Medicaid--what it was about and what it was offering them. Even our Welfare recipients didn't know why they were receiving these cards and what to do with them.

MRS. BEATRICE GOLDBERG: (Director, Medicaid Alert, Urban Opportunities Program, Goddard-Riverside Community Center)

Since the beginning of March, I regret to say that we have submitted 475 completed applications. I think we could have done four or five times that many had certain conditions been met.

In the first place, it was only the day before yesterday that the Medicaid Alert office sent us posters to distribute throughout the neighborhood. We still haven't gotten any flyers from them. We've produced some home-made documents that aren't really terribly good. We've never gotten any identification badges or buttons or what have you.

I think that if the city and the state and Medicaid Alert would really have an intensive campaign that would reach out, both in Spanish and English...if we could have an intensive publicity campaign through the press, through sound trucks, through radio and television programs, that we'd do a bang-up job before June 30th, which is the termination date of our program.

Lists of Practitioners

MR. BERGER: (Aide to Congressman Bingham)

We have found enormous problems in our district with people who cannot get either doctors or prescriptions filled, because people are resisting coming into the Medicaid program.

MRS. ANNA YANCEY: (President, Alfred E. Smith Tenants Association)

We don't have the places to direct these people, such as the name and addresses of doctors and whatnot to receive this attention after they fill out their Medicaid application and receive cards.

MRS. BARBARA HILL: (Nurse, Head Start, Union Settlement)

What I did with some of the mothers who had gone to doctors who were accepting Medicaid card holders was to get their names. And I asked a number of other doctors and dentists and pharmacists in the area would they accept people with Medicaid cards.

Then I made up a list of my own with the addresses and telephone numbers of different medical services in our area.

This is one of the things I felt, you know, that should have been done in the beginning.

COMMISSIONER LOUCHHEIM: I'd just like to say, on behalf of Dr. Brown who isn't here yet, one of the things that the Health Services Administration is going to be doing in the very near future is making a list of all of the doctors who agree to participate, so that those who have Medicaid cards can go to them.

Simplified Application Forms

EDWARD SHEA: (Senior Citizen, Forest Neighborhood House)

I think the information pamphlet is too complicated for the average person. I think I'm fairly intelligent, but it took me... hours...before I could get its substance.

MRS. BEATRICE GOLDBERG: (Director, Medicaid Alert, Urban Opportunities)

If you do persuade somebody to let you come in and fill an application form, it's like pulling teeth, if you'll pardon the expression, to get them to complete the necessary information.

It's extremely difficult for anybody to get eight pay stubs and when it gets to that point in filling out the application they say, "Forget about the whole thing," "We're not interested." "Don't bother us anymore."

MRS. MARY ECCLES: (Program Director, Bloomingdale Family Program)

The forms have proven to be quite complicated. There is general confusion regarding Medicaid and Medicare services, and we do feel that there is not enough literature available to the general public about the program.

PRISCILLA WEBB: (Director, Head Start, Grand Street Settlement)

At this point we have, aside from our jobs as Head Start workers, been able to enroll some two-hundred or more people in Medicaid. But, I am finding problems. And I'm having problems.

Some of the problems are that after we spend the time and we go through and consider the application and all the time it takes to do this, we then send in our applications and we're finding minor things that cause them to be rejected. One thing that has caused many rejections is the lack of people being able to get an eight-week pay statement. We have suggested that the Department of Welfare should accept the W-2 form from last year. And, they've given us reasons why they cannot accept this statement.

The next thing in rejections: We have some parents who have not been able to produce a record of their medical expenses for last year, or for this part of the year, because they have to use the out-patient health clinics and do not get bills. And when they send in the applications, they get them returned because they have not proven that they have medical expenses.

The most recent rejection we had, this morning, was of a family which did not have a birth certificate or, at least, did not have one at the time when the investigator came out to check. How much that means, we still have to find out.

Now I don't want to be negative about it; I think it's a very good program. But I do feel that we need all the help we can get to eliminate these problems in Medicaid.

I'm suggesting that you develop something that we call a snag book. The reason we call it a snag book...because we've never learned that these are the reasons we can't enroll people in Medicaid until long after the application. Thirty days, and sometimes more than thirty days, have gone by until we find out - "You should have said, 'I certify such and such'." And I feel you should do something about that.

ARTHUR COHN: (Executive Director, Grand Street Settlement)

For some, there is a language problem. And this would hold for our Spanish-speaking neighbors. For a great many of the others, the very appearance of the form and the many questions that have to be answered are a stumbling block...If the form cannot be simplified, or if there cannot be a form in Spanish for particular technical reasons...perhaps it is necessary then to provide more interpretive help, more counseling kind of help if we really are interested in having people register for this service.

Information for Users

MRS. KORTON: Even the people who are eligible and who do receive their cards, very often call us and say, "Now what? All I got in the mail was a card." They don't know what they're entitled to; no booklet apparently comes with the card...

MRS. MARILYN FARMER: (Community Aide, Forest Neighborhood House)

We have one member of our group--she's a senior citizen, who had gone to a dentist. The dentist had done extensive extraction work, in fact he removed more than half the teeth in her mouth. Then he found out he could not do any further dental work, he could not put in a plate or a bridge or any form of corrective work until he had gotten approval. The woman came to us in complete tears.

Part of our feeling is that more information should be put out both to the professional people and to the clients to know just how much work they can expect to be done, so that even if the dentist didn't know, the client would be aware of it and know enough to tell the dentist, "Well, I think you'd better do some checking."

MR. MULLANEY: The Department of Welfare, at its Medicaid headquarters at 330 West 34 Street now has a battery of phones manned by interviewers and interrogators at all times available; twenty-five lines being fed in through a board that will provide the information. (594-3050)

The calls do not go through a switchboard; when you call the number, the next voice you will hear will be a person who can directly answer the question.

Allow the Aged to Keep Savings

CAROLYN NASH: (VISTA Worker, Bronx River Community Centers)

One problem I've run into is with registering senior citizens. They live off of Social Security. But they have bank accounts, maybe a few thousand dollars. They have no other liquid assets. But we all know that living off of $80 a month, and with chronic-type ailments like heart disease and asthma, that no matter what size your bank account is, a sickness might come along and completely destroy it. And having to tap it every month because you can't live off the resources of Social Security. So I'd like to get across a point to someone, maybe that they should give more consideration to the eligibility standards where senior citizens are concerned.

UNITED NEIGHBORHOOD HOUSES
114 East 32 Street, New York, N. Y. 10016 • LE 2-7360

ITEM 4: INFORMATION FROM UNITED COMMUNITY HOUSES OF NEW YORK CITY

The following questions were sent to member organizations of the United Community Houses, New York City, on October 11 by Miss Helen Harris*

a. What effect has the $11 clinic charge had upon availability of health services for the elderly in your service area?
b. Have the elderly in your area expressed concern about having to declare the amount of their savings in order to qualify for Medicaid? What action do you recommend that they take?
c. If a hospital clinic serves the elderly in your area, what are their experiences in terms of: the average time spent in the waiting room, effectiveness of treatment, and accuracy of diagnosis?
d. Have limitations on dental services under Medicaid caused problems?
e. How effective, in your opinion, is the literature issued to explain the Medicare and Medicaid programs?
f. What, in your opinion, would be the effect of an increase in the Medicare, Part B, premiums? It has been suggested that the monthly premium may be increased from $3 to as much as $4.50, depending upon Congressional action on the Social Security Amendments of 1967.
g. Do you believe that many elderly individuals react negatively to the welfare context into which—as its critics complain—Medicaid has been put?
h. Would you say that the elderly feel generally less satisfied with health services now available to them, or more satisfied?
i. Do you find that the elderly have difficulties in obtaining services of private physicians under Medicaid?
We would like to have any other observations you may wish to present to the Committee.

Several replies follow:

LENOX HILL NEIGHBORHOOD ASSOCIATION, INC.,
New York, N.Y., October 16, 1967.

DEAR HELEN: In reply to your memorandum of October 11, 1967 in regard to information for testifying before the Senate Sub-Committee on Health of the Elderly, we submit the following comments, based on information we secured from the older adult members of the Settlement during our Medicaid Campaign in June 1967, during our registration interviews this month, and in direct response to the questions you posed.

The elderly population we serve at Lenox Hill is primarily of Central European, German, Czech and Hungarian origin, with some Irish and Italian. Many of them are still living in the same tenement apartments into which they moved when they first came to this country. Many are fiercely proud and independent and refuse to apply for OAA or welfare supplementation although managing on monthly social security payments considerably below welfare standards. The average social security benefit is under $70.00 a month. Yet only 12 out of 224 of our members receive any welfare assistance.

We have many members, over 72 years of age who now receive $35,00 a month social security, never having worked at all or having worked in "uncovered employment." A high percentage of our members spent their working years in service jobs. They manage without relief supplementation only because their rents are still low. They resist moving to public housing because higher rents there would necessitate their applying for welfare aid.

Although almost all of our elderly members are on Medicare, very few who are not on welfare have applied for medicaid. Many are not eligible because their dwindling savings still exceed the maximum savings Medicaid allows.

For example, one woman has $6,000 still in savings but only receives $44.00 a month in income. By careful managing, she estimates that her savings should last her about 8 years if she does not have any medical bills to pay.

To reply to your questions:

a. The $11.00 clinic charge has deterred many of the elderly who formerly utilized clinic services regularly before Medicaid, and who are not eligible because

*See testimony, p. 445.

of savings for Medicaid, from going to clinics unless they are seriously ill. They no longer go for check-ups or regular specialized clinic visits.

b. Yes, the elderly feel it is unfair to have to declare savings and also that the limits set on savings are unreasonably low. When one is dependent on utilizing a portion of one's savings each month for bare subsistence; one is hesitant to draw further on dwindling savings even for medical expenses.

c. Our members' experiences over the years at New York Hospital and Lenox Hill Hospital clinics have on the whole been satisfactory. Those attending Roosevelt Hospital and Metropolitan Hospital have no complaints regarding waiting time, effectiveness of treatment or accuracy of diagnosis.

d. As few are on Medicaid, experience regarding dental service has as yet been limited and we therefore have no pertinent information to share.

e. The effectiveness of the literature on both the Medicare and Medicaid programs is questionable in so far as its comprehensibility to those eligible for the services are concerned. Many of our members do not read well, and even those who do still have questions to ask and need more than just the literature for understanding eligibility, procedures and services. Both our group workers and caseworkers are besieged with questions in regard to both programs.

f. For the Lenox Hill elderly, any increase in Medicare, Part B premiums would be a real hardship. As previously stated many have such small income that any more deducted would make it an almost impossible situation for them. Eighteen dollars ($18) a year seems a gigantic sum to them.

g. Many of the elderly in our neighborhood react very definitely negatively to the welfare context into which Medicaid has been put. As previously stated, there are many individuals in this group who refuse to have anything to do with welfare even though patently eligible.

h. I would say generally more satisfied (mainly Medicare experience).

i. This has not been a significant problem among those on Medicaid in this neighborhood.

I hope this will be helpful.

Cordially,

Mrs. Celine G. Marcus,
Associate Executive Director.

From Mrs. Agnes Bryant—Willoughby House

a. The $11 fee caused most of our older people to register for Medicaid.

b. Yes. There are many who have refused to register for Medicaid rather than declare their savings. I think the limit on savings accounts should be lowered.

c. Yes. Must wait four to five hours, the doctor takes about five minutes to diagnose their ailment and tells them to return in about two months. They also have to wait too long for the prescription to be filled at the clinic.

d. Yes. Some dentists refuse to take people on Medicaid because of the slowness in receiving reimbursement.

e. Some senior citizens can't read; therefore, someone should interpret the literature for them. This we have tried to do.

f. Many are already concerned about the $3 that is presently being deducted from their checks.

Many who receive partial assistance from the Department of Social Services were greatly relieved when notified that the Department would pay the $3 fee.

g. Yes. Many of the older people resented it as long as it seemed to be part of welfare, but after it was explained to them they felt better.

h. Mixed reaction.

i. Very difficult for them to find doctors who will accept patients on Medicaid.

Henry Street Settlement,
New York, N.Y.

Memorandum

To: Helen M. Harris, Executive Director.
From: Maria Kron, Director of Services to Elderly of Henry Street Settlement.

I have attempted to answer the questions based on our experience and knowledge of our membership of 400 elderly neighbors and other elderly persons in our community.

a. The effect of the $11.00 clinic charge has been to send some of the elderly to private doctors. Their feeling was that it would be cheaper and nicer to have a private doctor. However, some of the private doctors in the community have raised their fees.

b. These are the elderly people who are afraid that they do not qualify for Medicaid because of the amount of their savings. Their greatest fear is that somehow these savings would be taken from them. We recommend that they apply for Medicaid in any case and let the Medicaid administration decide if they qualify.

c. Gouverneur Clinic serves our area and our elderly neighbors say, that the "services and treatment are just as good as ever."

d. We have gotten reports that many of our elderly neighbors have been able to receive dental services under Medicaid.

e. I do not honestly think that Medicare and Medicaid literature is not easily understood by the average person.

f. Elderly citizens are very upset at the suggestion that the monthly Part B premiums will be increased. A study of our membership revealed an average income of $65.05 a month. It is obvious, that they need a substantial increase in income rather than a decrease.

g. Many elderly individuals react negatively to the welfare context into which Medicaid has been placed. They complain bitterly that they spent a lifetime of struggling to live on incomes smaller than welfare standards in order to avoid the stigma of "Relief." It is therefore, hard to accept the welfare implications of Medicaid. Many had to be talked into applying for Medicaid because of this, many will not apply for this reason.

h. The elderly feel generally more satisfied with the health services now available to them. The combination of Medicare and Medicaid has made it possible for them to receive additional services such as Dental, Optometry, etc.

i. During the past year many of the difficulties in obtaining the services of private physicians in our community seem to have been more satisfactorily resolved.

East Side House Answer

a. No effect on people on Welfare. Those not on Welfare can pay less to go to a private physician.

b. Yes, because of embarrassment at not having much savings and in some cases it doesn't apply because they have no savings at all.

c. Two clinics serving this area:

Lincoln—very poor, overcrowded, spend all day waiting for service. Has become even more crowded since Medicaid.

St. Francis—in October a new program devoted only to senior citizens on Monday, Wednesday, and Friday from 8–10 a.m., has helped alleviate poor service. Before that time, very crowded. The complaint with this new program is the time limitations.

d. Not enough dentists for the number of patients in the area.

e. Information seems to be repetitive and difficult to understand. There is a health center which helps the elderly fill out the applications. The benefits are not described fully enough and as a result, for example, the 20 days free nursing care upon leaving a hospital, people don't take advantage of and as a result require additional hospitalization that may have been avoided had they had the nursing care, after leaving the hospital the first time.

f. It is a hardship on people with limited income. Also, expressions made that $50 deductible should be lowered.

g. People want it and everybody generally is gaining something so that they don't care whether or not it's under welfare. However, on the card itself it says Welfare Dept., and some people think that this means you must be on Welfare to be eligible. Also, there is a long waiting period (as long as 4 months) before people are getting their cards. In isolated cases, where there hasn't been a group presentation, people are hesitant because of the welfare context, generally because they don't understand that Medicaid is open to both Welfare and Social Security recipients.

h. People are generally using it a lot and it has helped them. However, there is a lot of complaint over waiting in clinics and also that doctors on Medicaid are letting their offices run down.

i. Doctors complain about not being reimbursed and can't take Medicaid patients because of that. Also, because of the clerical work which results in their having to hire additional personnel to process the forms which increases their costs.

BRONX RIVER DAY CENTER FOR OLDER PERSONS,
Bronx, N.Y., October 16, 1967.

Miss HELEN HARRIS,
Executive Director, United Neighborhood House of New York Inc.
New York, N.Y.

DEAR MISS HARRIS: In response to your questions on Medicaid, the following situations have been found in working with our members:

a. 100 per cent of our members have Medicare and approximately 75 per cent Medicaid. Therefore, the $11.00 clinic charge has had little or no effect upon them.

b. In the beginning phase our members hesitated undergoing the means test. This was counteracted by a speaker from Department of Welfare and buzz sessions to discuss a program and its benefits.

c. There is a definite problem around the area of hospital clinics. The most difficult problem has been all the time spent in the waiting room and accuracy of diagnosis. It is the feeling of many of our members that they are shunted aside and little attention is paid to their complaints.

d. The limitations on dental services under Medicaid has caused no problems.

e. The literature is very technical and has little effect. Another factor that must also be considered is that approximately 90 per cent of our Senior Citizens are illiterate. Therefore booklets, posters, and leaflets should use diagrams to present the program.

f. Any type of increase of Medicare would cause a hardship on our members because of the fixed income.

g. Medicaid under Welfare has caused some negative reaction. Because of Welfare, a small percentage of people refuse to join who are in dire need of the benefits of this program. We have also found that the private insurance companies has been advising their enrollees not to join Medicaid. While there has been some negative reaction, there is a much greater degree of acceptance of the present structure.

h. Senior Citizens are satisfied with the service received, but in our community of approximately 100,000 there is no clinic or hospital which results in long periods spent traveling to hospitals out of the area for services. This seems to be our Senior Citizens greatest complaint.

i. Most of the neighborhood physicians are registered under the Medicaid program.

I hope the above will be helpful in your testimony before the commission.

Yours truly,

FRANKLIN WHITE, Jr., *Director.*

TELEPHONE CONVERSATION WITH MRS. ALMADOVAR, BRONX RIVER, RE QUESTION NO. 2 ON QUALITY OF DENTISTRY AND DENTURES, NOVEMBER 17, 1967

One of complaints is color of teeth which is very different from the teeth that clients have already. "Dentures look like china." Some teeth are larger than others and patients have to have them filed. One dentist refused to file teeth—said not necessary.

Teeth are too yellow.

Dentists don't try to save natural teeth. Extract teeth that clients feel could be saved.

Takes too much time for approval of treatment and when client changes from one dentist to another.

Dentists refuse to take some people on. Reason—too crowded.

Standards (Mrs. A. feels) have lowered since advent of Medicaid.

ITEM 5: ADDITIONAL REPORTS SUBMITTED BY MRS. SUSAN A. KINOY*

EXHIBIT A: A REPORT ON "PROMOTING HOME HEALTH AND SOCIAL SERVICES TO NEW YORK CITY'S AGING"

Funding for a three-year project, starting February 1st, 1967, entitled "PROMOTING HOME HEALTH AND SOCIAL SERVICES TO NEW YORK CITY'S AGING," has been awarded to the Citizens' Committee on Aging of the Community Council of Greater New York by the New York State Office for the Aging under Title III of the Older Americans Act.

The goal of this city-wide project will be improving and prolonging the independent living of aging persons in their own homes. It will focus on the development of home health services now lacking, through consultation to neighborhood groups and coordinated community-wide action. It will stress improvement of the aging's dire housing conditions. It will be concerned with improved utilization of existing home health services through expanded information-referral-counseling services and better inter-agency coordination.

ADVISORY STRUCTURE

Maximum citizen involvement will be sought—with special emphasis placed on participation of older persons—in planning of program and influencing public policy. A first step in this process is the development of a *Citizens' Advisory Committee.* The details of the project design and policy, including evaluation, will be developed by the project director, the research associate and the *Citizens' Advisory Committee.* Sub-committees to concentrate on special problems will be created when needed. The project will report to the Citizens' Committee on Aging of the Community Council of Greater New York.

HOME HEALTH SERVICES

This project centers on all existing medical and related social services available to and focused on the needs of the aging in their own homes and neighborhoods. Personnel providing these services include home health aides, homemakers, housekeepers, escorts, friendly visitors, information and referral personnel, case aides, outreach workers and block workers.

These services are in extremely short supply.

The project will aggressively stimulate and promote new and creative neighborhood-based home health services. It will attempt to expand services currently offered by traditional and new community health and welfare agencies. It will seek to improve inter-agency coordination on a local and city-wide basis. It will encourage older persons to work with other members of the community and professionals to plan and promote such services and to take social action to obtain needed legislation or funding.

HOUSING

Basic to the elderly's utilization of a spectrum of home health and social services is radical improvement of sub-standard housing and new housing of many varieties suited to the needs of older people. Therefore, the project will seek ways to assist aging in sub-standard housing by making resources known to the elderly in respect to housing complaints, home-improvement benefits, tenant-rights, benefits to elderly home-owners, relocation, rent subsidies, applications to housing projects, etc. It will sort out and identify the most promising immediate and long-range paths to new housing. This will include stimulating agencies and private investors to utilize existing public financial aid programs for non-profit and limited-profit housing. It will give consultation to and mobilize support for sponsors who are attemptng to construct housing for the elderly. It will stimulate and organize social action among the community and especially among the aging to back new legislation or increased funding for additional housing units.

INFORMATION-REFERRAL-COUNSELING SERVICES

Information-referral-counseling services will be another component of this project. While providing information to elderly persons seeking help, the main purposes of these procedures will be: (1) to ascertain whether or not information given is acted upon and whether referrals "stick" and are useful; (2) to pinpoint trouble spots by geographic area and by types of needed service; (3) to

*See testimony on p. 449.

refine or develop techniques for improved information and referral; (4) to assist neighborhood based efforts to provide information and referral and to create new or improved home health services.

In order to enlarge the documentation of aging's needs and gaps in community services, special procedures will be instituted by the Community Council's *Information Bureau* for reporting inquiries involving home-health services and living arrangements which staff is handling. This will involve documentation of problems and needs presented and information and consultation given both to clients and to other agencies in an effort to meet client needs.

To supplement the work of the *Information Bureau*, selected cases in the project concentration areas will be referred to project staff members for counseling-referral and follow up. Volunteers will be recruited and trained to assist in this work.

Publicizing this area of activity will be phased in relation to the development of new or more effective services.

In order to focus most effectively on the development of home health resources, both city-wide planning and city-wide activities as well as consultation to and development of programs with neighborhood groups and organizations will be undertaken.

CITY-WIDE ACTION

City-wide ideas and activities to expedite housing and health services will be pursued on a comprehensive basis. For example, plans to make more home health aides available under medicare and medicaid; centers for training, supervision and employment of part-time housekeepers or homemakers not available under medicaid or through existing agency structures—a major unmet need; stimulating city-wide action around a selected piece of city, state or federal health or housing legislation.

During the first year, the specialists in housing and home-health services will produce written aids to assist all groups providing direct services to older people and written guides for groups who are initiating service projects or planning to construct housing. These will range from "how to do it" brochures to models for project proposals. During the second year, the housing and home health specialists will join the community organizer and the information and referral workers in the field and will provide consultation and stimulate resource development.

PILOT LABORATORIES

One or perhaps two pilot stations will be initiated in areas of high concentration of aging but with differing ethnic or housing characteristics, as laboratories for intensive activity. In each of these stations a project staff member will work with neighborhood groups and agencies to seek out community needs and to develop or advocate new or improved or better coordinated resources and services to meet those needs. Information and referral services, out-reach programs and self-help and the training of volunteers will be some of the keys to these out-post programs.

Anticipated Project Benefits

It is hoped that this project will result in richer community resources in housing and home health services for the almost one million persons 65 and over in our city through: improved and new techniques for information and referral; reduction of fragmentation of service and improved interagency cooperation; methods to achieve greater involvement of the aging in planning; utilization and integration of past experimental procedures; creative use of volunteers, including progression of responsibility.

Staff

The staff will consist of nine professionals—the project director, home health specialist, housing specialist, community organizer, three counseling and referral specialists, a research associate and a research assistant. They will be assisted by secretarial personnel and volunteers.

EXHIBIT B. HOMEMAKER-HOME HEALTH AIDE AND RELATED SERVICES EXISTING PATTERNS AND PROJECTED PLANS

I. BASIC PREMISES AND PURPOSES

Homemaker-home health aide and related services (i.e. homemakers, home-health aides, housekeepers, friendly visitors, etc.) are in extremely short supply. This Project, therefore, is devoted to promoting the expansion of all such

services to assure that the aging have the assistance which they require for their maximum independent living in the community and prevent or postpone institutionalization. In order to insure such expansion the resources of both public and private agencies must be focused and mobilized. There should be creative use of all financial resources provided by Medicare, Medicaid, O.E.O. and other federal and state funds as well as private philanthropy. Home-health services should be planned on a comprehensive and coordinated basis, serving the total family group and assuring continuity of service, (as for example, from Medicare to Medicaid funding preferably with the same personnel.) It is essential that high standards be established and maintained for the recruitment, training and supervision of all personnel.

This Project, in line with the national trend, stands for a generic service so that a carefully selected, trained and supervised homemaker-home health aide can assume homemaking responsibilities and/or, personal care as needed, depending on the composition of the family unit, the health needs and the medical and social plan.

II. HOMEMAKER-HOME HEALTH AIDE AND SIMILAR SERVICES NOW AVAILABLE FOR OLDER PERSONS IN NEW YORK CITY

a. *The Voluntary Non-Medical Agencies Providing Homemaker Services*, as of January 1, 1967 in the five boroughs, had a total staff of 310 full-time and 25 part-time homemakers. These staffs are well trained and supervised by social workers and frequently work in cooperation with the voluntary Visiting Nurse agencies. These staffs are available not only for the aged but for families with children, which often get priority. Services are of high quality but are generally provided only when there is ongoing casework service and the working out of a long-range casework plan. The service often includes personal care for which there is some training. The majority of cases have a medical component. Several voluntary agencies permit their homemakers' services to be purchased by the New York City Department of Social Services, thus decreasing the number of homemakers available for the aging not receiving D. W. assistance.

b. *The New York City Department of Social Services* employs 389 homemakers and plans to expand to about 800 in the next two years. Almost one-half of the present staff are being used for the aged. Only the aged receiving public assistance, (about 4% of the City's elderly,) are eligible. The D.S.S. homemakers are carefully selected, trained and supervised, and provide homemaker services and personal care as needed.

c. *The Voluntary Nursing Agencies—The Visiting Nurse Services of New York, Brooklyn and Staten Island* now employ about 125 home health aides. Home health aide service is provided when the patient meets the requirements for service by a home health agency under Medicare or Medicaid. That is service is provided in conjunction with nursing care and responsibility for supervision of the home health aide is by a public nurse. The medical plan may include some homemaking aspects.[1]

d. *The Division of Medical Care of the New York City Department of Social Services*, now operates under the same conditions as title XVIII.

e. *The Department of Hospitals* hires, on an hourly basis a considerable number of untrained and unsupervised housekeepers who give service to a patient who is on Home Care in some municipal hospitals. These housekeepers are selected from a roster maintained by the Home Care Administrator, the Social Service Department or by clerical staff. Quite often this service is undertaken only until a more highly qualified homemaker or home health aide becomes available. The process of providing a more qualified home health aide may now be expedited since, as of the latter part of June, 1967, the Visiting Nurses will be able to evaluate the patients' needs *before* discharge from the hospital.

f. *Community Health and Mental Health Centers* in new and experimental programs have been recruiting and training home-health aides, family health workers and other personnel with a variety of titles and job definitions. The sources of funds have been mainly OEO. We do not have exact figures but the total numbers are small.

g. Two *Commercial Agencies*, directed by social workers serve the metropolitan area. They charge fees to both employers and employees for the provision of homemakers, home-health aides, nurses and attendants.

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[1] For definitions of terms used in Medicare and Medicaid legislation, see H.E.W. State Letter 910.

h. *Housekeepers* or domestic service, when part of a casework plan, are sometimes provided both by voluntary homemaker agencies and the Department of Social Services by giving financial assistance to the family for this purpose.

i. *Subcontracting* for the services of homemakers or home health aides is an expanding pattern between agencies. For example, a number of hospitals secure homemakers from voluntary agencies. The Department of Social Services purchases homemakers from several voluntary homemaker agencies. The Visiting Nurses are working on plans to purchase the services of homemaker-home health aides from voluntary social agencies.

III. MISCELLANEOUS SERVICES AVAILABLE FOR THE AGED, HOMEBOUND

Friendly visiting, shopping, escorting to clinics etc. are provided under a variety of auspices, churches, fraternal groups, day centers, block workers in community action programs, agency volunteers, etc. However, these services are fragmented and meet only a very small part of the need. Each group tends to serve only its own membership.

IV. PROGRAM GOALS

The shortage of adequate homemaker-home health aides and related services for the more than one million aging persons in New York City is so critical that bold and creative approaches must be undertaken to meet this need. This shortage is not sufficiently visible because the effective demand for service is much less than the actual need. Both professionals and the elderly fail to request services either because they don't know resources or they have been discouraged by repeated failure to secure help when requested. Most of the following program ideas involve substantial or radical changes in agency function. In addition, the Project is calling for long-range legislative planning.

A. Proposals Affecting Agencies

1. *Department of Health*

We propose that the Department of Health become a certified Home Health agency, providing bedside nursing service when necessary and public health nursing responsibility for supervision of home health aides. This would make possible contracting with the Department of Social Services, Division of Homemaker Services or the voluntary homemaker agencies to provide the homemaker-home health aides. It might also be possible for the Department of Health to employ, on an experimental basis, its own staff of home health aides. Such additional responsibility for the Department of Health, Bureau of Public Health Nursing would, of course, require re-evaluation of the total services for which the Bureau is responsible and the setting of priorities. This proposal is in the keeping with new patterns of community cooperation to utilize the resources of Medicare and Medicaid which are developing all over the country and in many counties in New York State, thereby making possible the rapid expansion of services.

2. *The Department of Social Services, Division of Homemaker Service*

We recommend—

a. That the Department of Social Services work with the Department of Health as described above and thereby become eligible to provide homemaker-home health aides for Medicare patients with reimbursement at full "reasonable charges."

b. The expansion of homemaker services, even greater than that already planned, to meet the needs of the increasing number of aged in the community. We are especially concerned about the large number of the aging for whom medical problems may be secondary to feebleness and social problems due to age.

c. As a long-range goal, the Department of Social Services, in cooperation with the Department of Health, Bureau of Public Health Nursing, assume the responsibility for provision of homemaker-home health aide services to the medically indigent, not just to the aged receiving public assistance. This would be financed through Medicaid. This would mean that eventually there should be one department providing homemaker-home health aide services within the New York City Department of Social Services.

3. *Hospitals*

We recommend that some hospitals, with careful community and administrative planning, employ their own staffs of home health aides and provide for the necessary bedside nursing and public health nursing supervision of the aides. Thirty-three hospitals have some type of Home Care program and are already certified as Home Health agencies.

4. *Community Health Centers*

We recommend that Communty Health Centers which are hospital based, with careful community and administrative planning, expand existing staffs of public health nurses and develop new programs for homemaker-home health aides and other therapeutic services. Since the Office of Economic Opportunity and the Department of Health, Education and Welfare, now on a federal level, have contractual arrangements for comprehensive care, there are likely to be more funds available for training, demonstration and ongoing services. Qualifications and training of staff should have the long-range goals of reimbursement under Medicare and Medicaid.

5. *The Visiting Nurse Agencies*

We hope that the three Visiting Nurse agencies will continue to expand their excellent services to the entire community. Cooperative contractual arrangements with the non-medical voluntary agencies will make possible increased provision of homemaker-home health aides under both Medicare and Medicaid.

6. *Non-Medical Voluntary Homemaker Agencies*

We propose that the non-medical voluntary agencies—

a. Contract with voluntary and public certified Home Health Agencies so that their homemakers could, when appropriate, become home health aides reimbursed under Medicare and Medicaid. Staffs of voluntary homemaker agencies could thus be greatly enlarged.

b. Creatively expand their services to meet the psycho-social and physical needs as well as the medical needs of the elderly homebound. Proposals for increased homemaker-home health aide services which are not covered by Titles XVIII and XIX or private philanthropy, should be presented to the Albany planning bodies now making provisions for the utilization of Hill-Staggers funds.

7. *Community Progress Centers and Community Corporations*

We propose that the Community Progress centers and Community Corporations (now almost totally youth oriented) use their staffs imaginatively on behalf of their communities' elderly. This Project will encourage the Community Progress Center leadership to use their block workers and other staff, for case-finding, information and referral, escorting, friendly visiting, "meals-on-wheels", and employment of the aging in the Community Progress Center structure, in the community and at home. Finally, it will urge that the aging be brought into the leadership of the Community Progress Centers and Community Corporations.

B. Legislative Objectives

Several areas for legislative action have emerged from our activity to date. These action proposals will be amplified during the next few months.

a. We will work towards generic homemaker-home health aide services which are geared to meet flexibly the psychosocial and health needs of the aging and provide continuity of service. Legislation must provide homemaker-home health aide services of good standards for all the elderly.

b. We will propose amendments to the social security legislation to make it more workable and remove hurdles towards fuller utilization. Amendments should be concerned with such items as: increased numbers of reimbursed visits, removal of deductibles under Medicare, etc.

c. This Project is concerned with the implementation of national programs on the local level. We will support the new patterns of cooperation between various federal agencies: Office of Economic Opportunity, United States Public Health Service, Department of Health, Education and Welfare, etc.

We should influence state planning under the Hill-Staggers legislation to guarantee comprehensive planning for the home health needs of the elderly.

d. We will submit state and local legislative proposals when appropriate.

ITEM 6: ADDITIONAL STATEMENTS SUBMITTED BY DR. GEORGE HIMLER

EXHIBIT A. STATEMENT AT THE HEALTH PLANNING FORUM, SEPTEMBER 7, 1967

My name is George Himler, M.D. I am Chairman of the Coordinating Council of the five county medical societies of New York City, whose aggregate membership is approximately 17,000. I am pleased to have this opportunity to present the views of the Council on the type of organization that is to be given the responsibility for comprehensive health planning in New York City.

I have heard two major alternatives proposed. The first is that the Mayor appoint a Health Planning Agency with the Health Services Administrator as chairman and with various other members from the Boards of Health, Hospitals, Community Health, etc.

The Coordinating Council is strongly opposed to this choice for several reasons. This planning agency, by the nature of its composition, would be dominated by the Health Services Administration which, parenthetically, is not a permanent part of the municipal government, since it has not been approved by the City Council. The Health Services Administration has been in existence for less than two years and has not demonstrated the competence in the field of health planning that would justify its being given control of the sole planning agency for the City.

The proposed planning agency would not have the broad community representation that is called for by the federal eligibility requirements. The Coordinating Council does not agree with the contention of the Health Services Administration that this deficiency in representation can be compensated for by a broadly based advisory committee. Our experience has been that the Health Services Administration is not receptive to advice from advisory committees or any other source. Its direction of the Medicaid Program, before it was relieved of that responsibility, was characterized by unilateral and often arbitrary decisions and an astonishing degree of resistance to advice or persuasion. This is not the type of approach we interpret P.L. 89–749 to intend. Finally, as a general concept, it appears to us that no government agency, at the local or county level, should be given the direction of a planning program that should ideally be a community rather than a government effort.

For these reasons, we strongly advise against the designation of a Health Planning Agency with the structure recommended by the Health Services Administrator.

AGENCY FOR HEALTH PLANNING

The second alternative that has been brought to the attention of my group is that the Health and Hospital Planning Council of Southern New York, Inc., be charged with comprehensive health planning for New York City. As a member organization, we are aware of the excellent staff the Planning Council has developed for research and analysis in the health and hospital field. The Planning Council's competence is unquestioned and its facilities will be an essential element in the program, regardless of the agency that is given overall responsibility for it. In spite of these and other positive values, the Coordinating Council recommends against the designation of the Health and Hospital Planning Council of Southern New York as the planning body.

As presently projected, the agency would have no specific authority but would merely develop recommendations and policy for implementation by appropriate government subdivisions. This automatically interposes checks and balances between formulation and implementation that we consider highly desirable.

The original scope of the Health and Hospital Planning Council's activities was exactly of this research and advisory nature until it was given virtually complete control over the construction and modernization of health facilities in 1964. Many persons, both within and without the ranks of medicine, consider that the power thus vested in the Planning Council is already excessive. The perspective of history leads us to believe that what is now being created purely as a planning body, will ultimately seek and be granted authority. The Coordinating Council does not believe it wise or prudent to concentrate such pervasive influence in any one agency, regardless of its competence.

The argument has already been advanced that the Health and Hospital Planning Council could most efficiently conduct the planning effort. We concede that there may be some truth in this but, while we endorse the pursuit of efficiency, we would like to point out that the policies established could affect the

total environment of the entire population. Under these circumstances, they should be formulated with the widest possible participation and should be subjected to public scrutiny, discussion and control. We are prepared to sacrifice some efficiency to achieve these ends and have no doubt that in a long-range program of this magnitude the rate of progress will allow time for the development of an efficient organization.

The Coordinating Council therefore recommends that a new comprehensive health agency be established for the City of New York. Its directors should number between forty and fifty and should be drawn, in proper proportion, from all major professional groups, consumer groups, labor management, and the municipal government. Provision should be made for subcommittees of experts, not necessarily of Board status, to study specific problems relating to health or to delegate such studies to qualified organizations and institutions. The Health and Hospital Planning Council should constitute a major research arm of the agency although not necessarily its sole one.

I do not wish to prolong this discussion by going into further details of the organization of the proposed agency. The Coordinating Council will be glad to participate in designing its structure at the proper time, as it plans to have an active part in its function. I would, nevertheless, on the basis of previous experience in this City, like to suggest a few important considerations in creating a planning body such as this.

The members of the Board of Directors should be limited to a specific number of years or terms. This will result in a slow turnover and will provide flexibility of concept and receptivity to new ideas.

It will help to prevent the stubborn adherence to discredited policy that we have experienced all too often in the past. A maximum tenure of two five-year terms is suggested, with three classes of Directors.

The charter of the agency should clearly limit its functions to planning in the areas assigned to it.

The agency should have public accountability. It should publish its findings and recommendations, or at least make them available to interested groups, at regularly stated intervals.

The Board should elect its chairman from among its members.

The arrangement we suggest has several advantages. A Health Agency of this type would require relatively little staff, since it would draw on the resources of existing organizations like, for instance, the Hospital Review and Planning Council. This would prevent duplication of effort. The broad representation on the Board of Directors would provide educational feedback to the groups whose understanding and cooperation will be necessary. This should create the group involvement essential to successful planning and implementation. The limitation of the function of the agency to planning will prevent the possible later perversion of its purposes.

At this time, I would like to offer the cooperation and assistance of the Coordinating Council in developing the Health Planning Agency and in proposing well qualified physicians for its Board of Directors.

EXHIBIT B. STATEMENT AT THE NEW YORK ACADEMY OF MEDICINE, MAY 18, 1967

My appearance on this panel is due to the fact that my recent activities have put me into a position to interpret and elaborate the views of privately practicing physicians and the medical societies that represent them. This presentation will be made from that standpoint, although in many ways it may also be applicable to other health professionals and paraprofessionals.

I am reluctant to discuss quality before defining what it means in the context of medical care. In keeping with the ungramatical but current usage, I will use the term "quality" as an adjective meaning optimum or excellent. The simple and obvious definition is care that is ideally suited to the medical needs of the patient at the time he develops these. Beyond immediate therapy, a further important element of good medical care lies in the vast area of preventive medicine. Another essential ingredient is availability, which raises the complex question of how medical care of good quality can be delivered to the public in adequate quantity, in a dignified manner, and at a price they can afford. This encompasses planning for facilities such as hospitals, nursing homes, and clinics. It involves

the establishment of a sufficient number of schools of medicine and nursing to meet the present and future need for doctors and nurses who are currently in such short supply. It requires the devising of more effective undergraduate, graduate, and postgraduate training programs which represent the ongoing educational effort without which medicine cannot survive and progress. Finally, insuring the availability of good medical care, necessitates the development of improved and possibly new methods of delivering it, with consequent changes in present relationships among patients, physicians, hospitals, and government.

It is now generally recognized that, in addition to adding to our facilities and personnel, we must learn to make more efficient use of what we have. In the course of the abrupt expansion of facilities and the inevitable changes that will occur in our patterns of medical practice, special vigilance will be required to maintain the quality of care at a high level. That vigilance is someone's responsibility, but whose?

Since Medicaid and Medicare are the immediate stimuli for our soul-searching, let us consider the question of responsibility in the light of their development and subsequent supervision. The enactment of a law is the basis of all tax-supported programs, which places the initial responsibility directly with the legislators. They must create a law which not only permits but encourages the delivery of good care. Their responsibility is to legislate wisely and deliberately, preferably on the basis of advice and information from all groups that are likely to be involved.

The next stage is implementation, and responsibility passes to the government agency or department designated to administer the plan. In the discharge of its duties, this department pads the legislative skeleton with the tissues of standards, requirements, rules, and regulations. Ideally, this again is done with due consultation with those who will be involved with the execution of the program and regard for their advice and opinions. The exercise of judgment and restraint in the regulatory function is most important because the administrator's responsibility is best met by continuing cooperative efforts with the providers of services.

Scattered Responsibility for Good Care

Further along, the obligation of providing good care devolves on the complex entities known as hospitals and on the individual physicians who render the specific services. The hospital associations and medical societies share that obligation and can provide leadership in the areas of teaching, utilization, medical audit, and the distribution of facilities.

When quality is considered in the broad sense, it is apparent that responsibility for it is not, and cannot, be vested in any single agency or group, but rather must be shared by all those who have a part in providing medical services.

If we probe this question further, does our real concern center about who is to be responsible for the quality of medical care? Are we not more realistically and truthfully talking about who is to have the authority to determine the conditions under which care is rendered, to regulate the providers of health services, and to direct the future course of medical practice? Are we not talking about power rather than responsibility? Let us see where this thought leads.

In the Medical Assistance Law, the Department of Health of the State of New York is made responsible for the quality and availability of medical care. By a process of extrapolation from responsibility to authority, the Department has established rules, regulations, and standards for professional participation that are beyond what was intended by the law and beyond their authority. Repeated meetings between the Department and the Technical Advisory Committee of the Medical Society have failed to resolve this problem, as they have failed also to resolve the fee schedule and other important differences between the physicians of this State and government. It has gradually become apparent that the advice proffered by the Advisory Committees is usually disregarded, at least on matters of major policy. Although the committees may be of some use to the specific Department to which they are appointed, they have failed to serve one important function for Medicine. They have been ineffective in bringing about the modifications in the Medicaid program that physicians have indicated as necessary for their participation.

Disappointment in this relationship and in the failure of the Advisory Committees to achieve the goals set for them was made manifest at the Annual Meeting of the House of Delegates in February 1967. At that time, the State Medical Society expressed its official disapproval of the Medicaid program as it was being administered. It was made clear, nevertheless, that rather than withdrawing from the program, the State Society intended to increase its efforts

to bring about the changes it deemed necessary. The Governor and the Commissioners were called on to take specific and constructive steps in the discharge of their responsibilities to make the Medical Assistance Program a success. Beyond a bare acknowledgement, there has been no response.

I call to your attention the fact that the physicians of this State are declining to participate in Medicaid to an extent that endangers the entire program. This is the result of their personal dissatisfaction with its administration. It is the result of a great number of individual decisions, made by individual practitioners, and not a boycott by the profession. In New York City, where dissatisfaction is particularly acute, and where there is reason to question the ultimate objectives of the City Administration with regard to medical practice, only a handful of physicians have accepted Medicaid patients for private care.

From these and other indications, those of us who have been chosen to represent the State and County Medical Societies have sensed a new attitude on the part of physicians. They have become aware of the potential influence of medical assistance programs on the future of their profession. They intend, by every appropriate means, to have a hand in molding that future. At the same time, physicians are no longer willing to support and participate in programs unless they have a voice in their development and can influence or modify the terms and conditions under which they render service. It is important that this attitude be clearly recognized because without the foot soldier of medicine, the individual physician, there *is* no medical care; there *are* no programs.

The medical societies, particularly the Medical Society of the State of New York, in response to this new and almost militant posture, are reorganizing and expanding rapidly, in preparation for meeting their responsibilities toward their members and the public. New departments are being established to gather information and conduct research on professional education, medical care economics, and standards of medical care.

These continuing studies will enable a rapidly growing corps of informed and articulate physicians to advance the views of organized medicine with clarity and vigor. They will be prepared to negotiate the terms and conditions under which physicians will support old and new programs. Aware that the very existence of their profession depends on the provision of good medical care in adequate amount, their efforts will be directed toward improving that care and the delivery systems associated with it. They will demand a role in the planning that affects all phases of medical care rather than delegate the responsibilities of Medicine or passively abandon these to public agencies. They will be prepared to advise any and all bodies involved in programs for the delivery of health services, once they become convinced that their advice will be heeded and that advisory committees are not merely safety valves designed to let physicians blow off the steam of their accumulated frustrations. They will resist the assumption, by any individual, organization, or agency of authority beyond that which is proper and necessary. In a word, the medical societies and their representatives will do everything in their power to help create a system of medical practice that meets the manifold and stringent requirements of this new and exciting era. This is how the medical societies are meeting their responsibilities and I assure you that the term "Organized Medicine" is no longer a misnomer

I have thought it appropriate to present these facts to a representative group such as this because it is important that each of us who has an influence in modifying the development of medical practice understand the philosophies and motivations of the others. We will have no difficulty in identifying our various responsibilities. As far as the exercise of authority is concerned, let it be noted that Medicine has shown a capacity unequalled by any other profession to elevate its standards, police its members, and improve its services. Under these circumstances, an authoritarian approach by government and attempts at excessive regulation are not only unnecessary, they are a gratutitous affront.

The Medical Profession offers to be an active and equal partner in meeting the challenge of evolving new and more effective patterns of medical care. There is too much to be done and time is too limited for us to waste it with misunderstandings and disagreements.

EXHIBIT C. PRESENTATION ON MEDICAID AT CONGRESSMAN WILLIAM F. RYAN'S COMMUNITY CONFERENCE ON HEALTH IN OUR CITIES, APRIL 1, 1967

Physicians have long been aware that, with the steeply rising costs of hospitalization, drugs, and all the other elements entering into medical care, there are a substantial number of persons in this State who cannot afford necessary

health services. Although the voluntary and commercial health insurance carriers have made it possible for the public to obtain protection at a reasonable cost by spreading the risk, there are still many individuals who are not insured or who need further care after having exhausted their benefits.

Recognizing these facts, the physicians of New York State, individually and through their State Medical Society, gave their support to the Kerr-Mills Law. When this was supplanted by Title 19 of Public Law 89–97, which we know as Medicaid, they supported that, too, although they had serious reservations about some of its provisions. Immediately on the enactment of the implementing law in Albany, the Medical Society of the State of New York appointed a Technical Advisory Committee to the State Health Department. The purpose of the committee was to help develop the program along lines acceptable to its prospective beneficiaries, to the providers of health services, and to the administering agencies.

Among the conditions that the committee and the Medical Society considered necessary to a satisfactory plan for medical assistance were the following:

(1) That the State develop a uniform and centralized program to avoid the confusion and delays inherent in completely autonomous local administration.

(2) That the Title 18 intermediaries be used to administer the Title 19 program, based on the fact that they have the key personnel, the know-how, and the electronic data processing equipment to do the job efficiently. In addition, they have well-developed lines of communication and good relations with the medical profession, which would make for rapid and smooth development of the program.

(3) That the right of the patient to choose his physician and hospital be guaranteed. This right was finally established by an amendment to the rules of the State Department of Social Welfare but is not part of the law.

(4) That prior authorization for the care of Title 19 recipients be eliminated so that physicians could exercise their best judgment in the care of their patients.

(5) That the fees paid for the care of Medicaid patients be at the "usual, customary, and prevailing" level, in keeping with Governor Rockefeller's public statements of his intention that they receive their medical care in the same manner as persons of private means or those having health insurance coverage. The principle of "usual, customary, and prevailing" fees has also received the public endorsement of Dr. Hollis S. Ingraham, New York State Commissioner of Health, and of Commissioner George K. Wyman, New York State Department of Social Welfare.

When the Medicaid program was put into effect, almost the entire responsibility for its administration was placed on the State Department of Social Welfare until November 1, 1966, after which its further activities were limited to the determination of eligibility, enrollment, record-keeping, and payment to providers of services. On and after November 1, 1966, the State Health Department assumed the responsibility for the medical aspects of the program, including policies applicable to hospitals, doctors, and the paramedical professions. The Health Department was further charged with insuring the availability of care, supervising its quality, and recommending fees. This division of authority did much to delay the development of the medical assistance program, since neither department was willing to take effective action prior to November, 1966.

In February, 1967, after ten months of committee meetings, consultations, and close cooperation with the agencies responsible for Medicaid, the Medical Society of the State of New York, at the annual meeting of its House of Delegates, reviewed the status of the program as it was then being administered and found it wanting in almost every important respect.

There had been no effort made to centralize the program, and the Governor and the Commissioner of Social Welfare had indicated their doubt that the Social Welfare Department had authority over the district offices. This meant that instead of one program, the Society now had to deal with about 62 and that there could be no uniformity in the procedures involved.

The district offices had broken down badly in their registration of eligible persons so that neither patients, physicians, nor hospitals knew who was entitled to assistance.

It was evident that the welfare atmosphere had been carefully preserved. The recipients were not, in fact, enabled to receive their care like anyone else in the community and they were not "brought into the mainstream of medical care" as had been glowingly predicted for them. Both the prospective beneficiaries and the doctors showed their distaste for the conditions under which medical assistance was being offered, by their reluctance to participate.

If registration and record-keeping was bogged down in a morass of red tape, the reporting and billing procedures required of physicians were even more so and constituted an unnecessary and serious imposition on their time. In addition, regulations often varied from one county to another and became quite confusing when doctors treated patients from several adjacent counties, as was often the case.

The Departments of Health and Social Welfare made no effort whatever to encourage the district offices to use the Title 18 intermediaries for Title 19, in spite of the fact that Governor Rockefeller had publicly supported this procedure. In the absence of such direction, most of the welfare districts have elected to administer their own programs in spite of clear evidence that they are not equipped to do so.

Maximum Fee Schedule Offered

In July, 1966, the Director of the Budget promulgated a maximum fee schedule for physicians and other providers of services. This was done over the protests of the Medical Society, since the schedule was 30 to 35 per cent below prevailing fees on a State-wide basis. This substandard rate structure is still in effect while dilatory attempts are being made to "investigate" the concept of usual, customary, and prevailing fees which has already been supported by the Governor and Commissioners Ingraham and Wyman.

Even at these inadequate rates, in February, 1967, payments to physicians for services rendered to Medicaid patients were at least three months behind in most welfare districts, as much as six months behind in many, while in a very substantial number, no payments had been made at all.

In view of these facts, the members of the Medical Society reluctantly concluded that the medical assistance program, which they had approved in principle, was a total fiasco as it was being administered. They also recognized that it was not likely to improve in the near future because of the obvious reluctance of the departments involved to accept suggestions on necessary remedial steps. Finally, they saw that, with the continuing decentralization of the program and with the vesting of final authority in the welfare district offices, it would be difficult or impossible to bring the State program up to acceptable standards. Ironically, the Departments of Health and Social Welfare, while they were quite busy devising qualifications for physicians who wished to participate in Medicaid, had devoted no thought to developing standards of performance for themselves and their local branches. Rather than making it possible for physicians to participate without excessive penalties in terms of time and effort, these departments seemed to have settled on a course designed to dissuade doctors from accepting Medicaid patients.

The House of Delegates of the State Medical Society was keenly aware that, no matter how high the quality of medical care may be, it has no value unless there is an effective system of delivery and payment, and the conditions under which the care is rendered satisfy both the recipients and the providers. They therefore took the following actions:

(1) They indicated the dissatisfaction of the Medical Society of the State of New York with the Medicaid program as it was then being administered and withdrew their approval until substantial evidence is forthcoming that representatives of the State government intend to honor their commitments to the people and to the doctors.

(2) They called on Governor Rockefeller to require the State Departments of Health and Social Welfare to submit detailed and workable plans for the centralized and uniform supervision and regulation of the Medicaid program.

(3) They called on Governor Rockefeller to require these departments to create and enforce satisfactory performance standards for the district health and welfare agencies in the administration of the local plans.

(4) They called for the cutting back of eligibility standards to a more appropriate level, since the program was obviously too ambitious, both from the view of its cost and the obvious incapacity of the responsible departments to administer it.

(5) They called on the Governor to instruct the Health and Social Welfare Departments to actively encourage the district offices to use Title 18 intermediaries in the administration of Title 19.

(6) Finally, they called on Governor Rockefeller, in keeping with his publicly avowed policy, to instruct the Director of the Budget to adopt the usual, customary, and prevailing" method of reimbursement immediately.

There has as yet been no official reaction to these just demands, and it is becoming increasingly clear that it is the official intent to permit this program to muddle along as it has done for the past eleven months. This situation should be a matter of deep concern to everyone, not just the recipients and providers of care.

In the interest of humanity, those who need medical assistance should receive it in dignity and without having barriers interposed in their way. In the interest of fiscal sanity, government must provide effective administration or allow those who can do so to provide it for them. In the interest of developing sound, socially-oriented mechanisms for the purchase and delivery of health services, taxpayers and voters must demand prudence in legislation affecting medical and hospital care so that the essential elements of both may be preserved.

The physicians of this State have demonstrated their willingness to cooperate and to make Medicaid work. The Advisory Committee has continued to meet with the Health Department to make suggestions and recommendations for improving the program. What is needed now is either a stimulus from the Governor or a go-ahead signal to his commissioners to break the log-jam of official inactivity.

APPENDIX 2

STATEMENTS ON HEALTH MAINTENANCE PROGRAMS FOR THE ELDERLY

The subcommittee requested information on two health maintenance programs conducted in New York City for the elderly.[1] Statements on the two projects follow, together with commentary from the city budget director, Mr. Frederick O'R. Hayes.[2]

ITEM 1: STATEMENT OF H. DANIEL CARPENTER, EXECUTIVE DIRECTOR, HUDSON GUILD NEIGHBORHOOD HOUSE, NEW YORK, N.Y.

The plans for the Health Maintenance Program at the Hudson Guild-Fulton Center, 119 Ninth Avenue, began when the City approved the Robert Fulton Housing Project and it was known that the community facilities would be used primarily for a senior citizen's center. Because the planning started at this point, the architects were able to incorporate into the plans for the center appropriate facilities for the Health Maintenance Program.

Hudson Guild, the sponsor of the Center, welcomed the participation of the Health Department officials, particularly the local Health Officer, in the development of a Health Maintenance Program. The Hudson Guild felt the incorporation of a health program was a significant and important part of a comprehensive program for elderly people.

The program was in operation for approximately eleven months and in that time some 300 older people were given diagnostic examinations, and about two-thirds of this group were found to need follow-up care and were referred to St. Vincent's Hospital.

The staff of the clinic was rather unique because doctors from St. Vincent's Hospital, paid by the New York City Health Department, manned the clinic. Medical records in duplicate were prepared for each patient. The original, constituting the official hospital record, was sent to St. Vincent's immediately at the conclusion of each clinic session, the duplicate remaining in the clinic for instant reference when the need would arise. Thus, should a patient have to be referred for follow-up or for in-patient care, all findings elicited at the clinic would serve as officially recognized medical information, without need for duplication in effort, time and expenditure.

All Health Department staff worked in close liaison with St. Vincent's Hospital and their counterparts in the center in order to achieve a well-integrated program of health maintenance. The Public Health nurse attached to this project, conferenced each patient individually and made all hospital referrals directly by telephone in the presence of the patient, again, saving time, unnecessary expenditure and delay. Opportunity for misunderstanding and misinterpretation was thusly minimized. Advice on menu-development for the luncheon program at the center was also obtained from Health Department staff.

The Health Maintenance Clinic for the Aged was abruptly discontinued in the summer of 1966 because of a basic policy change within the health administration of New York City. In the next few months, following the discontinuance of the clinic, large numbers of older people who came to the center for services had to be turned away or referred to other resources. Many did not bother to go to the agency to which they were referred.

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[1] See testimony by Miss Patricia Carter, p. 438.
[2] See also testimony by Dr. Howard Brown, p. 360.

The new policy of New York City's Health Administration calls for the development of an ambulatory care program for citizens of all age groups, from the cradle to the grave. The policy of the Hudson Guild-Fulton Center for Senior Citizens was based on the philosophy that older people need comprehensive services "under one roof" which includes health and medical facilities as well as counseling, recreation, socialization, income maintenance, etc.

Hudson Guild welcomed with enthusiasm the initiative of the District of Health Officer of the Lower West Side, when he suggested the inclusion of a Health Maintenance Clinic for the aged in a day center back in 1961, long before such a program was in operation anywhere else in New York City.

"Aged individuals generally find it difficult to use public transportation and tend to limit their movements to their immediate area of residence. Medical facilities at a distance, however good, are not being utilized by the aged. Moreover, the distance factor frequently acts as a psyhcological barrier to utilization of any community resource. Thus, ideally, health services for the aged should be located in the immediate vicinity of adequate low-cost housing and close to social and recreational facilities". (Quotation from Dr. Eric Gordon's "Rationale and Function of the Proposed Health Maintenance Clinic For The Aged at Robert Fulton Houses", submitted on January 22nd, 1961).

Hudson Guild fully concurs with this basic philosophy and its translation into practice as executed during the period between April 15th, 1965, and July 1st, 1966. We sincerely believe that the validity of the quoted statement unchallengeable today as in January 1961.

Therefore, we plead for the reinstatement of the Health Department-administered Robert Fulton Health Maintenance Clinic for the Aged.

ITEM 2: QUESTIONS SUBMITTED TO DR. MILTON M. WALLMAN AND ANSWERS RECEIVED

We have been informed that you were the Physician-in-Charge of the Queensbridge Health Maintenance Service for the Elderly. That project is of great interest to the Subcommittee because of its potential application elsewhere, and we would like to have your observations on:

1. The advantages of having a health maintenance service solely for the elderly in areas where they live in large numbers (such as a housing project).
2. The benefits derived from having House-aides working in conjunction with health personnel.
3. Case histories of elderly who have benefited from the program. Do you have examples of individuals who would have been hospitalized without it?
4. What effectiveness did the program have in (a.) preventing (b.) arresting, or (c.) curing or relieving the effects of chronic disease?

The Subcommittee has annual reports and other information about the program and will enter them into the record with your statement.

ANSWERS TO QUESTIONS SUBMITTED

I. Advantages of a health maintenance service solely for the elderly

1. The broken appointment percentage is much lower than in hospital clinics because of the easy accessibility of the clinic.
2. The patient comes in for relatively minor complaints on a "walk-in" basis and serious conditions can be picked up sooner than usual because of this.
3. Because of the proximity of the clinic, the patient meets his neighbors and friends there. This gives him a feeling of belonging.
4. Because the elderly person can see the physician and the nurses more frequently, all these individuals get to know each other much better.
5. The elderly patient is not scared away by the tumult caused by the young generation in a health clinic.

II. Benefits derived from having home-aides working with health personnel

1. They are able to see that the nurses and physicians orders are being carried out.
2. They can check on the patient while he is shut in and report to the clinic.

3. They can see that the patient has food and medicine available.
4. Since they are an extension of the clinic, the old person gets the feeling that he is not being abandoned after he leaves the clinic and returns to a lonely apartment.
5. An intelligent home aide will notice and report any marked change in the patient's physical or mental condition.
6. Sometimes all the old patient needs is some companionship during the day. This is an important consideration in the rehabilitation of a sick, lonely person.
7. They help the weak who can still walk a short distance do their own shopping. They shop for the shut-ins so that they can have food and medications.

III. Case histories of elderly who have benefited from the program

M.B., age 70+, lived alone.—This patient was hospitalized at the psychiatric division of City Hospital Center, Elmhurst, for a chronic brain syndrome. She was slightly confused so the plan at the hospital was to send her to Creedmoor, the nearby state mental hosiptal. We prevailed on the psychiatrists to send her for a short stay to the geriatric section at the City Hospital Center. When she showed sufficient recovery, after a few weeks, we brought her back into the community and to her apartment where she lived alone. With the help of the Day Center at Queensbridge, we were able to maintain her in the community for an additional year when she fell and fractured her hip. She developed pneumonia and died.

A.L., age 70+, lives alone.—This is a patient with non-operable cancer of the sigmoid and a mastectomy 3½ years ago for cancer of the breast. During the first eight months following mastectomy she had three or four hospitalizations at City Hospital Center, Elmhurst. She entered each time in a semi-starved and confused state. We felt that the confusion each time was due to the fact that she did not eat, and made no attempt to keep her home in order. On each one of these occasions we felt that this patient would benefit from a nursing home, but she refused and returned to her apartment on discharge from the hospital. Each time the same confused status recurred. Following her last admission we finally impressed her with the fact that we meant business. We intimated to her that we could not continue to send nurses into her home, and home aides to keep checking on her if she did nothing for herself when she came home. She has been home for over two years, back in the community where she belongs. Her sigmoid malignancy has not reach the stage where she will need terminal care. She acts mentally clear now, is eating, and is keeping her apartment clean. This was a moral victory for the patient, and incidentally for our program because it demonstrates that sometimes it is quite possible to keep a desperately ill patient in the community, with the kind of assistance we can provide as long as she desires to remain there, which actually goes along with our aims.

There was a period of eighteen months when we had one of our physicians in charge of the Emergency program. He responded to calls for medical attention that occurred between 5 P.M. and 9 A.M. the following morning, when the clinic was closed. None of our physicians have been making house calls on a routine basis as this never was a part of our program. He took it upon himself as part of his duties to visit patients who are quite ill with heart conditions, anemia, malignancies, etc., who should have been hospitalized but refused to accept hospitalization. He thus established for a considerable period of time a type of Home Care Program which we felt was peculiar to Queensbridge. He felt that since we are still responsible for them, and since they are too weak to visit the clinic that he should look in on them periodically as part of his duties as Director of the Emergency Program. It is obvious that a considerable number of patients were able to stay out of the hospital for prolonged periods because of this service.

IV. Effectiveness in preventing chronic disease

We screened for glaucoma, cataracts, Pap smears, occult blood in stools, elevated blood sugars and cholesterols. All patients had chest X-rays, electrocardiograms, and complete blood counts as well as complete physical examinations from head to toe. Since the patients have been followed closely, it is obvious that many conditions were prevented, and a great many were arrested. You have all this information in our annual reports and other data about the program, which you

have indicated you will enter in the record. It is obvious that the answer to this question cannot be a simple statement. In addition, I find it necessary to refer you to the brochure, "The Queensbridge Health Maintenance Service for the Elderly," an evaluation which was issued by the New York City Department of Health Office of Program Planning, Research and Evaluation. This was the combined work of a research staff, Dr. Nicetas Kuo, Dr. Paul Densen, Dr. Mary McLaughlin, et al, and myself. I am sure you have this pamphlet. The basic impressions are there.

I quote from one of the conclusions of this report:

"It is apparent that the clinic had uncovered many conditions which were previously not known to the patient and might never have become known to him without the availability of the clinic services. Further, because of the organization of the clinic, whenever a diagnosis was found, appropriate treatment was provided so that, by definition, the clinic did accomplish its purpose of providing treatment and an approved therapeutic regime. Undoubtedly, many of these patients received treatment for a condition which might otherwise have been neglected, at least until the terminal state of the disease."

The man who inserted this paragraph was Dr. Paul Densen, who was in charge of the Health Department Office of Program Planning and Evaulation. He reached this conclusion on the basis of a careful evaluation as indicated in the aforementioned brochure.

ITEM 3: EXCERPTS FROM MAYOR LINDSAY'S BUDGET STATEMENT TO THE NEW YORK CITY PLANNING COMMISSION

November 7, 1967.

Dear Mayor Lindsay: Your absence at the hearing by the Subcommittee on Health of the Elderly on October 19 was much regretted, although it was certainly understandable.

I am writing to you now to ask whether it will be possible for you to send, for our hearing record, the portions of your annual capital budget message dealing with your proposals for improvement to city health resources, including your municipal hospitals and the proposed neighborhood family medical centers.

There was some discussion of hospitals and centers at our hearing, and I believe that our final record should have the most up-to-date information available.

I have also enclosed a statement from Mr. Carpenter of the Hudson Guild-Fulton Center. As you will see, he regrets the discontinuance of a Health Maintenance Clinic that apparently was of considerable usefulness to the elderly. I would appreciate your comments on his statement (I have addressed a similar query to Dr. Brown).

Sincerely,

George A. Smathers,
Chairman, Subcommittee on Health of the Elderly.

The City of New York,
Office of the Mayor,
New York, N.Y., November 29, 1967.

Dear Senator Smathers: Mayor Lindsay referred to me your recent letter. I am sending you, on his behalf, those portions of his annual capital budget statement to the City Planning Commission, and of the Report of the Budget Director to the Mayor which deal with the health services capital program of the City. As you will see our most urgent stress is on providing the capacity to service our medically disadvantaged population, which includes large numbers of our elderly citizens, with high quality comprehensive care in a neighborhood setting. I think that this approach offers more promise to our elderly population than the more limited services provided by the Health Maintenance Project of the Hudson Guild-Fulton Center. The latter was able to serve only a fraction of the need both in terms of demand and services rendered, and at a high cost both in money and in professional resources.

Please let me know if I can be of further assistance.

Sincerely,

Frederick O'R. Hayes,
Director of the Budget.

[Enclosure]

EXHIBIT A. EXCERPTS FROM MAYOR LINDSAY'S BUDGET STATEMENT

To meet this goal, an over-riding priority in the capital budget must go to facilities that directly serve the City's inhabitants. We must assure our residents of high quality education, health, public safety, sanitation, recreation, transportation, and other vital urban services. Though the cost be great, the cost of inaction and urban decay is far greater.

We must continue to advance the health services capital program. Neighborhood-oriented ambulatory care centers that relieve pressure on our obsolete hospitals—a major new program initiated only last year—is the top need in this regard. In addition, renovation on an emergency basis must parallel the complete reconstruction of our medically sound but physically deteriorated general hospitals. State-aided community mental health centers are the third rung in a ladder to comprehensive medical care: a health system centered on general hospitals, backed up by mental health centers, and extended throughout the surrounding neighborhoods by the most modern form of family care center.

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HEALTH SERVICES

The City of New York faces a formidable challenge with respect to its program of health care, a challenge which has major implications for the City's capital program. The era is past when public hospitals and clinics were built to provide welfare medical care and the poor had no choice but to resort to public medical facilities. Medicare and Medicaid have opened a new era of free choice between public and private medical facilities for the nearly one-half of the City's population entitled to their benefits. As a result, it is essential that public medical care facilities meet the best modern standards of physical plant as well as professional staffing. Achieving this goal will require tremendous changes in the nature and distribution of the City's health care facilities.

Health care services must be made more accessible and comprehensive by expanding the capability of the hospital to serve the community. This means the construction of community facilities offering medical care in close geographic proximity to the people they serve and linked to the staffing and medical resources of a general hospital. High priority should be given in this year's capital program to those programs and projects which give the most promise of advancing us towards the new and necessary health care system. Whenever possible, action on the capital budget should be such as to assure that all of the proposed health facilities for a single geographic complex—a general hospital, ambulatory care centers, and community mental health centers—are considered as a single, coordinated entity.

Attention must also be focused on the City's capacity to produce the necessary changes in a reasonable period of time. We face serious constraints in our capability to move a major capital program rapidly to conclusion, particularly a program of the complexity of health services, where the design and reconstruction of each hospital is a major task in itself, and where two major sub-programs, those for the construction of Neighborhood Family Care Centers and Community Mental Health Centers, are so new in concept that they require additional time for planning and design. A massive traffic jam in construction will do little to create the needed services. The entire job needs to be done, but it cannot all be done at once. Hard choices must be made in order that we may advance the most crucial parts of the program to completion.

First priority in health services should go to filling in the most serious gap in the system: creating Neighborhood Family Care Centers either through new construction or through the redesign of existing health centers to provide comprehesnive ambulatory treatment. Ambulatory facilities are vitally necessary to relieve the growing pressure on general hospitals and to discourage their use for illnesses which can as effectively be treated on an out-patient basis. Neighborhood Family Care Centers should be most rapidly advanced in communities where there is a high concentration of Medicaid eligibles and a demonstrable shortage of clinics and private physicians to care for them.

The physical condition of many of the City's general care and mental health facilities is so poor that we cannot allow them to remain in their sad state while we await their replacement by new structures. Unfortunately, the typical public

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hospital project has taken a total of over eight years to proceed from authorization to occupancy. Heavy emphasis is now being given to expediting these schedules but the size and complexity of the program is such that it will still prove difficult to achieve a pace equal to the urgency of the problem. Pending the completion of new hospitals and mental health centers, virtually all of the present capacity of the City is likely to continue to be needed and used. The Bellevue emergency rehabilitation effort now nearing completion is a prototype that is already being followed at Harlem, Lincoln, and Fordham hospitals. Second priority in the health services field should be given to expanding this renovation effort to the extent necessary to bring existing, heavily utilized general care and psychiatric facilities up to reasonable physical standards.

At the same time, we must continue to press forward with our plans for the full-scale replacement of obsolete hospital facilities by modern plants, including the replacement of obsolete and over-crowded psychiatric facilities with community mental health centers. The voluntary and private sectors of the health world lack the resources to provide these facilities. Unless the City does so, its residents will be faced with a serious shortage of modern health facilities in the next decade. Planning and construction of new hospitals should proceed in coordination with Neighborhood Family Care Centers and Community Mental Health Centers to produce the community medical networks which offer our best hope of providing comprehensive, accessible, high quality care to all New Yorkers.

APPENDIX 3

LETTERS AND STATEMENTS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1: INFORMATION FROM GREATER NEW YORK'S BLUE SHIELD, UNITED MEDICAL SERVICE, INC.

December 6, 1967.

DEAR SENATOR SMATHERS: On October 19, 1967 the Honorable Seymour Thaler addressed the Special Committee on Aging at the William Hodson Community Center in the Bronx, New York City. His testimony included several statements concerning United Medical Service as Medicare Part B carrier in the metropolitan New York City area. This testimony has created some concern at Blue Shield and I would like to clarify any possible misunderstandings which may have occurred as a result of the Senator's remarks.

It was mentioned that in this area most doctors have decided to bill their medicare patients rather than United Medical Service as Part B carrier. As you may know this according to the medicare law is the physicians' prerogative. What the Senator's testimony unfortunately failed to reveal was the fact that an increasing number of physicians have chosen to accept assignment as they became more familiar with the implementation of this program. During the last quarter of 1966 approximately 28% of physicians were accepting assignments. By August 1967 this figure increased to 30.1%. In the following month 32.7% of the physicians in our area were accepting assignments and in October this figure increased to 33.1%. While the figure is still below that which we would consider acceptable it nevertheless indicates a favorable trend and is a direct result of our physician educational efforts in this direction.

A possible reason for physicians not wishing to accept assignment in this area is that many claims involve small amounts of reimbursement especially for services relating to home and office care. In these cases it is difficult for a physician to accept an assignment where the unsatisfied deductible and the 20% co-insurance results in his not receiving any reimbursement for his services when he accepts an assignment or a very small reimbursement with the need to collect either all or the balance of his fee from the patient. This is substantiated by the fact that for services concerning procedures and care which involve considerable expense e.g. major operations or extensive in-hospital medical care, 45% of the total medicare payments made go directly to the physician. This would indicate that in cases of this nature 45% of the physicians are accepting assignments in an effort to assist their elderly patients withstand possible financial hardship.

The Senator then made reference to the fee survey made by United Medical Service and used to determine usual and customary fees. I might point out that UMS as Part B carrier has the exclusive responsibility to interpret the criteria and apply the mechanism used for the determination of usual and customary charges and is accountable to the government for defining medicare fees in accordance with the criteria established by the Social Security Administration.

The results of the fee survey, which incidentally was conducted in November 1965, and which predates our appointment as carrier by approximately 4 months, were tested for validity by comparison with considerable other source data. More specifically, the results obtained were tested against fee information available to UMS from its administration of the Federal Employees Program; from data obtained through previous county medical society surveys and from previous speciality society surveys. The results of this comparison verified the validity of the fee information obtained. Blue Shield has long recognized that its allowances in many cases are not commensurate with the physician's usual fee for service and that the times indicated a change in direction. With this in mind

the survey was conducted with reference to new approaches relative to health insurance protection and with reference to evaluating our present inadequate fee schedules. To repeat, at the time it was conducted the survey had no connection whatsoever with medicare and the results were carefully evaluated with other source data to determine their validity.

Further testimony given by Senator Thaler indicated "that the percentage of allowed charges to doctors charges is 83%. In simple language 17% of the doctors bills are in excess of the reasonable and customary fees." The Senator then charged that Blue Shield "is most generous" in allowing a doctor to change his fee profile. It is important that these points be clarified in their proper perspective.

In developing the data necessary for the determination of the prevailing fee UMS considered using both the mean or arithmetical average and the mode or the most frequent charge for a given service. However, the SSA subsequently issued a directive indicating that the approach of the carriers should be more flexible in determining the prevailing fee within specific localities. This directive dentified the use of the mean plus one standard deviation to accomplish the covering of the fees of at least 83% of the medical community. UMS in determining the prevailing fee complied with this directive. Concerning doctors charges in excess of the prevailing fee in the community; it is known that for reasons of special training and skills the fees of certain physicians in the community were always above those prevailing in the community. This was true prior to medicare and will continue to exist. The SSA, I am sure, expected this and that a certain percentage of physicians charges would be above the prevailing fee and would continue to be above the prevailing fee in the community.

According to information received from the SSA a physician's usual and customary charge is not necessarily a static amount and "where, on the basis of adequate evidence, the carrier finds that the physician has changed his charge to the public in general for a service the revised charge may be recognized as the customary charge in making determinations of reasonable charges for such service when rendered thereafter to supplementary insurance beneficiaries" the new charge could be considered reasonable by the carrier providing it does not exceed the prevailing level. As Part B carrier UMS has exercised a stringent control regarding physicians requests to adjust profiles to reflect current usual and customary charges. Attached is a copy of the procedure necessary for changing the profile.

Senator Thaler's remaining remarks concerned five Medicare cases handled by United Medical Service as Part B carrier. We have looked into this matter and our records show the following:

In the first two cases, although the basic facts indicated by Senator Thaler, regarding the disparity between the doctor's fee and the allowed charge are correct, the cases have been dispositioned properly. In each case the judgement exercised by United Medical Service in determining the allowed charge was based on information submitted by the physician and the reasonable charge criteria established by the Social Security Administration.

The third claim was again evaluated and paid correctly based on the information available at the time the case was dispositioned. However, there may have been an error in judgement concerning additional information requested by us from the physician. The correct information is being requested and the case reevaluated.

In the fourth case the Senator's interpretation of the procedure as a cataract removal is incorrect. The procedure in this case was performed to correct a retinal detachment of the left eye. He indicated that the patient had a cataract removed prior to medicare and was charged $175 and that the physician now charged $500. However, contrary to this, the receipted bill attached to the claim indicates a charge of $350. Although the nature of the surgery performed prior to medicare is not known the surgery as indicated in this case is not a cataract operation. This is a clerical oversight the procedure indicated on the claim may have been miscoded. Again, this case will be re-evaluated.

In case number five concerning a prostatectomy, the problem is one of misinterpretation of SSA guidelines concerning payment of medicare claims. The Senator correctly stated that the physician's fee was $1,000. However, his reference to Blue Shield setting $300 as the usual and customary charge was incorrect and merits some clarification. In this particular case the prevailing fee in the doctor's specialty and his locality for this procedure is $750. The patient only

received 80% of $300 because there was no assignment on this case and only $300 of the bill had been paid by the beneficiary. According to SSA regulations the carrier can, in the case of a non-assigned claim, only pay on the basis of a receipted bill. The receipted bill in this case was for $300. When we received the receipted bill for the additional $700 or any part of it an additional payment can be authorized.

I certainly hope this rather lengthly letter has clarified some points in relation to our administration of Medicare. I have appreciated the opportunity of writing you. Should you have any questions I will be pleased to discuss them with with you.

CARMINE F. AMMIRATI,
Vice President and Secretary.

[Enclosure]

EXHIBIT A. BLUE SHIELD COLUMN, NOVEMBER 1967, FOR THE COUNTY MEDICAL SOCIETIES' BULLETINS

A preliminary study conducted by UMS, of the relationship between medicare "allowed charges" and physicians' actual charges, shows that overall "allowed charges" equal 83% of actual fees. The allowed charge is identical with the physician's actual fee in a large majority of cases.

Nonetheless, there are some physicians whose fees are now higher than the charges recorded on their fee profiles, which leads to a difference between their actual fees and the charges allowed by medicare.

The physician's fee profile—i.e., a listing of his usual charge for each service he performs, which the doctor himself has supplied to UMS—provides a partial basis for the allowed charge.

Medicare payment is based upon the physician's charge, when it correlates with the charge he has listed on his fee profile, providing his fee is not higher than the range of prevailing fees in his locality.

Physicians whose fee profiles no longer reflect their correct charges, if their higher fees are the result of recognized economic and professional changes, may apply for updating of their fee profiles. UMS will of course revise them, when the circumstances are appropriate, since fee profiles are by no means static.

The UMS Medical Staff, in evaluating a request from a physician for updating of his profile, considers the following reasons for raising fees:

The physician's increased expenses and cost of conducting his practice, such as staff increases, salary increases;

A change in the doctor's specialty status;

Relocation to a new area where prevailing fees are higher than those of the locality in which the physician previously practiced.

Before UMS can revise a doctor's profile, its responsibility as medicare carrier demands it ascertain that the physician has extended the increase in charges to all his patients, and not just to medicare beneficiaries. To this end, the carrier may ask the doctor to provide a representative list of his patients who are UMS subscribers and medicare beneficiaries, so that UMS can verify from previously filed Blue Shield and medicare claims that the doctor's revised fees are in line with the guidelines established by the SSA.

After UMS has reviewed the validity of the physician's reason for upgrading his charges, including supporting data, and has verified that the rise is "across the board" for all his patients, the carrier will determine whether the higher fees requested are reasonable.

The following increases will be accepted as reasonable:

Those which are in line with published economic reports of changes in doctors' charges;

Those which are set by virtue of a change in specialty status and which reflect the custom of the medical community;

Thost resulting from relocation of his practice to another locality.

After approving the request for change, UMS Medical Staff will inform the doctor that his profile of charges is being updated. If UMS feels that a change in the doctor's fee profile is not indicated, the doctor will be notified with an explanation. If the problem is not resolved with the physician, either UMS or the physician may ask for advice and recommendations from specialty society liaison committees, or from the Physicians' Review Committee. A resource of a more general nature are the newly-forming county medical society medicare liaison committees. These committees are gearing themselves to work with carriers on various issues involving medicare, in the interest of the public and of the individual physician.

ITEM 2: MATERIAL FROM EVELINE M. BURNS, PROFESSOR OF SOCIAL WORK, COLUMBIA UNIVERSITY

October 12, 1967.

DEAR SENATOR SMATHERS: * * * I should be very happy for you—as requested—to reprint my keynote address before the 1966 Health Conference of the New York Academy of Medicine. It occurs to me that you might also be interested in another paper which I delivered on the same general topic, a copy of which is enclosed herewith.

Yours sincerely,

EVELINE M. BURNS,
Professor of Social Work.

[Enclosure]

EXHIBIT A

Reprinted from AMERICAN JOURNAL OF PUBLIC HEALTH, Vol. 57, No. 2, February, 1967
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The health legislation of 1965 established beyond any doubt that the health of the people has become a matter of conscious social policy. It is clear that these acts entail further change and the question arises: how and under what leadership? The Bronfman Lecture for 1966 addresses itself to this problem in a direct, incisive manner. All health professionals must read, reflect, and act on the issues discussed here.

SOCIAL POLICY AND THE HEALTH SERVICES: THE CHOICES AHEAD

THE SIXTH ANNUAL BRONFMAN LECTURE

Eveline M. Burns, Ph.D.

THERE appears to be universal agreement that the passage of the Social Security Amendments of 1965 opened a new era for the health services. On all sides one meets the expectation that nothing will ever be the same again. And yet at first sight it is not obvious why this should be so. For at least in comparison with the social policies of other countries, what was enacted by the 1965 amendments was modest indeed. Our adoption in Title 18A of the principle of compulsory social insurance was extremely timid. We limit it to paying for hospital and certain types of hospital-related care, and indeed only to some types of care received in hospitals. And the benefits are restricted to people 65 and over. This must seem a very conservative step to the over 50 countries which have, in some cases for generations, used compulsory health insurance as the basic method for meeting the costs of health and medical care with no age restriction on the beneficiaries.[1] Even in the United States the use of social insurance for health care is not entirely new. We have utilized for half a century a primitive form of social insurance, namely workmen's compensation, to pay for the costs of medical care received by those suffering from occupationally connected injuries or illnesses.

The use in Title 18B of a different method of meeting the costs of physicians' and certain other services, different in that coverage is voluntary rather than compulsory and in that people have to continue to pay premiums instead of benefiting from fully paid-up insurance at age 65, while the benefits take the form of indemnification or reimbursement rather than service, involves no major departure from our well-established systems of private insurance.

Even the potentially more radical Title 19 which opens the door to an extension of free health services to those higher up the income scale than the

public assistance recipients must seem a very tiny step toward universal access to needed health services to countries, such as Great Britain, which operate a comprehensive national health service available to everyone regardless of income. In any case, Title 19 is primarily an extension to more people of a policy we had already adopted in the Kerr-Mills Act of 1960.

Yet I believe the general view that things have changed is justified. The 1965 amendments are the culminating step of a change process that has been with us for some time, and the tempo of which has greatly accelerated in recent years. Starting with the Hill-Burton Act in 1946, we have witnessed a long series of acts providing for federal aid for health research, for mental health, for community health facilities, for medical and nursing education, for training other types of health personnel, and for the health care of the medically indigent aged.[2] Historically viewed, therefore, the 1965 amendments are but one more step in this cumulative process. There are, however, three facts that justify our attaching a special importance to them. To begin with, for the first time a public medical care program has been enacted which brings people of all social classes within its scope. Except for veterans and workers covered by workmen's compensation, governmental action to help people meet their medical bills has hitherto been limited to people who are found to be poor or indigent. This inclusion of middle-class people in a publicly operated program has important consequences. For it is the unfortunate and shameful truth that by and large we have been little concerned about the quality and adequacy of the medical care received by those we classify as "poor" or "indigent." Once middle-class people are involved, however, we become more sensitive about quality of service. Means test medicine is apparently not good enough for them. Quality standards are embodied in the legislation and the scope of government action becomes broader than the mere removal of a financial barrier.

Second, the very magnitude of the new programs places them in a different category from previous legislation. As a federal program Title 18 is in effect in all parts of the country, the people covered run into millions, and the dollar costs into billions. More people who, remember, are voters, will have a stake in how the program operates. Perhaps even more significantly for the long run, the administrators of public programs have to be accountable to the public and accountability means visibility. From now on we shall have much more adequate and precise information about the availability, adequacy, and costs of our health services in the nation as a whole and in its various subdivisions. The alibi of ignorance will be ever harder to maintain and the pressure for reform will be intensified.

Third, the 1965 amendments were passed in the face of the active and highly publicized opposition of organized medicine. By the very violence and duration of its opposition to compulsory health insurance the American Medical Association has unfortunately created the impression that it was challenging the right of the people to use their government to achieve objectives to which they attached importance. Inevitably, therefore, passage of the legislation is viewed as a "victory," symbolizing and legitimating once and for all the fact that there is indeed a public interest in health and that the opinions of professional groups cannot prevail when in conflict with that interest. Never again will the medical profession be able to assert, as it did in 1946 when testifying on the National Health Program Bill, that doctors and only doctors were "in a position to pass upon the medical side of it, as to the determination of medical care and how to obtain

it, and the effect upon medical care of the system."[3] Already this assertion has an archaic sound.

The Main Issue

Now that it is established that the functioning of our health services is a legitimate concern of social policy and that public action will be invoked when necessary, it is imperative that we clarify the ends of policy, assess the efficacy of available ways of obtaining them, and reformulate the role of the professional and other groups who must play a part in the enterprise. The overall goal is not difficult to define. The New York Academy of Medicine summarized it for us when, in a recent Policy Statement, they asserted that all people should have the assurance of an equal opportunity to obtain a high quality of comprehensive health care and that the availability of services should be based on health needs alone and not on ability to pay.[4] In moving toward that goal there would seem to be three important choices facing the nation.[5] First, shall the financial barrier to receipt of health services be lowered for more people and, if so, how? Second, shall social policy be concerned solely with removing the financial barrier? Third, is the primary concern of social policy with health services or with health?

Should the Financial Barrier Be Removed or Lowered for More People and, If So, How?

The main thrust and the main novelty of the 1965 legislation has been the deliberate use of social policy to remove or lower the financial barrier to access to health services. As we all know, this has been achieved by the use of compulsory, and voluntary federally subsidized, insurance for the benefit of people 65 and over, and by increasing the numbers who can secure publicly financed medical services through a liberalization of the concept of indigency. It seems inevitable in the years ahead that insistent questions will be raised as to the desirability of limiting access to these programs to the presently covered groups. Specifically, we shall surely see (indeed we are already seeing) demands for the extension of social insurance to benefit groups other than the aged, and efforts within the states to broaden the coverage of Title 19 by progressive increases in the income limits.

How far these extensions will go will depend mainly on the degree to which existing private arrangements for the financing of health services prove able to remove or sufficiently moderate the financial barrier for those not now benefiting from Titles 18 and 19. Great hopes are being placed on the ability of private insurance, freed as it now is from the impossible burden of trying to solve the problem of the health costs of the aged, to expand its coverage of both population groups and types of service. Yet despite the levels of affluence of this country which suggest that the potential is great, it seems highly unlikely that private insurance coverage can be extended sufficiently widely and rapidly to ward off demands for further extensions of governmental programs. The percentage of the population with coverage declines sharply as income falls.[6] Much of the rapid extension of coverage of the past has taken the form of health fringe benefits as part of the collective bargaining system. The better-off and the organized workers are the groups that have been easy to reach. But what of the employees of small firms, the domestic servants, and agricultural workers? What of the increasing numbers of older but not yet aged workers, many suffering from a variety of disabilities that limit their capacity to take employ-

ment, or the families that have lost their breadwinner through death? Nor will it be easy to deny the claims of the increasing numbers of older people who have exercised their socially accorded right to retire at age 62 and who will surely question the sacredness of age 65, more especially as the pre-65 retiree will necessarily be drawing a benefit that is lower than that of the worker who retired at age 65?

It seems inevitable that there will be sizable groups for whom protection through private insurance is an unrealistic hope. Even more uncertain is the ability of private insurance to offer even approximately complete protection for the population groups who are insured. Deductibles, co-insurance, indemnity payments that fail to reflect rising costs of service, and exclusion of important components of medical care help to explain why by 1964 private insurance met only 33 per cent of all consumer expenditures on medical care.[7] Even if the industry is able to maintain rates of increase in cost coverage characteristic of the last three years (actually since 1961 the rate has slightly slowed down) it will be 20 years before more than half of consumer expenditures will be reimbursed.

Methods of Removing the Financial Barrier

If dissatisfaction with the achievements, and distrust of the potential, of private insurance should lead to demands for the extension of governmental programs to groups not now covered, a choice will have to be made as to which type of program is to be expanded. We have available three major technics for overcoming the financial barrier. People may be given access to health services because they are judged by the community to have incomes and resources too small to enable them to meet their medical bills (i.e., they become eligible on passage of a needs test), or because they have in the past paid taxes (euphemistically called contributions) as members of a social insurance system (i.e., eligibility rests on the concept of insured status), or because they are members of a population group for whose health status the community feels a particular concern. The last group it should be noted may be as small as presidents, and important public figures, as sizable as veterans with service-connected disabilities, or nursing mothers and their babies, or as large as the entire population.

There is an important difference between the needs-test eligibility criterion and the other two. The latter give access to health services on the basis of legally specified, nondiscretionary criteria. The beneficiaries are claimants and not applicants and are not subjected to the humiliating procedures typical of most means test administration in the past. The absence of a test of income in systems of social insurance or free health services has another important consequence. As I have already indicated, the groups eligible are sizable and, economically, much more representative of the entire population—they are not composed solely of "the poor or indigent" and they have a significant middle-class component. This constitutes an important safeguard against the development of two systems of medical care: one for the population covered by the public program and one for everyone else.

It is, of course, not inevitable that publicly financed medical care for the needy should be of inferior quality. Indeed one of the choices we face today is whether or not to take advantage of the new funds and resources available under Title 19 to improve the quality of services instead of just giving more of the same old unsatisfactory service to more people. There are encouraging signs that in many of our communities

today a new wind is blowing and efforts are indeed being made to use the funds and the powers given by Title 19 to improve the quality of service.

Assuming that it would be possible to avoid the unfortunate perpetuation of two systems of health services, one for the needy or indigent and one for the insured or non-needy—and it is a big assumption—the question may perhaps be asked whether there is anything inherently wrong in using an income test as the instrument for overcoming the financial barrier. After all, we use income tests to determine who shall have access to certain other social benefits such as educational scholarships or fellowships or subsidized housing as well as to determine who shall contribute toward the costs of running the government, and no one seems to feel it is degrading to fill out an application form for scholarship aid or an income tax return. Thus some would argue that given the prevailing American social philosophy regarding individual responsibility, while society is prepared to ensure that no one shall be denied needed health services because of inability to pay for them, there is no necessity to provide free or subsidized services for people who have adequate financial resources of their own. They would, therefore, hold that some kind of an economic test of eligibility is desirable. But adoption of this approach means that society will then have to come to grips with a major social policy question: Where is the line to be drawn?

Already this issue has come to the fore in the implementation of Title 19 and the anguished reaction of Congress to the relatively liberal plans of New York and some other states indicates how much difference of opinion there is in the country as to the income level which is too low to enable people to pay for the medical care they need.

In any case, we must never forget that, contrary to prevailing beliefs, the purpose of eligibility conditions is to keep people out rather than to let them in. But we do not want to exclude anyone from needed medical care. Hence, whatever the form of income test adopted, it must not be of a character that deters people from using health services when they need them. From this point of view one can only regret that the Congress so deliberately specified in Title 19 that the test of financial eligibility must be administered by welfare departments. Although some welfare administrations are endeavoring to make the test nondeterrent by using affidavits in place of detailed investigation and verification, by simplifying and formalizing the information called for and by predetermination of eligibility wherever possible, it is doubtful whether most welfare agencies can so far break with their past traditions as to operate a truly nondeterrent financial test of eligibility for health services.

Given the improbability that our poorer and our meaner states will provide first-class health services for those whose access to them is determined on the basis of need, given the unlikelihood that the test will be everywhere administered in a nondeterrent manner, and in view of the violent differences of opinion that are likely to arise as to where, in a federally aided system, the income limit should be set, I suspect that the use of an income test will not prove to be the answer to our problem. If we really wish to ensure that availability of health services should be based on health needs alone and not on the individual's ability to pay for them, we shall have to resort to one or other of the non-needs test technics for overcoming the financial barrier, namely, to social insurance or to free health services for specified segments of the population. For it is one of the advantages of social insurance that it enables us to evade the awkward question of the exact income level which

should entitle people to free or subsidized health care. But since even social insurance excludes some people (notably, in most systems, those who are not employed), we may also find ourselves moving toward a free health service for some of our more vulnerable but strategically important groups such as children.[8]

This may not be so revolutionary as it sounds. The medical profession and the insurance companies must have had a severe shock in recent months as they have begun to see how dangerous Title 19 is from their point of view. As many of us warned them at the time, the Kerr-Mills approach which they saw as a safe alternative to social insurance had the potential in a liberal state of becoming a universally available free health service. They may yet come to regard a free health service for children as a lesser evil than the possibility of extending free services to an ever larger proportion of the entire population by a continuous raising of the income limits under Title 19.

Shall Social Policy Be Concerned Solely with Removing the Financial Barrier?

This is perhaps the most important of all the choices we face. The stimulus to enactment of Titles 18 and 19 was a concern about the burden of medical care costs. Both the Congress and the Administration have narrowly defined the objectives of the new programs, especially of Title 18. In the words of Commissioner Ball, "The main purpose of the legislation, of course, is to help older people meet the cost of the medical care they receive. The program does not itself provide care. . . . It is our direct concern . . . to help people meet their bills, not to make changes in the way medical care is given."[9]

Consistently with this objective the new programs have started out on a pattern that interferes as little as possible with existing structural and administrative arrangements, methods of operation and remuneration, and professional mores and relationships. So far as possible every agency, every purveyor of service, every health institution is to be enabled to go about his or its business as before. Indeed, a cynic might be tempted to assert that the main beneficiaries of the new legislation will be those involved in the provision of health services. Hospitals will be paid their full reasonable costs for care given to the aged and indigent, doctors will be more sure of collecting full payment of their reasonable charges and left free to collect whatever unreasonable charges they can induce their aged patients to pay, and they can continue to insist on the fee-for-service principle. Insurance companies have been relieved of a burden and have been given a new claim on the loyalty of their customers in their capacity as helpful administrators of a large reimbursement program.

In fact, the new legislation does have some impact on "the way medical care is given." Despite the brave words of the first section of Title 18 which, you will recall, states "Nothing in this title shall be construed to authorize any federal officer or employee to exercise any supervision or control over the practice of, or the manner in which medical services are provided . . . or to exercise any supervision or control over the administration of any such institution, agency, or person," there are some controls and some supervision even now. Ironically the most serious interference with the way medical care is given was inserted at the request of organized medicine itself, which may yet live to regret the precedent it has set. I refer, of course, to the removal from Title 18A to Title 18B of within-hospital professional services. Some measure of quality control exists through the conditions laid down for institutional participation in Title 18. A limited degree of control over hospital operation is

found in the requirement for utilization committees. The necessity to set national criteria for the determination of "reasonable costs and reasonable charges" theoretically makes possible some measure of social control over methods and levels of remuneration, although the composition of the advisory bodies involved, with their miniscule provision for representation of the public interest and their overwhelmingly heavy medical and insurance membership necessarily tempers one's hopes.

The Pressure of Costs

These controls are minimal and no more than would be necessary in any financial underwriting arrangement. The insurer, in this case the government, has contracted to meet the costs of certain kinds and levels of service and has to make sure that its customers get what they have been promised in return for their premiums. Because the program is financed on an insurance basis any rise in costs will have to be reflected in rising premiums. Because taxpayers are notoriously resistant to increased taxes even when they are called insurance contributions, government will of necessity be greatly concerned with practices or administrative arrangements that lead to rising costs. Hence, if the costs of the programs prove to be greater than originally anticipated we are likely to see more controls. If physicians' fees show a significant upward trend that coincides suspiciously with the inauguration of Medicare it will not be surprising if such a development becomes a matter of public concern and action. Questions might even be asked whether some system of payment other than fee-for-service might not result in lower costs. If hospital costs continue their spectacular rise it will be no surprise if government begins to take a hard look at the way hospitals are run with a view to reducing costs. Such developments are the more likely in that for the first time we have a national program, which greatly enlarges the possibility of making comparisons of performance on a more uniform basis. And, as I have already indicated, what is happening will be known and reported on. There will be greater visibility.

This concern with cost is unlikely to be restricted to the public programs. National expenditures for health services are large and continuously rising. In 1964 they amounted to $36.8 billions or 5.8 per cent of GNP. In 1950, only 14 years earlier, they were only $12.9 billions or 4.5 per cent of the then GNP. Per capita, the rise has been spectacular, from $84.50 in 1950 to $191.30 in 1964, an increase that, even when allowance is made for the rising price levels, is over 75 per cent[10]; and there is universal agreement that further increases must be expected.[10a]

Part of the rise in national expenditures on health is, of course, due to the fact that we are demanding more of our health services and that the scientific progress of recent years has provided new procedures and methods of treatment that involve additional expense. It is also true that we are a rich nation, growing richer all the time, so that to some degree we can indeed afford to spend more on our health services as on everything else; but even rich nations have to face up to the fact that at any given time and level of national income the more they spend for one type of goods or service the less they can spend on all other possible objects of expenditure. It thus becomes of the greatest importance to assure that whatever level of service is desired shall be rendered at minimum cost in the sense of not making a greater demand than is absolutely necessary on resources which might be available for other purposes.

As the total burden of health costs increases, we may well expect demands from the public that the suppliers of

health services demonstrate that they are indeed producing at minimum cost. This is already happening in the hospital insurance field where state regulatory bodies are no longer prepared to accept the insurer's argument that premiums must be increased because hospital costs have risen. They are asking with growing frequency, "Are these cost increases really necessary? Is it not possible by organizational or administrative changes to make economies without lowering quality?" In view of the sizable demand which hospitals make on our national resources we must expect more questioning of the necessity for additional hospitals, more pressure for the utilization of available beds, more challenging of the necessity for underutilized specialized equipment, and more attention to regional planning as a way of securing economies and, if necessary, there will be public action to bring about desired changes.

When the public is told that the country needs to train 50 per cent more physicians annually if its 1959 physician-population ratio is to be maintained by 1975, and begins to count the cost of producing them, it is inevitable that people will want to know whether we are making the best use of the physicians we now have by using them only for tasks which call for so costly a training. They may even ask whether the training need be so long and costly. We can expect increasingly insistent demands to exploit the possibility of using auxiliary personnel whose training involves a lower investment.[11]

Thus we may well expect more, rather than less, involvement of government with the way medical care is given. But note that the spur to action could remain merely a concern about cost. Even if, in the years ahead, the American people were to decide that they wished to extend the benefits of one or both parts of Title 18 to ever larger groups of the population by progressively lowering the age limit, the objectives of social policy could still remain restricted to removing the financial barrier. Even if all states were to exploit Title 19 to the full by progressively raising the income limits and including an ever broader spectrum of services, the undertaking could still be conceived of as merely a financial commitment. In both cases government's involvement with the way medical care is organized, administered, and delivered would still be restricted to those features which affect costs.

Pressure of Service Needs

Are the objectives of social policy to remain thus limited? I suggest that our answer to this question cannot be "yes." We all know that even if everyone could afford to pay all his medical bills or could have them paid for him, removal of the financial barrier would not automatically assure good medical care or, more importantly, a high standard of health for all.

It is not necessary to particularize the many other obstacles to the general availability of high quality and appropriate health services. The impressive body of evidence that has accumulated in recent years in commission reports, in conferences of health professionals, in articles in professional journals and in governmental publications has familiarized us all with the major weaknesses.[12] We are aware of the increasingly serious personnel shortages and of the inadequacies of much of our institutional provision. We know about the great geographical inequalities not only among states but within states in the availability of both personnel and facilities. The lag between new knowledge and its application is a painfully familiar theme at almost all health conferences and symposia. The deficiencies of our delivery system are notorious. The provision of health services has evolved along a series of tracks that often do not meet and are certainly not coordinated.

We still retain the curious distinction between the preventive and the diagnostic and curative services and between them and the rehabilitative. We still have largely parallel systems for the treatment of physical and mental illness. We make a sharp distinction between services for the vertical (or ambulatory) patient and those for the horizontal (or hospitalized) patient regardless of the fact that at different times the same patient may be both. We develop services on the basis of disease entities so that the care an individual gets may depend on whether he has the "right" kind of disease. We make distinctions between people for the purpose of the delivery of services that have no logical basis: special provision for public well-baby clinics but not for babies who are sick. We provide school health services to identify the health needs of school children but fail to follow through to see that deficiencies are corrected. We glorify the principle of free choice of physician, but fail to recognize that the choice that is given is primarily the selection of the door through which one gains access to a range of needed services. Thereafter, there is little free choice. If the general practitioner is incompetent or is professionally obsolete, or if he is barred from a hospital connection for reasons other than lack of appropriate qualifications, his patients are unlikely to find that free choice of physician is any guarantee of good medical care.

It is not surprising that the word "fragmentation" appears with such depressing frequency in all the recent literature or that the objective of "comprehensive care" seems to be Item I on the agenda of every proposal for reform. But if these deficiencies and weaknesses, these nonfinancial obstacles to receipt of high quality health care, are to be corrected, social policy must of necessity be concerned with the way medical care is given. There seems to be little doubt that social policy will come to grips with the problem of securing an adequate total supply of essential facilities and health personnel of all kinds. For here the major choice facing the nation is how much money it is willing to pay to achieve the objective, and all experience suggests that if people want something badly enough they will, if necessary, give up other things to get it.

The decision as to how much money to spend is one that is much easier to make than those to be faced if something is to be done to correct the geographical unevenness in the availability of facilities and personnel, or to improve our delivery systems, or to supply services at minimum cost. Solutions to these problems, whether brought about by voluntary action on the part of the professions or institutions involved or by governmental action inevitably touch raw nerves. Professional interests that include, but go far beyond, the purely economic are threatened. Long established methods of operation and well-recognized roles may have to change. Comfortable bureaucratic habits and practices may have to be abandoned or at least be severely modified. Local political loyalties may have to be subordinated to the necessity of adopting wider and more rational areas such as regions, as the basis for planning and operation.

Is the Primary Concern of Social Policy with Health Services or with Health?

Much of the ferment now under way or foreseeable focuses upon the health services as such. We are all eager to improve their adequacy, their availability and their quality, and this is not surprising. For all professions appear to suffer from what I once called "professional myopia." We tend to assume that the obvious solution to the human problems with which we deal is the provision of more and better services of the kind we have been trained to render.

Yet it is well known that the health of a people, while obviously affected by the nature of its health services and the presence or absence of contaminations in its physical environment, is also greatly influenced by other factors of a social character. Poor housing, inadequate nutrition, unwanted pregnancies, inability to secure employment, limited education, especially as it relates to elementary knowledge of the functioning of the body and mind, exclusion from participation in the ongoing life of the community, all these have a direct impact on physical or mental health and often on both.

If it is health that we are concerned with then the scope of our social policy for health must be expanded to encompass these social areas as well. It makes no sense to develop costly mental health services to undo the harm that could have been avoided if people had not been compelled to exist on inadequate incomes or forced to try to cope with essentially uncopable problems.

I must confess that those of us whose professional and civic interests involve us in so-called welfare activities, in efforts to secure sound and adequate programs in the fields of social insurance, public assistance, antipoverty legislation, education, or housing and urban renewal for instance, often have occasion to wish that we could count on more active support and cooperation from our colleagues in the health professions. For surely in this area the health professional, the economist, the sociologist, or the social worker whose professional competence lies in the area of social legislation, have a common interest—the improvement of health.

The Challenge to the Health Professions

The answer to my three central questions will, of course, ultimately be made by the American people themselves. I believe they will insist upon change in all three areas. We can expect a demand for the further lowering of the financial barriers and for a removal of the more important nonfinancial obstacles to the receipt of medical care, for a rationalization of our present chaotic system for the delivery of health services and for improvements in the social environment that will have a favorable impact on health. The only uncertainty concerns how these changes are to be brought about and where the leadership is to come from.

Some of the needed changes can undoubtedly be accomplished by action within the private sector. Some can only be carried through by government, while in other cases public action may have to be invoked because the professions and the private health institutions fail to act when they could have done so. It is clear, too, that effective implementation of these changes will require the cooperation of many disciplines: economists, political scientists, administration experts, sociologists, and the like, as well as health professionals.

Whatever form is assumed in the future by our institutional arrangements for the financing, organization, and administration of health services, our own past experience and that of other countries has shown that the extent to which the objective of high quality comprehensive health care is attained depends in large measure on the role which the health professions themselves decide to play. Whether the final form of organization and financing be some combination of public and private action, as seems most likely, and whether public action takes the form of a broadened health insurance system, a liberalized income-tested program or a free health service for larger or smaller groups of the population, the outcome will be influenced by the nature of the participation of the professions involved. The choice they face is whether to limit their role to the protection of professional interests, nar-

rowly conceived, or to subordinate these interests to the public interest by active participation in the process of developing adequate, universally available, economically operated, and high quality health services.

There are three groups within the health services whose decisions will be of crucial importance. The first is the medical profession itself, whose members do indeed have it within their power to withhold from the nation the expert guidance and professional help they could give by constructive participation, at every stage, in the planning and development of health policies and programs. The events of 1965 have already shown the unfortunate consequences of the withdrawn, narrow professional attitude. Medical men know what makes for good medical care and high quality and appropriate health services. In view of the importance attached in leading medical circles to the concept of "comprehensive care" I cannot believe that if the medical profession had been sharing constructively in the planning of both parts of Title 18, we would have adopted a system that treats health care as a commodity to be bought in a supermarket, item by item, with a built-in encouragement to the consumer to buy mainly those services for which the cost will be reimbursed. With all the lip service that is given to the primacy of prevention, had the medical profession been active at the planning stage the act would surely not have excluded periodic health examinations, screenings, immunizations, and eye examinations from the list of reimbursable items. Given all that is known about the limitations of solo practice, would not a law that reflected the forward thinking of the medical profession have embodied inducements to encourage group practice?

We must not underestimate the magnitude of the demand made on the medical profession in asking for their full cooperation in the exciting and challenging task of shaping and applying social policies directed toward excellence in our health services. For the agonizing decision to place public, ahead of narrow professional, interests has many consequences. It means that many members of the profession will have to give time to matters other than the treatment of patients or the conduct of research. Some of its leaders will have to devote time to that most repulsive and time-consuming of all occupations, serving on committees, committees concerned with the restructuring of our delivery systems, or the formulation of standards for practice or with negotiations on behalf of their colleagues about the forms and amounts of renumeration. It means fully accepting the responsibilities that flow from the claim that the profession should be the sole judge of what is or is not good professional practice. Some members of the profession will have to sit in judgment on others, whether it be in the functioning of utilization committees or testing qualifications for practice or, if certain systems of renumeration should be adopted, discriminating among colleagues on the basis of relative competence.

Placing the public interest ahead of narrow professional interests means also that as the key profession involved in the rendering of service, physicians must be prepared to pay more attention to the importance of economy. It means a willingness to abandon the performance of procedures and tasks that do not call for high levels of expertise and which could be performed effectively by less highly trained professional or auxiliary workers, alone or under medical supervision. It involves removal of some of the mystique of medicine by more vigorous support of efforts, starting in our schools, to disseminate to the population as a whole a better knowledge of the functioning of the body and the mind and of some of the more elemen-

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tary principles of medical care; and it calls for a willingness to reassess the character of medical education itself.[13]

Admittedly this is to ask much of the medical profession. Yet, is it really more than to ask them that they should behave as true professionals? For the justification of the special privileges that society grants to a profession is its claim to place service to the community ahead of pecuniary or other personal advantage. The public image of the medical profession is unfortunately badly tarnished today.[14] Constructive participation in the new social policies might yet restore its old splendor.

The second major group faced with difficult choices consists of those concerned with the policies and administration of our hospitals and especially the voluntary general hospitals. Essentially their choice is whether to conceive of the hospital's role as being that of serving as the community medical center responsible for comprehensive health services, or continuing to be an institution concerned mainly with episodic care and serving primarily the interests of the medical profession as vehicles for teaching and as expensively equipped workshops for practitioners.

The change of role will not be easy. It will involve de-emphasizing inpatient care and, in Dr. Falk's words "upgrading ambulatory care as an equal interest rather than as an unavoidable affliction."[15] It implies also a continuing concern with what happens to the patient after he leaves the hospital, and thus an active concern with the availability and appropriateness of community health services.

But more than this is involved. Now that the health services have become a matter of social policy the voluntary hospitals must come to terms with the fact that there is indeed a public interest in what they do or do not do. This interest stems not merely from the fact that henceforth an increasing proportion of their income will come from public funds and not only because they make heavy demands on the nation's economic resources. It arises even more importantly from their strategic position in the total structure of health services. Functionally considered, they are indeed quasi-public bodies and no longer purely "private" or "voluntary." As such they can no longer be answerable for performance only to their boards of governors or to the hospital administrator or to the dominant professional groups: they are answerable to the public. Nor can their governing bodies consist only of our richer or more prominent citizens. They must reflect, because they serve all classes of health consumers in the community.

The third group to whom the present situation presents a challenge, but also a great opportunity, consists of our public health departments and their staffs. As health becomes increasingly a matter of public concern and the subject of social policy, there will be an ever more intense need for some public agency that not only administers some of our public health programs but is also concerned with the totality of the health of our communities. I do not see how it will be possible to achieve all that is hoped for unless we can develop in all our localities and states strong and active health departments.

Dr. Luther Terry reminded us, in his Bronfman Lecture, that "the health officer and the health department remain the only agents which the body politic has been willing to pay to be concerned with the health of the public as a whole."[16]

Carrying out this mandate will however necessitate adoption of a broader view of the functions of a health department than generally appears to prevail. It will mean, as Dr. Trussell so cogently argued in his Bronfman Lecture,[17] becoming concerned with the quality of the medical care and health services

available to the community. It involves a preparedness to serve as the health watchdog of the community, letting the public know what it is getting for the money it spends on its governmental and private health programs. It is no credit to our health departments or to health professionals in general that it was newspaper reporters and politicians who exposed the shameful state of the municipal hospitals in the richest city in the country. It means taking up a position, in the interests of good health care, on proposals that might prejudice the sound development of the health services. It was unfortunate, for example, that when Title 19 was being drafted, the public health departments of the country were not mobilized to insist that the expanded program be conceived of as a health and not a welfare measure and as such should be made the responsibility of departments of health. It means adopting a broader view of the concept of prevention, not limiting it to physical environmental health in the traditional sense but undertaking also investigations of the impact of social factors, for example, of low incomes or poor housing on health, and bringing the findings forcibly to the attention of the public.

This will not be easy. Operation of public medical programs, especially if they are income-tested, will indeed mean undertaking administrative tasks that traditionally have been held in low esteem when done by welfare departments. Administrative responsibility for the economical operation and high quality of a publicly financed program will create new and inevitably less cozy relationships with medical practitioners. Carrying out the mandate to be concerned with the health of the public as a whole means reaching out to the community and involving its members through advisory committees and in other ways in both evaluation and pressure for change. The broadened function will inevitably involve the health departments in controversy and they will need the support of an informed and interested public. These are big risks, yet the stakes are so high that I cannot believe the public health profession will turn its back on this great opportunity.

The new element with which we all have to come to terms and which was symbolized by the 1965 legislation is that the question of the health of the people has now been *elevated* to the realm of conscious social policy. This means that change will come and the only question is how and under what leadership. It is evident that people are intensely concerned about health and it is one of the glorious traditions of this country, more obvious perhaps to those who observe us than to ourselves, that if the American people are convinced that something is desirable and ought to be done they will find ways of doing it.

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ITEM 3: INFORMATION FROM THE COMMUNITY SERVICE SOCIETY OF NEW YORK CITY

November 2, 1967.

DEAR SENATOR SMATHERS: Our regret was real that we could not participate in the hearings in New York City on the subject of Costs and Delivery of Health Services to Older Americans. As indicated to Mr. William E. Oriol prior to the receipt of your letter dated October 13, we had a serious conflict in respect to the October 19 scheduling.

As a matter of information we are pleased to send you a progress report on the project titled "Senior Advisory Service for Public Housing Tenants."[1] Its principal elements are reaching out to tenants aged 60 years and older in four public housing projects and rendering informational, referral, facilitative and generally supportive services. Basically it is a neighborhood-based "bridging" service given by in-service-trained workers.

At this point, project data are provocative but not definitive nor pinpointed. For example, we know that 547 tenants seen in the first ten months of service expressed 1039 problems or an average of two per tenant. We know that the three major problem areas into which 74% of all problems fell were (1) *inability to utilize resources independently* (32% including 4% Medicaid) because of lack of information, complexity of application procedures, physical immobility or difficulties and language barriers; (2) *physical health* (23%); and *insufficient funds* (19%). We know that service workers gave a total of 2023 srevices or an average of nearly four per tenant seen. What we do not as yet know—pertinent to the subject of the hearing—is what problem areas required the greatest effort on the part of service workers to achieve delivery of the needed services by existing community resources.

We shall keep you informed as the project goes forward and data are analyzed. At subsequent hearings, it is our belief that we will be in a position to file substantial and substantiated findings for the record.

With admiration for your leadership, I am,

Sincerely,

JEAN WALLACE CAREY.

ITEM 4: INFORMATION FROM THE OFFICE OF ECONOMIC OPPORTUNITY

November 9, 1967.

DEAR SENATOR SMATHERS: In response to your letter of October 14, 1967, I would like to outline a few of the central implications of OEO's Comprehensive Health Services Programs for the health care of the aged.

As I am sure you know, OEO makes grants under Section 211–2 of the Economic Opportunity Act for the purpose of establishing comprehensive health care centers for the poor of all ages. The guidelines under which such centers are planned have particular relevance to the aged poor, since age and infirmity often increase the barriers to health care beyond the barrier of poverty alone.

For example, the service of the OEO funded center is comprehensive and personalized. All relevant health care is provided at a single location and by a personal physician. There is unity and continuity of care. This permits the physician to practice a program of preventive, as well as curative medicine, an essential differences from the sort of care provided by traditional charity outpatient clinics.

The centers will provide transportation for the infirm. In addition, each center trains a number of outreach workers, who live in the community and will be available to help the aged, especially those who are homebound or handicapped. They will be available to supervise and assist the patient at home and, working closely with the physician, will help to implement the physician's recommendations, and advise him of problems as they arise. Since chronic disease is especially prevalent among the aged, planning of this sort is essential to ade-

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[1] In subcommittee files.

quate health care for this group. Finally, the centers may provide a source of training and employment for the aged.

I believe this program is a significant advance in the difficult and troubling problem of health care for the aged poor.

Sincerely,

JOSEPH T. ENGLISH, M.D.,
Assistant Director for Health Affairs (Actg.).

ITEM 5: MATERIAL FROM DR. LOUIS FRIEDFELD, NEW YORK CITY

October 10, 1967.

DEAR MR. ORIOL: Enclosed please find our reprints describing the operation and findings of the Geriatric Clinic at Beth Israel Hospital in New York City. Started in 1954, it is now one of the oldest comprehensive Geriatric health programs in the country. Our experience permits certain observations.

(1) At least one comprehensive health inventory is advisable in the health program for any aged person. This should include medical, psychiatric and socio-economic evaluation, defining not only deficiencies but also resources and potentials for rehabilitation. This comprehensive estimation is invaluable in preparing a program of management, with avoidance of costly fragmentation and duplication of health services. It would help oldsters to function at maximum efficiency while living in the communities of their choice. Such health inventories may readily be developed utilizing the services and facilities of most community hospitals. It may also be prepared by multi-disciplined group practices and by geriatrically oriented physicians.

(2) There is the need for improved standards and resources, and where necessary, expanded services in the following areas:

(a) Public assistance,

(b) low cost housing,

(c) social security eligibility and coverage,

(d) Government participation with industry in more flexible employment and retirement policies,

(e) Government support for improved recreational and employment facilities.

Further comment on this subject is in our letter published in "A Survey of Major Problems and Solutions in the Field of the Aged and the Aging", by the Subcommittee on Problems of the Aged and Aging, Pat McNamara, Chairman; 1959, pages 77–78.

Very truly yours,

LOUIS FRIEDFELD, M.D., F.A.C.P.

[Enclosure]

EXHIBIT A. GERIATRICS, MEDICINE, AND REHABILITATION

[Reprinted from the Journal of the American Medical Association, Feb. 18, 1961]

(By Louis Friedfeld, M.D., New York City)

A geriatric clinic in a general hospital has developed a diagnostic and therapeutic program with rehabilitation goals for the aged. Medical, psychiatric, and psychosocial studies were integrated to determine needs and to provide broad, flexible, centrally coordinated services. Hospital resources were supplemented by other community facilities. This enables many elderly people to live within the community and to avoid more costly, less satisfactory institutional living. Out of 100 patients re-evaluated after two years, 65 showed improvement in medical, psychiatric, and psychosocial areas, and 12 remained stabilized without further deterioration.

As individuals enter the elder years they often are burdened with the difficulties in effective functioning that appeared and developed earlier in life. They then are exposed to new medical, social, psychological, and economic problems. Solutions may present difficult and perplexing alternatives, but efforts should be directed to furnish the services and resources required for adequate rehabilitation and the maintenance of optimum health. Planning must be broad in scope,

flexible with changing needs, financially feasible, and centrally coordinated within the community. A plan that utilizes the existing skills and facilities of a general hospital in such a comprehensive program has previously been described.[1]

PROBLEMS CREATED BY AGED PORTION OF POPULATION

Problems created by an increase in the aged portion of the population affect the individual, his family, and society. There is also an associated increase in the prevalence of long-term illness as the elederly now survive the acute diseases that formerly were fatal. These lead to an increased need for health services in the elder years. Urban, rural, and other environmental differences affect these problems, but essential principles must be defined. The individuality of the aged person is of paramount consideration; there is no stereotype. Diagnosis and treatment are related to differences in total status, which depend upon variations in physical and emotional health, economic and social position, the level of intelligence and personal experiences, personality flexibility, and familial relationships.[2] This emphasizes the need for total diagnosis, including the appraisal of resources and functioning, motivations and goals, strengths and dormant potentials, needs, weaknesses, and flexibility in compensations.

In the United States the general population has doubled since 1900, but the number of persons past 65 years of age has multiplied five fold. All over the world there is a developing awareness of existing and impending problems arising from greater life expectancy, and the general increase in the number of aged. Yet, in a period of their lowest productivity the aged have need for the costliest services. In a 65-year-old person this need may continue during a life expectancy which averages 14 years.

There are at present 16 million persons in the United States over the age of 65, constituting about 9 per cent of its total population. Of the total population, 40 per cent of all those disabled were within the elder 9 per cent group. It is noteworthy that 4 out of 5 of these have been able to function within their own home, or homes of their children, or in private homes otherwise arranged.[3] Since the community harbors 95 per cent of all persons over 65, any plan for comprehensive services to this segmnet of the population should be directed to treatment and rehabilitation for the maintenance of effective and satisfying living within that local unit.

If rehabilitation were to be defined as "the restoration of the handicapped to the fullest physical, mental, social, vocational, and economic usefulness of which they are capable,"[4] to accomplish what is implicit in this definition would require comprehensive services and integrated functioning of a professional team, including skills in medical, psychological, social, and vocational fields.[5] The program could involve short or long-range goals, with degrees of change ranging from limited improvement in self care to maximum improvement in functioning in all aspects of living including home, jobs, marital relationships, and rearing of children. This may be effectuated by individual step-by-step stages, or through comprehensive and broad, long-term planning.

The key to individualized service is the flexibility which stems from the recognition that the needs of individuals differ, and that these needs change with time and circumstance. Rehabilitation should be an innate element of care, beginning early in illness and affording continuity, with planning for realistic goals. The rewards may be improved productive activity, enhanced self care, raised morale, dignity, and increased self reliance—all of these at moderate financial cost.

Not all patients can be rehabilitated to a self-care basis. If a patient with a long-term medical problem cannot be treated at home, he may be transferred to an institution furnishing desired services for the duration of his needs. Aside from the home, rehabilitation may take place in a general or specific hospital,

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[1] Friedfeld. L., and others: Geriatric Clinic in General Hospital, *J. Amer Geriat Soc* 7:769–781 (Oct.) 1959.

[2] Report of Conference, Central Bureau for the Jewish Aged, New York City (Nov. 15) 1959.

[3] Bureau of Census: U.S. Census of Population: cited by Statistical Bulletin, Metropolitan Life Insurance Company, 46:6–8 (Aug.) 1960.

[4] Brochure of National Council on Rehabilitation (Jan.) 1948, cited by ref. 5, infra (p. 133).

[5] Care of Long Term Patient, Commission on Chronic Illness, Commonwealth Fund Book, Cambridge, Mass.: Harvard University Press, 1956.

rehabilitation centers, or nursing homes, but the patient should not be maintained in a high cost facility when a less expensive one is available to serve his needs as well or better.

Major problems of the aged include suitable housing and living arrangements, physical and emotional health, satisfying social relationships, participation in the mainstream of community life, economic security, education, recreation and meaningful activities, rehabilitation services, religious opportunities, and welfare services.

EMPLOYMENT AND RETIREMENT OF OLDER PERSONS

Since health and functioning are closely related to economic and social factors, the problems of employment and retirement are significant. If productive, gainful, and satisfying activities are desiderata, we must deal with the existence of compulsory chronologic retirement and job discrimination for older people. Public education is needed to establish the advisability of employing older workers, and retaining those capable and indicating a desire for work. Job engineering may develop training programs in new skills, reassignment to lighter work, the creation of new jobs, and sheltered workshops. It may be necessary for older workers to release seniority rights and for older applicants to waive retirement benefits. Finally, counselling and planning should start long before retirement to ease the adjustment to work-separation.

Environmental factors, forced inactivity, and the feeling of uselessness contribute significantly to the deterioration of older persons. Feelings of frustration create functional disturbances and a sense of inadequacy in the period of declining strength, skill, and endurance. Of those so affected, many seek permanent institutional care with relatively minor or transient physical and emotional illnesses, or because of their inability to resolve socioeconomic problems. This removes them from their familiar and more favorable environment and transfers them to institutions, at great financial expense and with inestimable loss in human values. Such drastic measures could often be obviated if there were adequate facilities at the outset to furnish health services and counselling.

THE GERIATRIC CLINIC AT BETH ISRAEL HOSPITAL

A Geriatric Clinic was established in 1954 at the Beth Israel Hospital in New York City. It seeks to develop comprehensive diagnostic and treatment services in an integrated program to help the elderly live effectively within their own community as long as this is their choice, and for their own welfare. Many professional skills and extensive physical facilities are coordinated in this program of health care and rehabilitation.

The basic diagnostic treatment unit consists of 4 physicians, a psychiatrist, a nurse, and a full-time social worker functioning as an integrated team in the outpatient department of a general hospital. It also has access to the many other professional skills, laboratory, x-ray, and other facilities in the hospital that may be needed in particular cases. All the members of the team are geriatrically oriented, understand the multiplicity and interrelationship of stress forces in the aged group, and have a desire to work with them. They assess the potentials for patient rehabilitation after comprehensive diagnosis and estimation of resources, impairments, and needs. Additional services may include dietary counselling, physical medicine, dental restoration, and education in self care. In the treatment program, varied community resources may be utilized to broaden the hospital skills and facilities. The approach is holistic; the goal is rehabilitation.

Patients over 65 are referred to the Geriatric Clinic from the hospital inpatient department, or from other outpatient clinics, or are directed by private physicians or community health and welfare agencies, or make application on their own initiative. A preliminary screening by a clinic physician and caseworker may separate those unable to benefit from our method of treatment. All others receive comprehensive diagnostic assessment.

PATIENT, FAMILY PREPARATION

The social worker undertakes a psychosocial study and assessment of the patient's functioning and social and family relationships as these relate to the medical symptomatology, and prepares the patient and his family for the clinic program and procedures. The psychiatrist assesses the personality strengths and ego-integrative capability as well as indications of psychopathology in relation to

known medical and social factors. With this initial information available, the examining physician then conducts a comprehensive medical survey, including indicated specialty consultations and laboratory and x-ray studies. The case is now ready for the Geriatric Team Conference.

At the team conference, a comprehensive and differential diagnosis, statement of treatment goals, and a program of services and management are formulated. The conference participants include the team members and consulting specialists. Each discipline contributes the considerations in its own area of expertness so necessary in setting dynamic diagnostic and treatment goals and priorities. In the development of diagnosis, an effort is made to estimate the patient's functional capacities. These may be impaired by disorders in one or more of the medical, psychiatric or social areas. Not alone the degree but also the direction of functional change needs to be assessed, including the potential for further improvement, or the likelihood of deterioration. This careful weighing and judgment is essential for the determination of reversibility of functional impairment, or the possibility of stabilization or compensation for limitations that cannot be corrected, or for the need and ability to develop compensating dormant resources. It is our experience that the correction of one or more of the limiting factors can minimize the handicapping effects in daily living of irreversible disability in other areas. Following the comprehensive inventory of health, disability, functional capacities, and impaired or untapped resources, the patient enters the treatment and management phase. In its implementation, any of the extensive resources in our general hospital may be utilized.

Following the team conference, the findings, recommendations, and planning are presented to the patient by his clinic physicians and the social worker. Regular appointments with the various treatment personnel follow. The patient is brought into a collaborative relationship within the program. Where indicated, family members also participate.

Two years after the start of treatment, the patient's status is re-evaluated. When health and functioning have become stabilized at a satisfactory level, he may be transferred to the general medical clinic for further on-going care, or he may remain in the geriatric program for the medical treatment required to safeguard against breakdown. The relationship of our clinic to the patient is close, flexible, and dynamic.

BROAD AND WELL-BALANCED PROGRAM

The geriatric program is broad and well balanced, and is designed to meet patient needs, with minimum disturbance in his way of life. It offers continuity of care in medical management that is well controlled. Costly and time consuming unnecessary clinic visits are reduced, medical facilities are more economically and more effectively used, and duplication of expensive tests or fragmentation and overlapping of care are eliminated. In addition, full use is made of other existing community resources which are fitted into the program. Where the cause for a poorly balanced diet may be traced to limited finances, poor dentures, lack of motivation, or lack of energy to market or to prepare, the need for a comprehensive program is apparent.

Analysis of our first 100 cases[6] disclosed that there were 18 patients in whom significant medical conditions had been revealed in our surveys that had previously escaped detection in symptom-tracking examinations. In 53 instances there were reversible physical disabilities that had potential for functional improvement. Only 20 patients had medical conditions that seriously impaired the activities of daily living.

Psychiatrically, there were 2 patients with neurotic emotional disturbances of sufficient intensity to influence organic disease, behavior, and general functioning. These patients gave a long history of neurotic reaction to traumatic experiences of life. They had always demonstrated an inability to deal with inner instinctual conflicts and problems and the demands of reality, so they reacted to the stress and traumata of old age with neurotic solutions and with exacerbations of their fundamental emotional difficulties. Nine patients suffered from psychoses, but evidences of such illness existed in their earlier years. Sexual interest was maintained in a majority of the group, with regular gratification for those with available sexual partners. Those whose sexual interests and

[6] Friedfeld, L., and Goldfeld, F. B.: Geriatric Clinic in General Hospital: First Year's Operation, *J Amer Geriat Soc* 4:41–45 (Jan.) 1956.

capacities were not maintained had generally demonstrated neurotic sexual patterns and difficulties in early adult life. At this time we are investigating the relationship of memory recall to stresses in living.

The social worker reported that counselling on individual and family problems was required by 67 patients and their families in 64 households. Ninety-seven patients required additional environmental services which were provided to help maintain, stabilize, or improve the use of capacities and resources for greater comfort and satisfaction. These often served a rehabilitative purpose, and included home equipment, appliances, self-help devices, and domestic help. In particular, dentures, glasses, and hearing aids helped restore a degree of normalcy as well as promote normal social relationships.

Re-evaluation after 2 years of treatment disclosed that 65 percent of the patients showed improvement in the medical, psychiatric, or psychosocial areas, and 33 per cent in all areas. An additional 12 per cent remained stabilized, without further deterioration.

COMMENT

As individuals are helped to live comfortably and productively within their own group, high costs for institutional construction and maintenance are avoided. Beyond obvious dollar savings are the salvaging of human values and resources. Individuals may thus be enabled, despite handicaps, better to utilize their capacities and to live in the ways they prefer.

Whether for the aged or others, prevention and care of chronic illness or disability should be an integral part of general medical service, directed within the community, centrally controlled, and offering a full range of services, planning, and counselling.

Ordinarily, general hospitals treat only short-term illness and the acutely ill. Medical care at home is usually inadequate in the long term planning, implementation and supervision of chronic illness. Given the central control and the range of services and planning within the outpatient department of a general hospital, individuals may be cared for as well or better, and more economically at home than in long-term institutions. Hence, making comprehensive general hospital facilities available on both in- and outpatient department bases in an integrated diagnostic and treatment program helps provide the health services which permit patients to remain in their own home with satisfaction and security. No single agency may meet the complex needs, but the facilities of other community resources and home care programs can also be marshalled to provide covering and economic health services while patients remain emotionally and intellectually in the mainstream of their lives. The patient's own physician may participate with benefit in this medical care program.

SUMMARY AND CONCLUSIONS

In the total diagnosis and treatment with rehabilitative goals, medical, emotional, and psychosocial factors must be considered. A geriatric clinic of a general hospital offers a comprehensive program in medicine and rehabilitation to help maintain the elderly effectively and satisfactorily in their own homes, in which 95 per cent of all people past 65 years of age continue to function.

121 E. 60th St. (22).

I am indebted to Freda B. Goldfeld, Director of Social Services, Dr. Max Needleman, Associate Psychiatrist and Dr. Aaron Silver, Associate Physician, Beth Israel Hospital, who participated with me in the development of the Geriatric Clinic goals and method of operation.

ITEM 6: INFORMATION FROM THE DEPARTMENT OF SOCIAL SERVICE, NEW YORK CITY

November 14, 1967.

DEAR SENATOR SMATHERS: Thank you for your letter of October 27th regarding the New York City Medicaid program and its impact on the elderly who require extensive health care and who are not in a financial position to pay for such care. New York State has the most liberal Medical program in the nation and we feel that we have carried out the intent of Congress by making certain that no person or family will become impoverished as a result of medical expenses. The liberal provisions of our Medicaid program are particularly important for

the elderly who cannot afford the cost of prescription drugs, dental care or nursing home care out of their income. Our experience has shown that most of the elderly who apply for Medicaid in New York City do so because they cannot afford the high cost of prescription drugs and dental care.

During the past summer we carried out an intensive Medicaid information and enrollment program. From June to September 30, 1967, 598,000 New York City residents were enrolled in the Medicaid program. As of the current month there are now over 2,000,000 persons eligible to receive Medicaid in New York City. At the present time 137,000 persons 65 years of age and over are enrolled in the New York City Medicaid program. In our summer enrollment and informational program we had frequent occasion to speak to large numbers of elderly persons. We learned from them first hand the problems they face in meeting the rising cost of medical care. We were able to do this because we carried out our Medicaid information and enrollment program on the streets of New York, particularly in the busy and crowded neighborhoods of Manhattan, Brooklyn, the Bronx and Queens. We also instituted a "Medicaid Shopper's Week" in a number of large department stores, thereby gaining further first-hand contact with many elderly persons. Most of their questions concerned the relationship between Medicaid and Medicare and their eligibility for Medicaid if they were already receiving Medicare.

As a result of our first hand experience with great numbers of elderly people who were confused by the two programs, I hope to establish a special office within our Medicaid program that will deal with problems of elderly persons who seek information, guidance and assistance in the completion of their Medicaid applications. The office would also give assistance to elderly persons after their applications are accepted for Medicaid, and maintain constant contact with Senior Citizen groups throughout New York City.

I quite agree with you that many of the passages in our current publication entitled, "Medical Assistance Program" can stand revision and rewriting, and the booklet will be revised in the next edition. The present booklet is on order from the printer until January 31, 1968. We are awaiting the action of Congress on H.R. 12080 before preparing a revised text. The new edition will carry a special section for the elderly and will contain all the information an elderly person needs to know to secure the health services available through the Medicaid program. We are particularly grateful to you for reminding us of the constant need to be alert to the special problems of elderly persons.[1]

In reference to the New York City resident who wrote to you regarding the Medicaid informational booklet we feel her observations are quite often justified. However, the booklet does make clear that there are 21 Medicaid offices throughout New York City that are concerned with giving Medicaid information and assistance to persons who require such help. In addition, at our Medicaid Center, we have 32 telephone lines that are manned from 9 A.M. to 5 P.M. to provide information to persons who cannot visit a Medicaid Registration Center.

In reviewing the marginal notations made by the New York City resident in the Medicaid application booklet, I note only two direct questions. They both appear on Page 9. The first question is concerned with liens and encumbrances. The explanation given in the booklet, put in the most simple terms, means that children under the age of 21, have the right to the estate. This also applies to children over the age of 21, if the child is blind or permanently and totally disabled. If there are no such surviving relatives, the state takes over the property.

In reference to the question on page 9 regarding the problem of families with incomes, savings and insurance above the exempt level, it is not necessary for the family to suffer a catastrophic illness in order to be eligible for Medicaid. We have a number of families whose income is slightly above the exemption limit, but who have medical expenses that are greater than their surplus income and these people apply for Medicaid. The catastrophic illnesses covered by Medicaid are mostly applicable to persons with considerable income but who find themselves faced with staggering medical bills which they cannot afford out of their earned income.

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[1] See testimony by Miss Patricia Carter, p. 438.

Thank you again for your letter and for your very generous interest in our Medicaid program. And please express to the New York City resident who corresponded with your Committee our gratitude for her observations and suggestions.

With best wishes, I am,

Sincerely yours,

MITCHELL I. GINSBURG,
Commissioner of Social Services.

ITEM 7: MATERIAL FROM THE COUNCIL CENTER FOR SENIOR CITIZENS, BROOKLYN, N.Y.

October 4, 1967.

DEAR MR. ORIOL: * * *

I am taking the liberty of sending you a record of our own experience in dealing with senior citizens who have applied for and had problems with Medicare and Medicaid in New York City. The introduction in the attached material is self-explanatory.

If you have any further questions relating to it, please do not hesitate to get in touch with us.

* * * * * * *

The members of the Council Center for Senior Citizens join me in urging you to continue the work of your Sub-Committee in bringing to light an evaluation of the Federal and State Health Programs for the Aging.

Sincerely yours,

LEO LAKS, *Executive Director.*

[Enclosure]

The Council Center for Senior Citizens, is a project of Brooklyn Section, National Council of Jewish Women and is located at 1207 Kings Highway, Brooklyn and has a membership of more than 550 men and women over 60 years of age. This is a non-sectarian, non-profit agency serving the Flatbush community in Brooklyn, N.Y.

As part of its services to the aging in this area, the Center provides the time of a volunteer who is available to any Center member who may have questions or problems related to Medicaid and Medicare. Following are excerpts from a recent report made by this volunteer at a Center staff meeting.

Our senior citizens who apply for Medicaid, and the number seems to be increasing, are either widows or widowers, or husbands and wives with no dependents and who are not wage earners. Therefore their assets and income are all that are necessary to know, when helping them with their applications.

It is important that Medicaid patients be told *not* to pay for any medical services, such as physicians, dentists, nurses, optometrists, drugs, podiatrists, and other professional personnel. Medicaid pays the provider of these service directly, but should the patient pay any of these bills he will *not* be reimbursed.

When our members apply for Medicaid, there seems to be no difficulty in processing their applications and getting their medical cards in a few weeks, in most cases. But the difficulty has been in finding doctors for these people, who will accept them as patients. When this plan first went into effect, each neighborhood did have a few doctors participating, but now it is almost impossible to find them. More and more members are complaining about this, and last week one woman came in who had been to a number of doctors in her neighborhood, and all refused to accept her as a Medicaid patient. I called Medicaid and they gave me a list of doctors who they had been using. Out of the six I finally found one that would take her as a patient. Medicaid asked me to call them back and tell them if I found a doctor. A few of the doctors said they are not participating any more as they had not been paid for months. Others said they are not participating at all. And another said he had so many Medicaid patients, he couldn't handle his own practice and is not accepting any more. Some say they have too much paper work and have to get more office help, which means they have to raise their fees. The patient must tell the doctor he is a Medicaid patient and it is very unpleasant and discouraging for them to go to the doctor's office and be refused treatment.

The prescription situation at drug stores is better at present as many druggists

in most neighborhoods are participating in Medicaid and they have a notice posted in the windows saying so. But this may also change as the pharmacists are also complaining that they have not been paid for many months for their Medicaid prescriptions.

When our members applied for Medicaid at it's inception, they wanted to know if they should drop other insurance or keep it. According to the advice I received from Medicaid, they felt the members did not need additional insurance as Medicaid would pay *all* bills, but since it's a question of whether they should hold on to other insurance, at this time it might be more advisable to keep it. With the situation as it is, Medicaid is not able to get doctors to take patients.

The picture looks very discouraging at present, and unless more funds are made available the situation will get worse.

Up to the present time I have seen 55 senior citizens and of that number 24 have applied and received Medicaid cards.

Usually they come in with problems that they think are unique and unsurmountable. By the time we have filled out the request for payment form, or the application for Medicaid, or discussed their problem, they feel much better and usually come back in a few weeks and show me their card, or tell me that they have received a check.

The members are most appreciative and I can see how their anxiety and sense of confusion is gone by the time they have finished their interview.

As Medicare pays only what they consider reasonable charges, we have had many complaints of not receiving the same amount as was paid to the doctor. After explaining this they understand the situation.

One woman came in who could not afford to go to a hearing-aid center and I finally located one at Kings County Hospital where they have a clinic and she did not have to pay any fee.

They ask should they send in the bills for the $50 Deductible and this is a good idea, as then they could show their card to their doctor and he would know that their deductible was paid.

There are many questions that have to be answered as, whether they can receive payment for drugs under Medicare; or why certain bills are not considered covered charges; or how much money can they have in the bank to be eligible for Medicaid.

There are some older people who just miss being eligible for Medicaid or who for personal reasons do not want to apply and yet have such limited incomes that they find it difficult to pay the doctor under Medicare and then wait for a refund.

Unfortunately there are not many doctors who are accepting assignments, as they prefer being paid directly by the patient. The doctors claim there is too much paper work and then they have to bill the patient for the amount that Medicare does not pay the 20%.

Many senior citizens have made inquiries about dropping other insurance. On the advice of Medicare, if there is a duplication of coverage and the patient cannot afford the insurance they do drop it. But they should continue with Blue Shield which pays the 20% which Medicare does not, and any other insurance which picks up where Medicare stops.

One woman came in who has a mother and a mother-in-law living with her, and both have such large medical bills, she wanted to know how to go about getting them on the Medicaid plan. They both had small bank accounts, which were larger than would be permissible, they were both joint accounts with the daughter and daughter-in-law respectively, which made them both eligible for Medicaid. This relieved an already over-burdened household of medical bills for two people.

With each interview there is always something new, but we are trying to help the members wherever possible, and if I don't know the answers I try to find out from Welfare, Blue Shield or one of the other agencies.

A woman of 84 came in and wanted to apply for Medicaid. She has $6000 in the bank which is left her from the sale of a small business. Her husband is deceased. She receives only $32 per month as she has no social security and neither did her husband. With this amount of money in the bank Medicaid might not accept her and she cannot afford her medical bills. Should she have to use up half of her small capital to be eligible?

ITEM 8: INFORMATION FROM THE NEW YORK STATE OFFICE FOR THE AGING

November 9, 1967.

DEAR SENATOR SMATHERS: * * *

The following will briefly answer the three questions in your letter:

1. The New York State Office for the Aging has indirectly committed itself to serving the health needs of the elderly through contracts with three volunteer agencies. The cost of these projects is satisfied with Title III funds of the Older Americans Act of 1965, and monies appropriated by the New York State Legislature to offset one-half of the cost of the non-federal share.

Our direct relationship with other State agencies involved in health care service has been principally as a member of three interdepartmental committees concerned with problems of the aging. Our concerns are reviewed and as necessary, action to provide problem solution is initiated at the State level.

2. I am of the opinion that the regional medical programs, Public Law 89–239, and the Comprehensive Health Planning and Public Health Services Amendments of 1966 will, when fully implemented, permit marked changes in all of our health programs. I am also thoroughly convinced that your bill introduced in 1966, "Detection and Prevention of Chronic Diseases Utilizing Multiphasic Health Screening Techniques," would have provided the instrumentation to identify pre-clinical problems. Until such a program is implemented, the causes of late age chronicity will continue to progress unchallenged and untreated.

3. Reference is now made to the questions you so aptly raised in your opening statement to the hearings of June 22 and 23, 1967 in Washington, D.C.

a. The gradual increasing cost of medical care services are of special concern to the elderly. The cause of such increased costs are quite apparent when one examines the vast improvement in our medical technology over the past decade. The elderly in our State are involved either conversationally or by impact of public statements. They are keenly aware that individual shares for Social Security will be increased in order to meet ongoing and increasing costs of "Medicare." The cost of Medicaid will require increase of taxes on personally owned property in order to meet the rising cost of such services. I am not of the opinion that our health care services are inefficiently organized, I do admit, however, that continued effort must be made to achieve a uniformity of problem definition and solution by the varied disciplines concerned.

A first step should include at the Federal and State level a standard formula for computing reimbursement for care received under Title XVII and Title XIX.

b. The availability of health services are as adequate as the motivation of the individual seeking such services. New York State at the State and local level cooperatively with volunteer agenices, has the capacity and desire to meet the needs of almost anyone requiring definitive health care services. The personal desire to have these needs met are not always compatible with the means for resolving the problem. Education will in time, I am sure, correct this inadequacy.

c. It has been our observation that "Medicare" has been accepted on a personal level as highly successful. However, we do recognize that many of our older citizens, because of personal pride and independence, do not wish to avail themselves of "Medicaid" simply because of the connotation of welfare that is involved.

d. The institutional and community service structure of the New York State Department of Mental Hygiene does afford adequate institutional and out-patient services for the mentally ill elderly in New York State. I am cognizant of the effort made by the New York State Department of Social Services and Mental Hygiene in attacking the problem faced by the approximately thirty thousand oldsters in New York State who have been institutionalized for a protracted period in this State's Mental Health Hospitals. The problem does not permit a quick resolution, however, the steps that have been taken will in time insure a vast improvement in the manner in which these persons can be cared for in a non-institutional environment.

e. The trained personnel problems in the medical and medically related professions affect all segments of the population. I am concerned however that the onus and fruitlessness implied in serving the health needs of the elderly, as expressed prior to ten years ago, and expressed less frequently in the more recent past, indicates a very slow change in attitude, and in turn the public "value concept" of aging. The means must be provided to accelerate this rate of change.

Your question relative to the desirability of more group health practice to reduce personnel shortages in the health care establishment is interesting. If such group practices would permit and foster an individual intermediary physician-patient relationship, I am sure that in the long run the expertise of the service that this type practice would avail to our elderly, would be the greatest singular success in providing economic "pre, in and post institutional care" for all our citizens. It is this element, the relationship between the doctor and his patient that must be sustained in order to assure personal confidence by the individual patient in continuing a therapeutic regime to resolve a health problem. When this is lost, the despair, despondency and loneliness faced by the great number of our elderly is compounded. It only complicates the many problems they have to face irrelative of individual mental and physical health.

Thank you for this opportunity of expressing my views on the very serious questions you have raised. I sincerely trust this will be helpful to you and your committee in their deliberation of this highly critical problem.

Sincerely,

MRS. MARCELLE G. LEVY, *Director.*

ITEM 9: QUESTIONS SUBMITTED BY THE CHAIRMAN TO DR. GEORGE S. MIRICK, SCIENTIFIC DIRECTOR, HEALTH RESEARCH COUNCIL OF THE CITY OF NEW YORK, AND REPLIES

1. Has the Health Research Council conducted studies that in any way are related to the delivery of health services to the elderly? If so, may we have summaries for our hearing record?
2. Has the Council conducted studies on medical manpower shortages that in any way may be related to the delivery of health services to the elderly? If so, may we have your findings?
3. What information do you now have on the effect of Medicare and Medicaid on the health resources of the city?
4. The Subcommittee is especially concerned about health problems faced by the elderly in large urban centers, and we would welcome information on that subject.

REPLY RECEIVED

October 26, 1967.

DEAR SENATOR SMATHERS: Unfortunately your letter of the thirteenth arrived only one day prior to deadline date of October 17th, but we are replying by mail to your Washington office.

Perhaps the best way for your subcommittee to see the type of studies we are supporting is to excerpt brief summaries from the investigators' progress reports or research plans. We have done this with nine studies which we felt were germane, at least in part, to the subject of Health of the Elderly.

The investigators themselves, of course, are the best sources of information in their spheres of study and you may want to have your staff get in touch with them direct, or have a member stop in at 125 Worth Street and read through the complete reports.

Cordially,

GEORGE S. MIRICK, M.D.,
Scientific Director.

[Enclosure]

EXHIBIT A. BRIEF SUMMARIES OF HEALTH RESEARCH COUNCIL STUDIES ON MEDICAL CARE FOR ELDERLY

"COMMUNITY CASE-FINDING METHODS"

Ernest M. Gruenberg, M.D., Columbia University, College of Physicians and Surgeons, U-1474, April 1, 1964–June 30, 1967

"Routine questions in household surveys can be used to ascertain the presence or absence of certain psychiatric symptoms in the community, but only with coniderable margin of error.

"Excessive guilt, phobias, obsessions, excessive worrisomeness, compulsions, depression, feeling apart were symptoms for which adequate questions were identified. While these were the symptoms found to be most readily ascertained, the best of them produced both false positive and false negative responses.

"The calibration of psychiatric symptom questions inserted in morbidity surveys by reinterviewing with trained interviews is practical and yields valuable information regarding the viewpoints of the respondents. . . . The possibility of offering treatment to a portion of these people to see if improvement follows should be considered."

"COMMUNITY MASTER SAMPLE SURVEY IN THE WASHINGTON HEIGHTS HEALTH DISTRICT"

Jack Elinson, Ph. D., Columbia University, School of Public Health and Administrative Medicine, U–1053, January 1, 1961–December 31, 1970.

"The Case-Finding Method Study, supported by the Health Research Council is designed to develop, and estimate the validity of, improved techniques for case finding of individuals with symptoms of mental disorders in metropolitan New York City. In the 1965–66 MSS, a subsample of some 1200 adults, selected from specific ethnic groups, were interviewed about symptoms suggestive of psychiatric disorder. Reinterviews were conducted by study staff social workers with individuals who reported specific types of symptom patterns."

"URBAN MEDICAL ECONOMICS RESEARCH PROJECT"

Nora K. Piore, M.A., Hunter College of The City University of New York, U–1153, July 1, 1961–June 30, 1969.

"A first report on Physicians in New York City has been prepared. It provides information on the number, type of practice, specialities, and other characteristics of physicians in New York City in 1959 and 1966, and compares physicians in New York City with New York State, the New York S.M.S.A., and the United States as a whole. . . . A breakdown of the city-wide data on physicians by boroughs has been completed. Plans are in progress to provide, at the request of the Health Services Administration, a further breakdown, by health areas. Also being worked on is a method of obtaining and analyzing information on physicians providing services to Medicaid (and possibly Medicare) beneficiaries, so that the characteristics of physicians participating in these programs can be compared with the profile of all physicians in the city."

"A MODEL OF DEMAND FOR MEDICAL CARE IN LOW INCOME NEIGHBORHOODS"

David L. Littman, Hunter College of The City University of New York, U–1153, July 1, 1961–June 30, 1969.

"This study is aimed at constructing a model of demand for medical care in low income neighborhoods. The model is constructed in order to assist in achieving an optimum allocation of medical care resources. In a city such as New York, programs of health and medical care are sponsored by many agencies, public, private, and philanthropic. Particularly in low income neighborhoods, where perhaps three-quarters of the population is eligible to receive some amount of publicly supported medical care, there appears the greatest concern over waste which results from non-integrated services supplied by a variety of sources and from the lack of information regarding the population which is eligible to receive, or is in fact actually receiving such care."

"THE SAMPLE DESIGN OF THE NEW YORK CITY POPULATION HEALTH SURVEY"

Paul M. Densen, D. Sc., The New York Academy of Medicine, New York City Department of Health, U–1662, June 1, 1965–August 31, 1966

"Population surveys are made by age, race, sex and local area within the City. This allows for estimates of changes in demand related to population changes. Also, it permits an assessment of the impact of such programs as Medicare and Medicaid on utilization and expenditure patterns by the population. . . . Our questions were designed to determine not only the amount of medical care received by New Yorkers and the diseases for which this care was required, but also to determine the auspices under which it is given, and how families finance their care."

"PATTERNS OF MEDICAL CARE AMONG THE INDIGENT AGED ENROLLED IN H.I.P."

Sam Shapiro, Health Insurance Plan of Greater New York, U–1321, July 1, 1962–June 30, 1966

"The study shows that Old Age Assistance recipients enrolled in H.I.P. and those not so enrolled (referred to as H.I.P.–OAA's and non-H.I.P.–OAA's:), had the same physician utilization rates; also that no change in hospital utilization is attributable to the demonstration project. However, there were important changes in patterns of utilization of physician services, H.I.P.–OAA's were more likely to see a physician during the year; there was a shift from home calls to office visits among H.I.P.–OAA's; and those who are usually low utilizers (e.g., Puerto Ricans) increased their utilization in H.I.P. Mortality among the H.I.P.–OAA's was lower than the rate among non-H.I.P.–OAA's in the 18 month period after the study year. . . . H.I.P. and non-H.I.P. nursing home patients had similar physician and hospital utilization rates. Drug costs were lower in H.I.P.; laboratory services were frequently provided in H.I.P. Welfare officials viewed these as indicators of improved quality of care."

"MORNINGSIDE GARDENS RETIREMENT HEALTH SERVICES RESEARCH AND DEMONSTRATION PROJECT"

Theodore B. Van Itallie, M.D., St. Luke's Hospital Center, U–1148, July 1, 1961–June 30, 1965

"On September 1, 1964, the Community Health Studies Unit began a three-year research and demonstration project to determine the best methods for maintaining elderly adults in a self-sufficient status within their own homes for as long as possible. The project is a joint effort between the Community Health Studies Unit and the residents of a middle-income, non-profit cooperative housing development near St. Luke's Hospital.

"The primary goal of the project is to determine the medical and ancillary services which a middle-income elderly group need in order to remain in a self-sufficient status in their own homes, despite advanced age, disability, and chronic disease."

"WELFARE MEDICAL CARE PROJECT"

George G. Reader, M.D., Cornell University Medical College, U–1042, July 1, 1960–June 30, 1965

"The New York Hospital-Cornell Medical Center Welfare Care Project was designed to determine over a five-year period the feasibility of a voluntary teaching hospital's providing complete medical care to a randomly-selected panel of Welfare cases and to study the cost, utilization, and quality of this care. . . . Centralization of care in a medical center was found to be feasible for the number of patients in the study group who responded to the invitation, about 1,200 persons. . . . Comparison of utilization under the two systems showed that doctor visits per patient at risk in the first year averaged 6.5 in the control group vs. 7.6 visits per patient at risk in the study group. In the second year it was 4.1 visits per patient at risk for the control group vs. 5.2 in the study group."

"LONG STAY HOSPITAL CARE"—

"THE AGED, PATIENTS SIXTY-FIVE AND OVER"

Frank Van Dyke, M.S., Columbia University School of Public Health and Administrative Medicine, U–1040, July 1, 1960–June 30, 1967

"One hundred sixteen (116), forty seven per cent, of all patients found not medically in need of the general hospital were 65 years of age or over. The majority, 74 patients, were age 75 or over and represent nearly a third (29.8%) of all patients found to be in the hospital for non-medical reasons.

"Diseases of the circulatory system, strokes, diabetes, injuries, and malnutrition ranked high as reasons for their admission, along with an acute episode of some kind, pneumonia, for example, complicated by infirmities of old age.

"About one-half the aged patients examined needed some degree of direct skilled nursing care, generally on an institutional basis. Half needed primarily personal and protective care, but not necessarily in an institutional setting."

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ITEM 10: QUESTIONS SUBMITTED BY THE CHAIRMAN TO DR. CHARLOTTE MULLER, PRESIDENT, PUBLIC HEALTH ASSOCIATION OF NEW YORK CITY*

1. I am very much impressed with the arguments you and the Association present for extension of coverage to preventive services and out-of-hospital prescriptions, as well as your recommendations for elimination of deductibles, coinsurance, and limits on certain services.

I would very much like to have additional discussion from you and—if possible—other members of the Association—on the reasons for your recommendations, and if at all possible, examples of the difficulties caused to the elderly because of current policies on Medicare and Medicaid.

2. I am especially interested in the observations of the Association on group practice mechanisms. We will have testimony at the hearing on the HIP-welfare-Medicaid programs, and I would welcome some discussion from you on the need for similar efforts elsewhere.

3. I very much appreciate the guidance and help you have already given to the staff in preparations for the hearing, and I would welcome additional discussion from you individually or as a policy statement by the Association on matters already discussed, including several of the questions I raised on page two of the opening statement, enclosed.

ANSWERS RECEIVED

October 10, 1967.

DEAR SENATOR SMATHERS: Our organization welcomes the interest of the Senate in the delivery and financing of health services for the elderly. We also welcome the opportunity to point out issues on which Congress could take useful action. In using this opportunity we shall draw on our recent expressions of policy. The first concerns the expansion of Medicare coverage to eliminate deductibles, coinsurance features, and limits on units and types of service; to add an outpatient drug benefit; and changes in the Medicare law to embrace hospital-based specialties in Part A methods of payment. We would like to see coordinated and effective delivery of service encouraged through such means as setting up standards and incentives for group practice and developing cost criteria for medical services. (The full text of our statement is appended.)

The reason for these recommendations is our recognition of the conjunct biological, economic, and social problems of the aged. All deductibles, co-payment features, and service unit limits are designed to hold back utilization, to shift costs from fund to patient, or both. These purposes ill suit the restricted retirement income and the heightened medical needs of large numbers of aged persons. Some restrictions, by discouraging out-patient and home-based services, may actually help cast the aged patient into the institutional population with higher service costs and less opportunity for independent living.

The aged have more multiple medical conditions than the younger patient, and greater difficulty in moving from place to place in search of service. Many are hardly able to communicate their medical needs, let alone to effect the coordination of complex services through their personal efforts. In hospitals, which have prided themselves on developing a variety of specialty clinics, the patient is often shunted from clinic to clinic before a complex or multiple medical problem is dealt with. Nor is he always better off in dealing with private solo practitioners. This situation makes the prospect of expansion of group practice especially attractive as a way of bringing coordinated care to aged patients in a single location. If group practice results as well in lower cost per service, this makes possible use of a given volume of program funds to achieve a more ample delivery of service and a higher level of population health maintenance in old age. Indeed, a view of the relatively limited number of doctors in New York State standing ready to render care to Medicare beneficiaries, group practice may be essential to assure an adequate supply of physician-hours for the elderly.

Delivery of service can also be improved by covering transportation costs and by making arrangements for actual transportation for receipt of care. Bringing service to aged patients is another useful device. The Queensbridge program for the elderly residents of a Queens housing project has been effective enough to change over from a demonstration project with Federal support to a sustained activity of the New York City Health Department.

*Additional information from Dr. Muller appears in part 1, p. 292.

It is worthy of note that the eligibility age at Queensbridge is 60 years. This raises the question of progressively lowering the starting age for Medicare. In some conditions, such as hypertension and coronary heart disease, chances of reducing later disability and service costs would be enhanced. Lowering the age of coverage can be viewed as good preventive medicine. And regardless of the type of disease, persons suffering disabilities but under age 65 could logically be included in medical benefits for the same reasons of policy as they now are included in cash payments under social security.

In a statewide conference on *Barriers to Utilization of Health Services*, which our organization sponsored jointly with the New York State Public Health Association in March, 1967, it was recommended that health services be made available at community information and service centers which would be equipped "to provide assistance on a wide range of community services." Reaching out to the patient population is especially relevant to the condition of the aged as described earlier.

Our organization would like to protect Medicaid as a tool to deal with present medical indigency against restrictive financial eligibility rules. Such rules return us to an indigent program, reversing the action of Congress in passing Title XIX in 1965. We have informed our New York Senators and the Senate Finance Committee of our wish to see Congress firmly block retrogression at the state level. Medicaid funds will make it possible for many aged to receive non-ward hospital care and other health services under improved conditions of dignity and privacy—but not if eligibility rules cut off those with modest retirement incomes.

Consonant with our opposition to barriers to utilization of health services, we have made known to the members of the Senate Finance Committee that we regard proposals to allow flow of Federal funds under Medicare to segregated hospitals as inimical to the development of quality care for all. Although this is not a local issue, we feel that the principle of maintaining a desirable standard at the Federal level is important to each locality. In similar spirit, we see the evolution and strengthening of programs for the aged as a process closely related to improving health planning and resource development for the entire population. These processes take money, attention, and staffing. Some of these inputs should clearly be devoted to experiments in new ways of organizing and delivering service at low cost so that program funds can have the maximum positive impact on the public's health.

Sincerely yours,

CHARLOTTE MULLER, *President.*

October 10, 1967.

DEAR SENATOR SMATHERS: The enclosed statement is sent in response to your request of October 4. I trust it will prove useful to your Committee. Since time really was limited, I would like to reserve the opportunity to supply additional information before November 10.

Will you kindly inform me of the exact place and hour of the October 19 hearing, as I would like to be present.

Sincerely yours,

CHARLOTTE MULLER, *President.*

October 10, 1967.

DEAR SENATOR SMATHERS: I would like to add the following to the statement previously submitted by our organization in response to your request:

Laboratory and X-ray out-patient services cannot be provided under Medicare by a home health agency because they are not specified in Section 1861(m) of P.L. 89-97, which defines home health services. This is the ruling of the Social Security Administration. Although laboratory and X-ray services would be reimbursable if provided through a hospital, two problems arise. One, the beneficiary is exposed to additional deductibles and co-insurance. Two, the arrangement detracts from coordinated and continuous responsibility for care by a home health agency for aged patients in the home.

It would be desirable that an interpretation more conducive to comprehensive care, or a change in the law, be secured.

Sincerely yours,

CHARLOTTE MULLER, *President.*

ITEM 11: INFORMATION FROM THE NEW YORK MEDICAL COLLEGE, FLOWER AND FIFTH AVENUE HOSPITALS

October 12, 1967.

DEAR SENATOR SMATHERS: * * *

Since the average age of patients in our nursing homes study was approximately 80 years, I think that this population would meet with your definition of "elderly." It was our finding that not more than two percent of the population in New York nursing homes might be considered as appropriate candidates of active rehabilitation therapy and have a good potential in that area as judged by expert physiatrists. Our major study examined records of approximately two thousand residents of all the nursing homes in the borough of Manhattan. Most of the methods and findings are reviewed in the article "Rehabilitation of Nursing Home Residents," *Geriatrics*, Vol. 17, pages 402–411, June, 1962. A study of our disability and disease findings are probably best summarized in the article "Preventive Rehabilitation" in New York State Journal of Medicine, Vol. 64, No. 15, July 15, 1964. This study demonstrated that the broad application of rehabilitation service to nursing home residents is probably *not* called for by the facts. In my estimation, this would be the case because this population has been too long neglected and has deteriorated beyond recall. The major implication is a call for action in the areas of preventive service in early adult life and in early states of disease among the elderly.

This job requires a reorientation of all medical care service providing care to the elderly, as well as the assignment of responsibility to responsible physicians for the review of disability in the majority of patients among the elderly, predictably developing chronic disease and disability following acute crises and appropriate care at this time can delay or provide the onset of disability. A good restorative job of the rehabilitation specialists involves not only reactivating the patient's ability to capture his abilities or residual capabilities after the onset of a chronically diseased or disability state, but involves training the patient in maximum use of his capabilities before any more of them are deteriorated. Not only does this call for the reorientation already noted in the education of physicians, but for new demonstrations in the prevention of disability. We hope to expand the operations of our Center for Chronic Disease in this direction in the near future. We should call not only for help in connection with the care of the clinic population of the chronically ill, but for Federal help in sponsoring programs in early detection of chronic disease and for more aid in the training of patients or potential patients who will become more active in the coordination of their care.

You will note in our followup study of hospitalized chronically ill patients, we have noted that the patients themselves serve a major role in the identification of appropriate illnesses and continuing care services. Because of attitudes expressed toward themselves, these patients tended to select a chronic disease hospital rather than an acute general hospital for all long term post-hospital care.

One of the findings of current significance is the lack of significant relationship for medical care in the currently required transfer agreements between hospitals and nursing homes. The earlier Medicare proposals call for genuine affiliation agreement between hospitals and nursing homes. The latter would permit and assure some medical care services in the paper transfer agreements which would have national impact in improving long term planning for the extended care of chronically ill persons. I hope that these suggestions have at least touched on some answers to your questions and I will be happy to try to extend the answers at the hearings.

* * * * * * *

Sincerely,

JONAS N. MULLER, M.D.,
Chairman, Department of Preventive Medicine.

ITEM 12: QUESTIONS SUBMITTED BY THE CHAIRMAN TO DR. ISREAL ZWERLING, DIRECTOR, BRONX STATE HOSPITAL, AND REPLY RECEIVED

OCTOBER 14, 1967.

* * * * * * *

1. Adequacy of existing services, particularly in central urban areas, intended to prevent institutionalization of the elderly?
2. Community services—now available or still needed—that will enable earlier discharge of the elderly patient from such institutions?
3. Any details you may be able to give us on problems or promising experimental programs related to our subject, either in New York City or elsewhere?

ANSWERS RECEIVED

This statement is addressed to three specific questions posed in a letter by Senator George A. Smathers to the undersigned and dated October 14, 1967.

A number of antecedent consideration form the background against which the views expressed must be seen. These may be summarized as follows:

1. "Geriatric patients"—i.e., patients over 65 years of age—account for more than one-fifth of all admissions to, and comprise about two-fifths of the resident population in, public mental hospitals in New York State. The dimensions of the problem created by this population group may perhaps best be appreciated by the contribution it makes to the average daily census of all hospital patients: geriatric patients in *mental* hospitals occupy one out of every five hospital beds of all descriptions, for all age groups and all medical and surgical illnesses, in the country. This does not include aged persons in general hospitals, in nursing homes, in chronic disease hospitals, or in old age homes.

2. The magnitude of this problem is increasing relatively as well as absolutely, i.e., the percentage of first mental hospital admissions accounted for by persons over 65 years of age is increasing more rapidly than is the total population of persons over 65 years of age. The reasons for this change are undoubtedly complex. In part, the greater longevity consequent to improved medical and surgical care permits more persons to survive to a sufficiently advanced age to manifest the symptoms of chronic brain syndrome. More important in my view are the accelerating pressures of urbanization and technologic change; these pressures are altering cultural value orientations, with productivity increasingly becoming a measure of worth, with respect for tradition and for the past diminishing, and with family life becoming more individualistic and increasingly typified by the two-generation, mobile nuclear family. The aged in our society are becoming increasingly more alienated, more isolated, less valued and on each count more vulnerable to mental illness.

3. "Geriatric patients" in mental hospitals do not constitute a unitary diagnostic population. Three major categories in particular must be identified and differentiated: (a) non-psychotic elderly persons who are brought to the hospital by their families because their care in the home is burdensome; (b) patients with schizophrenic or affective psychoses who have reached the age of 65 during a long period of hospitalization or who decompensated after age 65 and require hospitalization after a life-long marginal adaptation in the community; and (c) patients whose mental illness grows out of the loss of cortical tissue—i.e., patients with Chronic Brain Syndrome. The lattermost category represents for the present purpose the crucial problem population; there can be little disagreement that nonpsychotic persons should not be admitted to mental hospitals, or that patients with functional psychoses should be treated for their schizophrenia or depression, whatever their age.

4. Patients with diminished cortical tissue are vulnerable to what has very aptly been termed a "catastrophic reaction"—i.e., persons barely able to cope with life and who encounter a stressful situation (an anxiety-provoking episode, an acute grief reaction, a severe infection, etc.) frequently become grossly disorganized; this often causes their families to panic, which intensifies the patient's anxiety and the process escalates rapidly and eventuates in a mental hospital admission. With good care and management these patients may be expected to reconstitute rapidly, within two to six or eight weeks. As brief as this period is, it is nevertheless too often sufficient to alter the equilibrium of the social system of which the patient was a member prior to admission. The family which has extruded him frequently will not accept him back, and in our experience this is particularly true of a widowed or widowered parent living with a child. If the patient previously lived alone, he may be too frightened of another episode to

undertake independent living again. If he had been in a residence or home for aged persons, the bed he vacated has been occupied by a new resident.

5. The level of functioning of which a geriatric patient who has been stabilized by a treatment program is capable, ranges from the capacity to cope with any average expectable environment to a level of gross incompetence, requiring total care. The hospital, a highly differentiated institution with a specialized staff, has a very critical role in stabilizing an elderly person thrown into disequilibrium by whatever forces, but it is simply a gross misuse of the hospital as a medical facility, and it reduces the capability of the hospital to fulfill its legitimate community mission, to have it serve to *maintain* patients in equilibrium once stability is achieved.

Against these considerations as a background, the specific issues on which my views are requested may now be addressed.

1. Adequacy of Existing Community Services

Community resources for preventing the institutionalization of the elderly are severely inadequate.

(a) Homemaker services, arrangements for the delivery of meals, day center programs for the aged, foster home programs and homes for the aged are among the resources which provide alternatives to mental hospitalization for many aged persons who are intact mentally but are left uncared for by an event such as the illness or death of a spouse; these are in grossly inadequate supply, and the shortage results in many avoidable mental hospitalizations. The guilt of family members who are forced to resort to the mental hospital in such instances is compounded by the lies they learn they must tell (e.g., that the patient is assaultive, or suicidal) to gain admission for the non-psychotic aged member.

(b) Nursing homes and chronic disease hospitals are an alternative to mental hospitals for many aged persons convalescing from a medical or surgical illness, who no longer require treatment in a general hospital but whose care is too burdensome to permit return to a marginal home situation. Such homes are also inadequate in number; further, they frequently have such low standards of care that families who can obtain a place in a nursing home for an aged person elect a mental hospital instead.

(c) There is reason to expect that concerted efforts to develop community education and counseling programs, both for the aged and for their caretakers, could significantly reduce the number of geriatric patients requiring admission to mental hospitals; such programs are woefully inadequate, particularly in contrast to similar programs for other high-risk populations (e.g., high school dropouts).

(d) Finally, it should be recognized that social disturbances are at least as potent in determining mental hospitalizations as are medical and psychological factors: a classic study in New York State, for example, revealed that the single most reliable prognostic indicator of the risk of mental hospitalization was rent—the lower the monthly rent for the apartment, the higher the risk of hospitalization. More adequate and more flexible welfare and housing resources and practices would unquestionably reduce the number of aged persons requiring mental hospitalization.

2. Community Services Required for Earlier Discharge of Psychiatric Patients

A huge reservoir of geriatric patients who do not require the specialized skills and resources of a hospital nevertheless remain in mental hospitals because of the gross inadequacy of community resources which would permit their discharge. The same factors which in the first instance could serve to reduce admissions from the community to the mental hospital act patently to block the re-entry of recovered or stabilized patients into the community. Apartments, homemaker services, day centers with activity and recreational programs and with the range of social services, foster homes, and homes for the aged, in larger numbers, could permit the discharge of large numbers of recovered patients who are able to cope with independent or near-independent community living. Nursing homes and sheltered or supervised residences in large numbers could permit the discharge of large numbers of patients stabilized at a less competent functional level. *A wide range of competency must be recognized as separating fully recovered patients from the most severely disabled, and consequently a range of community resources must be made available if large numbers of the aged are not to be left to live out their lives in mental hospitals.*

One special factor merits attention in this regard. Significant numbers of recovered geriatric patients hesitate to accept discharge to independent apartment living because they are afraid to undertake a lease or to invest any of their

resources in furnishing an apartment for fear of becoming ill again. Appropriate public assistance should be provided to take care of this contingency.

3. Experimental Programs at Bronx State Hospital

Three aspects of the program currently in operation or in a dry-run inaugural phase by the Geriatric Service of the Bronx State Hospital are respectfully commended to the attention of the Subcommittee on the Health of the Elderly. The full details concerning the operation of each program will be provided on request.

a. *Intensive Treatment and "Hotel Ward" Unit.*—Patients whose response to treatment indicates a potential for recovery to the point of being able to live independently are transferred to the Intensive Treatment Ward. A selected and slightly augmented staff provides group psychotherapy, a carefully prescribed program of chemotherapy, and an intensive program of milieu therapy to the patients on this ward, which is organized as a therapeutic community. Patients who improve sufficiently are then transferred to the "Hotel Ward," a unit which is completely unstaffed. Patients must assume complete responsibility for their own care—they clean their own areas, provide for their own toilet and laundry needs, medicate themselves, make their own appointments with the infirmary doctor if they do not feel well, and, within the limits of the refrigerator and stove facilities available, take turns in preparing their own meals. Experience has supported our expectation that the patients' confidence in their capacity to care for themselves is increased, and dependence on the hospital is diminished. One important error on our part—a miscalculation based upon our failure to appreciate how awful most old age and nursing homes are—is that in our zeal to encourage frightened patients to take this step toward independence, we made the Hotel Ward too attractive. It may appear inhumane to characterize a hospital ward for intact aged persons as "too attractive," but in a sizable number of instances, patients have refused nursing or old age home placements we have secured for them because these were so inferior to their "Hotel Ward" accommodations.

b. *"Community Living Project for the Aged."*—This is a five-way project, in which (1) the New York City Housing Authority will provide apartments (in most instances, 2-bedroom apartments, for three tenants) in a large housing project; (2) the Pibly Fund, a private philanthropic agency, will furnish the apartments and assume responsibility for the lease; (3) the Morrisania-Montefiore Neighborhood Medical Care Demonstration Program will provide a full range of medical services (the organization of this very sophisticated community health program can be obtained from its director, Dr. Harold B. Wise, Neighborhood Medical Care Demonstration, 1637 Washington Avenue, Bronx, New York 10457); (4) the Hodson Center, a community center for the aged of national repute, will provide activity and recreation programs and the full range of social services; and (5) the Bronx State Hospital will provide discharged geriatric patients, generally from the "Hotel Ward," a program of group psychotherapy, and a liaison attendant in residence in the housing project.

Approval of the project by the Housing Authority was added to that of the other four participants on October 31, 1967, and the stepwise details are currently being worked out by representatives of all five agencies.

c. *Geriatric Mobile Emergency Team.*—Whenever any receiving hospital in the Bronx admits a geriatric patient, the Bronx State Hospital is disadvantaged—when this patient is transferred to us, he comes without his family, and he has had the trauma of an intervening hospital experience. We have no choice but to admit him, and even with the most favorable response to treatment, the family which has extruded the patient is given the opportunity to close ranks behind him. We have therefore organized a unit, including a psychiatrist, an internist, a psychiatric social worker, and a nurse, and have selected a modest catchment area for a dry-run effort to intercept all applicants for admission as geriatric psychiatric patients to any receiving facility *before* the aged person is accepted as a patient. Every effort is made to effect an alternative disposition whenever psychiatric hospitalization is not felt to be indicated. The experience of a similar program in San Francisco has been extremely favorable.

Additional programs—a Geriatric Day Hospital, a Geriatric Work-for-Pay Clinic, and a Geriatric Volunteer Service Program—are being planned.

Few programs can reasonably lay claim to a higher priority than programs for geriatric psychiatric patients. Slogans proposing a Great Society, a good society, or even a morally justifiable society, in our future are hollow indeed if the reward for so many for a lifetime of service remains domiciliary care in a mental hospital.

Respectfully submitted.

ISRAEL ZWERLING, M.D., Ph. D.,

Appendix 4

ARTICLES DEALING WITH NEW YORK CITY HEALTH SERVICES

ITEM 1: SERIES OF ARTICLES BY WILLIAM RICE IN THE NEW YORK DAILY NEWS, ENTITLED "WHAT'S THE MATTER WITH MEDICAID?"

[From the New York Daily News, Sept. 19, 1967]

Exhibit A. What's the Matter With Medicaid?

(By William Rice)

Medicaid, launched 16 months ago as the most imaginative health plan in the nation's history, has become mired in controversy, confusion and escalating costs.

Instead of meeting its lofty goal of first class health care for every New Yorker, whether he can afford it or not, medicaid has ensnared its eligibles in a maze of complex paperwork, doctor boycotts, charges, countercharges, fiscal logjams and mounting shortages.

Medicaid's cost has been so enormous that even Congress, which kicks in half the cash and usually thinks in billions, is appalled.

And despite countless conferences, demands, pledges and promises, medicaid's administrators and those who provide the health services under the plan, cannot agree on medicaid's ailments, let alone solve its ills.

In fact, in some areas medicaid has caused more complaints than cures. Everyone—doctor, patient, druggist, hospital administrator, nursing home proprietor—has at one time aired his gripes.

Among them are:

Eligibility levels are far too high, with possibility as much as 50% of the state's population technically qualified to receive aid.

The massive amount of tax money being poured into the medical community has helped push the already skyrocketing costs of health care toward the point where medicaid may be priced out of existence.

HOSPITAL CHARGES SKYROCKET

Forms and paperwork are too voluminous and confusing, forcing up administrative costs, and creating an enrollment barrier to those who need help.

Payments to hospitals—with some institutions getting $90 a day or more for each medicaid bed patient and as much as $29 for each clinic or emergency room visit—are overly lavish and out of line with costs.

Lags in payments are forcing the medical community to boycott the plan, thus depriving the medicaid recipient of an important goal of the legislation—the guarantee of freedom of choice of doctor, dentist, druggist, etc.

Nursing home care promised under the program is almost non-existent because of a critical shortage of beds.

There are more complaints, many more. Some have been aired publicly, others have been confined to closed-door conferences, medical society meetings and legislative caucuses.

And they tend to obscure one important fact: Almost everyone agrees that medicaid's goals, in theory, are sound; that something must be done to help people meet the ever-increasing expense of staying healthy.

Medicaid, officially known as Title 19 of the federal Social Security Act, received Congressional approval and the President's signature almost unnoticed in 1965. The nation's attention was glued to another segment of the bill—Title 18, known as medicare, which freed those over 65 from the fear of medical bankruptcy.

But while medicare was geared to the elderly, medicaid was aimed at everyone. And New York State was willing to take full advantage of it.

FROM HAY FEVER TO MAJOR SURGERY

On April 30, 1966, Gov. Rockefeller signed the enabling legislation which, roughly, qualified a family of four with an annual income of $6,000 or less after taxes to have all its medical dental and drug expenses paid with the exception of a small deduction, usually $50 or less. Whether it be hay fever pills or surgery involving a long hospital stay, medicaid reached for the tab.

Under the plan, children are not legally responsible for relatives.

And even if a person makes well above the qualifying level, medicaid may still be of help if medical expenses are very high.

It is estimated that just about every person in the state is affected, by qualifying personally or having a relative who does.

To date, more than a half billion dollars has been spent in the state under medicaid, $300 million of it in New York City alone.

An estimated $420 million is expected to be doled out in the city during this fiscal year. A whopping $600 million is earmarked for the city's medical indigent in 1968–69.

Statewide, the 1967–68 cost is anticipated to reach $732 million. No estimate has been made for the following year.

Under medicaid, the federal government antes up half the cost with the city and state splitting the rest. And Congress, stunned by the massive cost of New York's program, is threatening to institute more stringent eligibility requirements.

HALF THE POPULATION MAY BENEFIT

Dr. Harry Posman, director of social research and statistics for the State Department of Social Welfare, which administers the plan, carefully pointed out that much of the huge medicaid budget covers areas which the state and local governments supported in the past without such massive federal help.

More than a million medicaid recipients, with two-thirds of them living in the city, are welfare recipients for whom the medical tab had been picked up before medicaid.

But the legislation opened the way for others. Just how many is in dispute.

In the furor which accompanied passage of the state bill, estimates of those eligible ran from 3.5 million to 9 million.

State Social Welfare Commissioner George K. Wyman now places the number at 6 million, or roughly one-third of the state's population.

The State Medical Society, which has accepted medicaid "in principal," claims that possibly half the state—or about 9 million people—can meet the requirements.

City Welfare Commissioner Mitchell I. Ginsberg, in charge of medicaid's administration here, estimates that 3.5 million city residents are technically eligible.

He declared, however, that about a million will never apply for various reasons, including already having private health insurance through their jobs and, for some, an aversion to "welfare" oriented programs.

CITY GOES LOOKING FOR TAKERS

Whatever the number, the city, despite a high-pressure enrollment campaign, has been uanble to get many of the eligibles to sign up. A total of 1.7 million have been issued medicaid cards—and this includes about 700,000 welfare recipients who automatically qualified.

"One major factor has been obscured," declared Health Services Administrator Howard J. Brown, in charge of the city's health and hospitals departments. "There is a substantial number of people who won't have anything to do with anything connected with welfare. Less than half of those eligible have enrolled.

"Our worry is not in patients freeloading but in getting people in to get medical care."

The biggest enrollment headache—and to this everyone agrees—is the enrollment form, entitled MA–11. It is more thorough—and more confusing—than the federal income tax long form.

EVERY POCKET TURNED INSIDE OUT

Four pages long, it calls for information ranging from the policy number, premium amount and date of one's life insurance policy to the armed forces serial number of anyone in a family to be covered.

Income must be documented and all assets and real property of each household member must be itemized.

An official in one of the city's busiest hospitals complained that when a patient comes into a clinic or emergency room—where the enrollment form is expected to be filled out by those who don't have medicaid cards—the applicant and his family are in no condition to answer the many questions.

"It's hard enough to get some of the mothers-to-be in our gynecology clinic to give their right names, let alone information concerning their jobs and families," he declared.

FINDS SLUM DWELLERS HARD TO REACH

And, the official pointed out, those who live in the city's huge slums, and who almost to a man qualify for medicaid, move so often in their search for better dwellings that the forms never seem to catch up to them.

Without the completed form and certification of the applicant, the city cannot get state and federal reimbursement.

Julius Horowitz, Ginsberg's coordinator for information and enrollment, said that of each 100 applications received at the medicaid processing center, 330 W. 34th St., 35 must be sent back for further information. Of these 35, only 5% are eventually mailed back to the center.

When the forms finally are completed, only one of each 20 is given an in-depth check by the 450-man staff. Investigators question the family, check the applicant's assets and otherwise make sure of qualification. As of last month, over 41,000 applications had been disapproved.

Currently, the Welfare Department is working against a backlog (it won't say to what magnitude) and is receiving 45,000 new applications each month. Those responsible for enrollment look forward to utter chaos.

All those who hold medicaid cards, except for welfare recipients, face annual reapplication and recertification.

Of the MA-11 form, Ginsberg said: "We are trying to get around it. The state agrees that the form is bad but claims it is mandated by the law.

"It is essential that there be as simple a way as possible to register the people. Under present methods it is an almost impossible task."

SUGGEST A LESS EXPENSIVE WAY

Ginsberg suggested that a simple declaration of eligibility could be used instead of the form. The same spot checks could be run and, "it would save a heck of a lot of money" in administrative costs, he declared.

Wyman agreed that MA-11 was far too intricate but, he pointed out, it would take state and federal legislative action to change it.

Wyman also agreed that the recertification task was nearly impossible. "We are trying to work out a way where we could determine eligibility . . . by staggering the workload over the whole year," he said.

But this, too, calls for legislative action.

[From the New York Daily News, Sept. 20, 1967]

EXHIBIT B. WHAT'S THE MATTER WITH MEDICAID?—HOSPITAL COSTS SKYROCKETING

(By William Rice)

Hospital costs, spiraling skyward at better than 15% a year, threaten to price medicaid out of existence. Medicaid itself is responsible for part of this phenomenal increase.

This is the considered opinion of some of the men who run our hospitals and some of the officials who administer the broad-based, controversial medical care program.

They charge that medicaid, by pouring millions of dollars into an already short-staffed field, is stoking fires of inflation.

They contend that hospital and nursing home rates for medicaid patients are paid without reward for those who economize and penalties for those who don't.

They complain that now that the city, state and federal governments will pick up the tab many doctors are too hasty in hospitalizing a patient rather than keeping him on his feet.

While quick to point out that medicaid has done much—both for the patients and for the institutions—they are dissatisfied.

Why?

Let's look at the costs.

Each day, medicaid picks up the tab for about 11,000 patients in the city's municipal, voluntary and private hospitals. Nursing home care is financed for another 6,000 though an extreme shortage of beds bars thousands more.

OTHER HOSPITALS' RATES ARE COMPARED

Of the $300 million that medicaid has spent in New York City, more than $212 million has gone to hospitals and another $40 million to nursing homes.

Medicaid rates to these institutions are eye-popping:

For each day a medicaid patient occupies a semiprivate bed in Memorial Hospital for Cancer and Allied Diseases, the plan antes $96. For each visit to this hospital's out-patient clinics or emergency rooms, another $12.75 is paid.

Montefiore Hospital and Medical Center gets $90.19 and $26.20, for those two services, Mount Sinai Hospital $83.95 and $17.56, Long Island Jewish Hospital $94.82 and $20.25, the city's municipal hospitals $85.24 and $10.97.

Nursing home rates range from $387 to $1,337 a month per patient with an average monthly fee of $500.

These fees are all-inclusive. In the hospitals, they cover, in addition to the usual room charges, all X-ray and laboratory fees, diagnostic tests, drugs, nursing services and a small percentage of the institution's cost for depreciation, research and major repairs.

A private patient, paying his own tab, would be charged room fees plus charges for each service rendered. Some would be charged less per day than the medical patient, some more. Their bills, however, supposedly average out to the medical rates.

Dr. David M. Schneider, the State Health Department's economics expert who had the major responsibility of setting rates, insisted that each application was carefully studied to insure that each fee reflected true costs.

But, he declared, modern medicine is expensive: Open heart surgery calls for a team of as many as 17 physicians and technicians with each person involved playing a vital role.

A cobalt machine for the treatment of cancer may cost $30,000 but the facilities to house it can run as high as $300,000.

Payrolls, which make up about 70% of a hospital's expenses, historically low, are zooming up at a fantastic rate.

MORE NEEDS, MORE COMPETITION FOR EXPERTS

"New medical techniques, new machinery, also means more sophisticated personnel are needed," Schneider said. The hospitals must pay top wages to compete with other areas for these highly skilled men and women.

"You cannot automate the care of patients," he asserted.

He admitted that some applicants try to slip unnecessary expenses and jacked-up administrative salaries into their costs.

Nursing home owners have attempted to pay themselves salaries of $30,000 and more in each of several facilities they owned, wives appearing under operating costs as interior decorators, charity contributions listed as overhead—these are some abuses that have been discovered.

More difficult to handle are cases where hospital doctors get minimum salary guarantees of as much as $80,000, where there is unwarranted duplication of equipment or services.

"I don't trust anybody until I'm convinced." Schneider warned. "The only thing to do is to be slow and not get excited."

Dr. Martin Cherkasky, director of the 656-bed Montefiore Hospital, declared that while medicaid has not as yet had any appreciable effect on Montefiore's population—the institution always has accepted patients without regard to their ability to pay—the plan certainly has had a great impact on its budget.

"FANTASTIC" INFLATIONARY PRESSURE IS CITED

"Inflationary pressure (engendered by medicaid) on doctors' salaries and other health salaries is fantastic," he said.

"A radiologist who received $14,000 annually a few years ago is paid $29,000 now.

"It is the same in most areas. Doctors' salary increases have been enormous in cost.

"This happens when you enfranchise new people without buiding hospital staffs. We need thousands of additional doctors, nurses and other personnel in the hospital field."

Cherkasky said that the torrent of money medicaid and medicare (the plan for those over 65) have poured into the medical community has also forced up the salaries of many of the historically underpaid hospital workers.

Nurses, he pointed out, have increased their annual salaries from $5,100 to $6,400—"and that's still not enough."

Medicaid's payment to doctors for work previously done on a charity basis also has zoomed costs but, Cherkasky declared, "it is a poor system that depends on a man donating his time."

Montefiore's per-day medicaid fee, $90.19 a patient, has enabled the institution to meet some of these demands. But, Cherkasky said, the hospital still needs philanthropic support and inflationary pressures will force costs to more than $100 a patient day before the year is out.

The solution?

Cherkasky said the nature of a doctor's practice must be examined. The patients, he declared, must be kept vertical instead of horizontal whenever possible.

"That way we can give better care."

OBJECTS TO PAYMENT WITHOUT ECONOMY

Another hospital administrator, who preferred not to be identified, echoed Cherkasky's view that medicaid was inflationary.

His gripe centered on the fact that the plan pays for all provable expenses without regard to whether the hospitals were attempting to operate economically.

'The unions know this," he asserted, "and come marching in waving the medical rules.

"Pay our demands, they say. "The government will pick up the added costs."

He also charged that doctors, in the main, were boycotting medicaid, filling his hospital's emergency rooms with patients who, while not emergency cases, needed a physician but could not find one.

Many hospital chiefs credit a problem faced primarily by the city-operated institutions for at least temporarily holding off the crush of medicaid patients expected at the voluntary and proprietary hospitals.

Many of the city's millions, especially in the ghetto areas, are clinic-oriented and would rather attend a crowded clinic than go to one of the many hospitals now open to them.

One woman, after being issued her medicaid card at the city's Harlem Hospital, burst into tears. She thought she was being forced from "her clinic" to some other hospital or to a private doctor.

Her tears dried when she was told this was not so, that the choice was hers.

PATIENTS SEEN SHIFTING FROM CITY HOSPITALS

At Harlem alone, 275,234 visits were made at the outpatient departments and 119,517 in the emergency rooms last year. This year's attendance is running about the same.

However, a change has been noted in in-patient service at the municipals. The Health and Hospital Planning Council of Southern New York recently reported that there has been a 10% drop at city hospitals and an increase of 7% at voluntary and private institutions since medicaid and medicare began.

And, said an official of a ghetto area hospital, this shift is bound to increase. "These people have never heard of elective surgery (necessary but not immediately needed)," he declared, "Watch out when they do."

Health Services Administrator Howard J. Brown, the city's health and hospitals czar, said the big question is whether medicaid's money is going to produce a change.

"I don't object to the paying of these rates provided the hospitals change the way they treat the patients," he said. "If these hospitals are taking this money to set up group practices where patients have an appointment system, where there are waiting rooms instead of long lines waiting in the clinics, fine.

"What I fear, however, is that this is not happening . . ."

Irwin Karassik, executive director of the Metropolitan New York Nursing Home Association, complained that in addition to being inflationary, medicaid "rewards inefficiency."

RESULTS? SOME ARE "LUDICROUS," HE SAYS

He said there have been such "ludicrous results" as one nursing home getting $80 a month more per bed than an almost identical but more efficiently run home on the same block.

"What we want is a system under the American theory of profit which holds costs down and gives us a reasonable profit," Karassik said.

"I have never seen such a poorly run administration in my life. If it were private enterprise, it would go broke."

He denied that current rates meet costs, as contended by Schneider.

Another major problem yet to be faced, Karassik said, was the shortage of facilities. Almost every one of the 25,000 nursing home beds in the state are filled.

Prior to medicaid, this shortage was acute. Now it approaches the impossible.

[From the New York Daily News, Sept. 21, 1967]

Exhibit C. What's the Matter With Medicaid?—Doctors and Dentists Boycott It

(By William Rice)

A boycott by thousands of doctors and dentists in the city has nullified one of medicaid's major guarantees—freedom of choice of a private doctor or dentist for every citizen of the state. The reason: for the most part, money.

While the state sets the qualification requirements for medicaid, it is doctors, dentists and druggists who decide who receives treatment as a private patient or customer.

Through boycott and selectivity, it is they who rule the private sector of this intensive pay-for-everything health plan.

Without their cooperation, medicaid's freedom of choice guarantee isn't worth the paper on which the legislation was written. Some have embraced the plan, many have not. Statistics tell the story:

Only about 3,000 of the city's 13,000 doctors in private practice have so much as waved a thermometer at a medicaid patient in their offices. And of the 3,000, some take only a token number of patients and others after taking part, already have closed their little black bags to the plan.

Of the city's 8,000 dentists only about 2,000 are pulling for medicaid.

While the majority of the city's 2,700 pharmacies accept medicaid customers, there is a growing rumble of dissatisfaction and many druggists are threatening to dump the plan.

All three groups—doctors, dentists and druggists—are shouting for potent legislative and administrative prescriptions to cure what they consider the program's ills.

And some aren't even waiting. They are taking the law into their own hands by quietly setting personal criteria for medicaid eligibility. They won't publicly admit it, but some accept medicaid patients only if they think the patients are in need and they refuse those they believe can afford the service.

DOCTORS OFFER MANY REASONS FOR OPPOSITION

Why is it so difficult to accept medicaid patients when payment is guaranteed by the city, state and federal governments?

The doctors say many of the fees are too low, that it takes too long to get paid, that there is too much complicated paperwork involved in shaking the dough

loose from governmental bureaucracy. And, they charge, medicaid is a boondoggle for too many patients who should be able to pay their own way.

One thing is certain, according to Dr. George Himler, coordinator of the city's five county medical societies. Medicaid is not making doctors rich.

Others disagree. One-high-ranking official of the City Health Department contended that it was possible for a hard working doctor to make $100,000 a year on medicaid fees.

This official, who declined to be identified, said there were at least two reasons why some doctors weren't overly enthusiastic about medicaid—reasons which they couldn't shout about.

If certain doctors switched to a heavy medicaid practice, he said, Welfare Department checks would replace a lot of cash they've been receiving from patients. And with checks, there can be no hanky-panky on income tax.

Secondly, he said, some doctors are afraid they will lose their "respectable" practice if "undesirable" medicaid patients are seen in their waiting rooms.

Himler, however, sees other reasons for the doctors' lack of enthusiasm.

POINTS TO LOWER FEES AS DETRIMENTS

Medicaid's fixed fees, he said, are below city doctors usual fees and benefit rural doctors who historically charge less.

A doctor, under the plan's maximum fee schedule, receives $6.50 for a patient's first visit and $5 for each subsequent visit. A nonmedicaid patient would pay about $10, Himler said.

Doctors would be delighted to treat medicaid patients, he declared, but many simply can't afford to do so with the fee differences and still meet their financial obligations.

"The State Medical Society approves of medicaid in principle, to the extent that it helps those who need aid," Himler declared. But, he said, far too many people are eligible.

And, he charged, the city is at least 60 days behind on paying the doctors for treatment given under medicaid, with some bills dating back to 1966.

Himler asserted that solutions could be found by reducing the number of eligibles, placing medicaid in the hands of a statewide intermediary—such as Blue Cross—and replacing fixed fees with fees based on the doctor's customary charges and the prevailing rates in his community.

A State Health Department official warned, however, that if customary and prevailing fees are granted, "the doctors will be driving a peg into their own coffin. They'll price the medicaid program out and bring in socialized medicine."

Another physician's gripe concerns medicaid's setting professional standards which, the doctors say, is the province of the State Education Department and the medical societies.

DENTISTS FEEL MANY PATIENTS CAN PAY

City Health Services Administrator Howard J. Brown replied that low-income areas, which have the most medicaid patients, "tend to have fewer doctors and the quality of practice (there) is inferior to other areas. Lower-income people don't have access to the same kind of doctors as do the higher-income areas."

Most of Himler's complaints were echoed by Dr. Herbert L. Taub, spokesman for the State Dental Society.

"As far as the concept is concerned," he said, "we are sympathetic to the need of availability of dental care for those who can't find the resources for it."

But, he declared, many of those now under medicaid can find the resources.

Taub, too, urged that a fee schedule based on customary and prevailing rates be set. He said his state group has conducted a survey showing that the fee change would actually save money.

Taub also damned the present system under which a dentist must get prior authorization for much of his work. He gave these examples:

A patient is sent by his dentist to a dental surgeon for the extraction of one tooth, for which authorization is not needed. But the tooth is snagged onto another which, under normal conditions, would have to be pulled with it. Prior authorization is needed to extract two teeth. The surgeon must send the patient back to his dentist for a "dental survey." The dentist then must apply for medicaid authorization and the patient must wait weeks for it to be granted.

Root canal work is needed to save a tooth. If it is a single-rooted tooth, go ahead. If it is a bicuspid, with two roots, get prior authorization. If it is a molar, three roots, forget it—authorization is given only in unusual cases. So, Taub said, many dentists just yank—with no authorization needed.

Taub suggested that a dentist be paid his usual fees with a patient paying a small deductible—whatever he can afford. Set an annual limit on the amount that can be spent on a patient, he suggested, and if extensive work is necessary, some can be done now and some next, as is done with paying patients.

And extensive work is needed by a large segment of the medicaid population. City Welfare Commissioner Mitchell I. Ginsberg declared:

"The area of services showing the most dramatic change (under medicaid) is the dental system. People are now getting dental care where they never saw a dentist before.

"And dental care is expensive. Those who cry about costs will cry most sharply about this. There is a tremendous backlog.

"The costs are going to be high."

But, whatever the cost, first-class care cannot be given until more dentists and doctors participate.

Druggists also have medicaid ailments and their own prescriptions for solving their problems.

Benjamin L. Gudes, secretary of the Emergency Committee for Pharmacists and Public Health, estimated that $2.5 million already is owed the city's 2,700 drug stores and the debt is still growing.

"It's been a mess since October and that's a pretty long mess," he declared. "Let the city pay the money. There is no excuse for this kind of behavior."

The problem is so great that a number of pharmacists, forced to take out loans to meet their bills, are preparing to sue the city to collect, Gudes said.

Another thorn is the dispute over prescribing drugs by generic names rather than by the more expensive brand names, he said.

Under present regulations, for a druggist to be paid the full wholesale cost of each prescription, plus the allowed 66⅔% markup under medicaid, the generic drug must be given unless the doctor specifically notes otherwise.

PRESCRIPTION NAMES ARE A HEADACHE

If the doctor prescribes by brand name and fails to mark the prescription that this brand specifically is to be given, the druggist is to fill it with the generic equivalent.

"We are legally and morally bound to dispense whatever the doctor writes," Gudes declared. "If they want to save money their problem is with the physician—get him to prescribe generically."

A spokesman for the Health Services Department said this squabble is the major cause of payment delays. The city has installed a computerized payment system but the computer spits out bills that don't comply with the rules.

The computer became so confused recently that it mailed a check to a Brooklyn druggist with the amount left blank.

The pharmacist, Samuel Hankin of Brooklyn, threatened to fill it in for $1 million if the Welfare Department didn't come up with the $2,500 owed him, some of it dating back to last November.

Hankin and other druggists complain that even when the bills are paid, up to 25% is missing with the computerized statement giving no reason.

Gudes feels the issue could be resolved if the city established a flat service fee for filling each prescription instead of squabbling over percentages on each order.

Until this comes about, pharmacies face financial disaster, he warned.

[From the New York Daily News, Sept. 22, 1967]

EXHIBIT D. WHAT'S THE MATTER WITH MEDICAID?—PROGRAM ITSELF IS VERY SICK AND URGENTLY NEEDS A DOCTOR

(By William Rice)

Medicaid, designed to bring costly modern medicine to everyone who needs it, has proved itself to be an unwieldy cripple.

But the cost of medical care is zooming to a point where only the rich can afford it and someone must pick up the tab for those who can't.

Like it or not, medicaid—or something like it—is here to stay.

This is the opinion of those who administer it, of those who run the public health agencies, and even of many physicians who are the most vocal critics of the plan.

In the first three segments of this series, THE NEWS has chronicled many of the failures of New York State's medicaid program, the most far-reaching health legislation in the nation.

The complaints are universal—doctor and patient alike are in pain.

What are the answers? What action must be taken? These facts emerge:

The four-page medicaid enrollment form, just as complicated as the one you fill out for your income taxes, must be shortened and simplified to help bring millions of eligible people into the plan.

Fees to hospitals, nursing homes, doctors, dentists, druggists and others must be sharply revised to keep the lid on costs, and a schedule of incentive payments must be set up to reward efficiency.

Fiscal logjams which have tied up medicaid payments for many months must be unscrambled to draw boycotting doctors and dentists into the plan.

Everyone agrees these are medicaid's most urgent needs, though there are many other problems. And they sound simple, but they aren't. Implementation is the hitch—a big one.

DOCTOR COOPERATION MOST VITAL

Legislation is needed now both on the state and federal levels to take medicaid out of its tortured infancy. And the cooperation of the entire medical community must be gained, not just a small percentage of it, to take the program into maturity.

Many believe the solution ultimately lies in the hands of the medical community. It is they who must hold down costs.

Computers can solve payment problems. Legislation may simplify forms. But all of this is worthless without doctors, dentists, druggists, technicians, optometrists, hospital staffs.

State Social Welfare Commissioner George K. Wyman emphasized that it is they who make the decisions upon which medicaid depends.

"They are the people in charge," he declared.

Others think the problem lies in a quiet revolution within the health field. Medicine is undergoing a dramatic change; where, in the past, it was oriented to the private practice it is now becoming a hospital-based science.

HE CAN'T AFFORD EQUIPMENT

A private physician cannot afford to surround himself with the extremely expensive equipment now available for diagnosis and treatment. Indeed, even hospitals at times are forced to pool their resources.

City Health Services Administrator Howard J. Brown sees the solution to this, to rising medical costs and to the shortage of physicians in the formation of neighborhood group practice units where the doctors work on salary rather than on fees.

His administration, which oversees the city's health and hospital departments, currently is converting 25 health centers throughout the city into neighborhood ambulatory care centers where patients can get just this kind of treatment.

Brown said the Hospital Insurance Plan, under a city contract, already has enrolled 60,000 medicaid families under a flat rate per year—paid by medicaid—for total medical care except for dental work.

"A PLACE FOR ALL PATIENTS"

"This is not inflationary," he declared. "Fees for services results in inflation. In certain areas fees may be more than a doctor charges for. He raises his price."

Brown also pointed out that the city has mapped a massive plan to bring its municipal hospitals up to snuff.

"There are enough beds in New York City," he claimed. "But there is a shift from city hospital to private and voluntary hospitals which no doubt has resulted in the voluntaries becoming quite crowded . . .

"This is why we are so concerned in turning our hospitals into a place for all patients.

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"The municipal hospitals are getting $85.24 a day for each in-patient from medicaid and that ain't hay. I take the position that these (medicaid patients) are private patients. To give them the proper care we are undergoing a complete major renovation and a complete building program. The money is now there and we are doing it as fast as we can. But it will take time."

Dr. George Himler, coordinator of the city's five county medical societies, prefers a simpler solution.

"With medicaid, there no longer are any charity patients," he declared. "There is no need to have municipal hospitals. Phase them out and hand them over to the voluntary agencies."

But voluntary or municipal, medicaid is still going to be stuck with the hospital bill.

And Congress, usually freewheeling with public funds, is raising a storm over the mounting cost of its 50% share of medicaid.

The House has approved amendments to the Social Security Act which would deny federal medicaid funds to more than 600,000 of the estimated 6 million New Yorkers now eligible. The legislation now is before the Senate Finance Committee.

USING BRAKES ON THE UPGRADE

Wyman called the proposed cuts "utterly unrealistic."

"This is cutting down at the very time costs of medical care are skyrocketing," he declared.

"The state program is geared to help the guy who can't otherwise help himself, the employed who is faced with a medical bill he can't handle without spending his small savings or mortgaging his house.

"It keeps his off welfare. You might call it a preventive welfare service.

"Illness is the major cause of dependency in this country. Now we're going to cut it out (the plan) for everybody in the false hope that it will be an economy move."

This cut, if passed by Congress, will not cripple the state's medicaid program if Gov. Rockefeller has his way.

He announced that he will seek approval of the Legislature to have the state pick up the tab for any medicaid expense faced by the local counties above what they pay for this fiscal year.

This, a Rockefeller aid declared, includes any expense brought about by federal cutbacks.

Of course, the Legislature has the final decision but, as Himler posed:

"What politician will withdraw aid from those already given it, even if it is too expensive?"

City Welfare Commissioner Mitchell I. Ginsberg backed this thought with the observation that a new power structure is being formed by medicaid.

SEES NATIONAL INSURANCE NEED

Before the program, he explained, the public assistance recipient made up a small segment of the voting public. Now, with about one-third of the state eligible for financial help, at least in the health care area, the little voices are swelling into a roar.

There are those who believe this roar will continue to grow, that someday there will be no question as to who qualifies for aid.

Wyman declared that the ultimate solution to the medicaid mess, not only here but throughout the nation, will be the institution of national health insurance.

"Then we wouldn't be involved with eligibility," he said. "Eventually, this is exactly what's going to happen. Sooner or later we're going to have a national health insurance program on a prepaid basis.

"But it will not be of the type used in England or Scandinavia. Doctors will not be employes of the government. It's going to be something resembling private enterprise.

"It will be like medicare (the federally legislated health plan for those over 65), national in scope, involving some form of prepayment."

But, until that day comes, if ever, New York is saddled with its medicaid. One question remains:

Will it continue to be a mess or will something be done about it?

ITEM 2: ARTICLE FROM THE NEW YORK DAILY NEWS, SEPTEMBER 19, 1967

ROCK TO STATE: PAY MORE TO MEDICAID

KIAMESHA LAKE, N.Y., September 19 (Special).—Gov. Rockefeller pledged today to seek legislative approval for the state to pick up all local medicaid costs beyond the level of those reached in the 1967–68 fiscal year.

In New York City alone, this would mean a cost of about $45 million. This year's medicaid tab is estimated at $420 million. At least $600 million is expected to be spent on the plan the following year.

The federal government now pays about 50% of the cost of medicaid, with the state and local communities splitting the rest.

PROBLEM ON LOCAL LEVEL

The Governor declared that rising hospital and medical costs under medicaid program had "undeniably created a financial problem" for local governments.

He told delegates to the 42d annual fall conference of the County Officers Association meeting here in the Concord Hotel:

"I shall recommend to the 1968 Legislature that the state assume all the increase in local medicaid costs over the level of the 1967–68 program."

Although Rockefeller made no direct reference to it, an aid declared that the Governor's pledge also covered the underwriting of any increase brought about by a medicaid cut being threatened by Congress.

The House of Representatives has approved amendments to the Social Security Law which would deny federal medicaid funds to more than 600,000 of the 6 million people now eligible in the state. The bill now is the subject of hearings before the Senate Finance Committee.

Rockefeller already had estimated that the proposed cuts would result in a federal aid loss to the state of $29 million in the first year, $40 million the second and $50 million the third.

Rockefeller's statement came shortly after the 2,000 county officials at the conference asked for a meeting with him to discuss curtailments of the medicaid program to relieve their communities of financial burdens brought about by rocketing medical costs.

THEY SUPPORT A MOTION

Delegates unanimously backed a resolution offered by Onondaga County Executive John Mulroy.

Mulroy said that $11 million was being spent annually in his county, with 30,000 on the medicaid rolls.

If all the 140,000 who were eligible for medicaid took advantage of the program in Onondaga it would cost the county $60 million, he said.

In New York City, only 1.7 million of the 3.5 million estimated to be eligible have enrolled.

And even without increased enrollments, medical costs have been rising at better than 15% annually.

THE UPSTATE SITUATION

Many upstate counties, in which large percentages of the community qualify for medicaid, are facing new taxes and bankruptcy.

The more affluent metropolitan area counties, while not quite as hard hit, also are facing increased medical costs.

ITEM 3: ARTICLE FROM THE MEDICAL TRIBUNE AND MEDICAL NEWS, SEPTEMBER 11, 1967

ESCALATION IN HOSPITAL COSTS

The strong annoyance with John W. Gardner, Secretary of Health, Education, and Welfare, expressed by George E. Cartmill, president of the American Hospital Association, at the association's 69th annual meeting may have had justification—but it wasn't all that justified. Mr. Cartmill complained that the Federal Government was trying to put responsibility for increases in Social Security taxes on the

nation's hospitals and cited a report by Secretary Gardner that charged hospitals with "long-standing inefficiencies." Mr. Cartmill pointed out that more than 90 per cent of the proposed tax increase has nothing to do with medical or hospital costs but is "in major measure occasioned by the increased cash benefits to be paid to Social Security beneficiaries."

Mr. Cartmill is undoubtedly correct in his estimate of the major and minor contributory factors to the increase in Social Security taxes. Hospital costs and their current escalation is another matter, however, as is the rightness or wrongness of Secretary Gardner's charge about "longstanding inefficiencies" in our hospital setups.

The A.H.A. is itself concerned about rising hospital costs, as is everyone affected by them. In May, 1967, hospital charges were 21 per cent higher than they were in May, 1966. The cost of hospitalization over the past eight years has gone up faster than any other element of medical care. Mostly this has been due to higher pay for hospital employees, many of whom—including nurses—were grossly underpaid in the past. It would be inadvisable, nonetheless, to deny the presence of inefficiencies in hospitals, and it is difficult to calculate to what extent these contribute to the cost of a hospital stay.

It is perhaps a remarkable fact that the steepest rises in costs are making their appearance today in the voluntary hospitals—those hospitals that to a large degree throughout their history were built and maintained on a structure of charitable bequests. It takes very little insight to recognize that the voluntary hospital system is presently undergoing a crucial revision. With the advent of Medicare and Medicaid the charitable purpose of the voluntary hospital largely vanishes into a world of the past.

Mr. Cartmill, in his address, referred to "the long tradition of underpayment for services on the part of the government." This was particularly true in the money provided by city governments to voluntary hospitals as payment for the care of charity patients. When one reads about Medicaid fees in the City of New York exceeding $90 per day for inpatient care in some voluntary hospitals and over $29 for outpatient visits, the cost-accounting aspect of hospital administration becomes predominant.

It may be, as claimed, that this is still below actual costs. A New York State Senator in rabble-rousing fashion laid about with a blunderbuss and accused the medical profession of trying to price Medicaid out of existence—blithely ignoring the fact that these were purely hospital costs that did not include any fees for physicians. Someone else, we are certain, will shortly point to these costs and attribute them to the prescribing of brand-name drugs, blithely ignoring the fact that these hospitals operate by formulary and boast, more or less, about the virtues of their formulary system.

Yet the fact remains that our hospitals must expect an avalanche of criticism because of these rising costs and that there is a very real threat that our voluntary hospitals will face a decrease in charitable donations. We think the time has come for rationalization of hospital prices and for a strict cost accountancy system that will clearly differentiate actual costs for patient care from costs for research and costs for training and various amenities. This is essential, even though tax dollars are contributing mightily in every one of these areas.

ITEM 4: ARTICLE FROM THE NEW YORK TIMES MAGAZINE, OCTOBER 8, 1967*

A Hospital Administrator Says That the City Should Get Out of the Hospital Business

(By Martin Cherkasky)

Six years ago I spent half a year visiting New York's city-run hospitals as a part-time unpaid consultant. One of my first visits was to Lincoln Hospital, an institution of 400 beds in a heavily populated, underprivileged area of the Bronx which has been likened to Watts. At the time of my visit, the hospital had only two electrocardiograph machines, one of them broken, to serve 400 inpatients and more than 1,000 outpatients each day. Cardiac disease is the greatest single cause of death in the United States; an electrocardiograph is a simple, inexpensive, often critical test which can help a doctor determine whether a chest pain is

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cardiac, and therefore vital. A doctor overwhelmed by great numbers of patients is helpless when he lacks adequate electrocardiograph support.

At another city hospital, Morrisania, intravenous infusions for critically ill patients had to be cut off for 12 hours each night because there was not one to keep an eye on them. When there was a nurse, there frequently were no needles. Operating rooms were sometimes closed for lack of linens. X-ray equipment had already been secondhand when it was installed back in 1929. We found one patient who had been deprived of digitalis, despite doctor's orders, for a week; he went into congestive heart failure.

A story that used to be told about one of our major municipal hospitals—only possibly apocryphal—was that a man was found dead there, and that it was obvious he had been dead for a week because there were seven glasses of orange juice by his bed.

Despite the spotty improvements produced by the current affiliation program, New York's city-run hospitals are still critically sick. It is clear that the level of care in most of the city institutions is a caricature of what hospital care should be. The obvious prescription is that the city should get out of the hospital business and that a single integrated system should replace the present hodge-podge of municipal, voluntary and proprietary hospitals.*

The recent announcement by Commissioner of Hospitals Joseph Terenzio that a leasing arrangement is being worked out whereby Memorial Hospital will assume full responsibility for the Ewing Cancer Hospital has been followed by discussion of New York University's possibly taking over the management and operation of Bellevue Hospital. These developments entitle the Lindsay Administration to high marks for recognizing the logic of freeing the city's hospitals from the city's bureaucracy.

The structure of city government makes it impossible for municipally operated hospitals to be first-rate—at least at this advanced stage in the development of medicine. The situation is not unique to New York City, although no other city in the United States has a system like New York's—most have never even tried operating more than one municipal hospital.

To my knowledge, there is not a first-rate municipal hospital in the entire country. A recent poll by medical experts cited the 35 best hospitals in the United States, and not a single municipal hospital—in any city—appeared on the list.

The reason is no mystery. The very nature of the beast makes it a dinosaur. The system is hopelessly bound by red tape: The Board of Estimate voted Morrisania Hospital an autopsy table but there was no money for installation, so it sat for two years in the receiving area. Another example: Patients requiring crutches had to be sent home by ambulance at a cost of $40 because no one was authorized to spend a quarter for crutch tips.

Commissioner Terenzio recently discovered that it takes 18 different steps to add an X-ray technician to the staff of a city hospital. Four bureaus in the Hospital Department have to approve the request, then 10 agencies outside the department have to approve it and, finally, the form is returned to the Hospital Department for the approval of four other bureaus. From six to nine months usually are needed to complete the round of approvals—after which the actual search for a technician begins. (By contrast, the voluntary hospital determines its need after a few days and usually has the technician hired within the week.) The Commissioner recently stated that the situation with maintenance or emergency changes required in a hospital plant is even worse. Requests now being made by the city hospitals will not even be processed until 1969.

At a recent public meeting former Commissioner Alonzo Yerby reported that more than 20 different agencies within and without the city have veto power over the city hospital system, and yet share no responsibility for its operation. He also noted that with this kind of bureaucracy it was impossible to operate hospitals.

In the late nineteen-twenties, when the present city hospital system was created, medicine and hospital operation were relatively simple. But there was a steady increase in the utilization of the municipal hospitals during the Depression years because patients could not afford the cost of medical care elsewhere.

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*A municipal hospital is one owned and operated by the city; there are 21, with 18,000 beds in New York. A voluntary hospital is privately owned but operated on a nonprofit basis and controlled by a lay board from the community (82 with 37,000 beds in New York). A proprietary hospital is privately owned and operated for profit (36 with 5,000 beds in New York.

Then World War II brought a dramatic change in medical and hospital practice: New instruments and sophisticated procedures were developed, new technical skills were needed and doctors, nurses, social workers and technicians were suddenly in short supply and great demand. The cost and complexity of hospital care soared so much that it has outstripped all other items on the consumer price index.

The city hospitals could not compete in terms of plant and equipment nor did they have the budgetary and administrative flexibility to keep abreast of the fast-moving developments in medical science. Consequently, they began to have difficulty in retaining and recruiting high-quality people, especially internes, residents and nurses. In the Bronx, the Lincoln Morrisania and Fordham Hospitals, with a total of more than 1,100 beds, once sought-after as internship plums, offered 400 internships from 1955 to 1963, but only six were filled by graduates of American medical schools. Without internes, the whole structure of physician training in a hospital crumbles—and, eventually, all of its medical and nursing staffing.

Only those city hospitals staffed by medical schools—such as Bellevue, staffed by New York University, Columbia and Cornell; Kings County, by Downstate; Bronx Municipal, by the Albert Einstein College of Medicine—were able to prevent this erosion. The medical schools maintained high-quality physicians in their municipal hospitals, thus attracting better American graduates as internes and residents. However, the physical deterioration of even these city hospitals and the suffocation of the hospital system by an increasingly inept, bureaucratic, red-tape-ridden administration meant that the physicial surroundings, supporting staff and scientific equipment essential for good patient care were lacking. Even where tens of millions of dollars were appropriated for construction, day-by-day operating maintenance was ignored.

There is really no reason for city-run hospitals any more. The "charity" patient for whom they were set up originally no longer exists. Medicare and Medicaid have made everyone a "private" patient.

Medicare, which throughout the country will spend about $4-billion this year alone, and Medicaid, which will spend another $2.5-billion, have provided medical and hospital funds for just that section of the population the municipal system was designed to serve. It is estimated that, between them, the two programs will cover 90 per cent of hospital patients heretofore cared for primarily at city expense. Add in Blue Cross and other third-party insurance plans, and virtually all New Yorkers will now be entitled to private care.

A similar transformation is taking place in the financial underpinning of the voluntary hospitals. Where once the great bulk of their support came from private patients paying out of their own pockets, or from private philanthropy, they will now be getting three-quarters or more of their operating revenue from Medicare, Medicaid or Blue Cross.

On this basis, there is plainly no justification for different standards of service—if, indeed, there ever was. Poor man's medicine should long ago have been tossed in the ash can; it would be criminal to perpetuate it now. Yet gaps in service remain glaringly unfilled because we hang on to a dual system of hospitals—one providing high-quality care and the other still geared to a ward concept as outmoded as transporting passengers on an ocean liner in steerage.

The way to eliminate that service gap is not to drag all the hospitals down to the deteriorated level of the municipal system but to pull all hospitals up to the standards that prevail in he best of the voluntaries. This cannot be done by putting the whole structure under direct city operation, a theoretical possibility; there are simply too many rigidities built into city management. But it can be done by establishing a unified system under the direction of the medical schools and better voluntary hospitals.

I believe the city should begin at once by turning over the complete operation of appropriate municipal hospitals to selected voluntary institutions which have demonstrated their robustness. The selected voluntary hospitals would take full responsibility for all medical and administrative functions with, of course, correspondingly full accountability.

The suggestion that the voluntaries are making a grab for the new moneys available under Medicare and Medicaid is laughable to anyone who understands the facts. The best that any institution which takes over a city hospital can hope for is that the payments from Medicare and Medicaid may equal the total cost of operation. The laws and regulations which control payments to hospitals under these programs are based on cost-reimbursement formulas which are very stringently defined.

At present, we have a limited affiliation system involving 19 hospitals at a cost of $70-million to the city. Under the present system, the voluntary hospitals are responsible for medical staff, including full-time and part-time physicians, and extend the benefits of medical education to staff assigned to the municipal institutions. In addition, some of the voluntary affiliates get funds for supplying individual equipment in certain of the municipal hospitals. Each contract is individually negotiated by the specific affiliating voluntary hospital and the city.

The advantages that full affiliation would bring can be seen if one examines the results already achieved by only partial affiliation. In the most recent interne-matching program, for example, the city hospitals strengthened by affiliation got more American-trained internes than at any time in the past 15 years. The unaffiliated city hospitals did worse than ever.

Our experience over the last five years with the limited affiliation between the city's ailing Morrisania Hospital and our own voluntary Montefiore Hospital further indicates the kinds of benefits we can expect from such a system. For example, in anesthesiology, prior to the affiliation, Morrisania had no full-time staff and no residency program. Equipment was inadequate and in disrepair or obsolete. Today, Morrisania has a full-time director, four full-time anesthesiologists and seven registered-nurse anesthetists.

Prior to affiliation, there were no full-time pediatric staff and no facilities for treatment of premature infants. The inpatient area consisted of two overcrowded, poorly equipped wards. Space for outpatient care was totally inadequate. Since affiliation, a director and two full time pediatricians have been appointed, a 33-bed pediatric unit is being completed, the nursery has been renovated and new vital equipment purchased. A new premature nursery is now being built. Because we could not tolerate the interminable delay in city construction, Montefiore Hospital agreed to expend $26,000 of its own money to pay for the renovation and construction of a floor in the house staff quarters at Morrisania to house a combined pediatric outpatient department and emergency room. This project took four months; if it had been attempted through the city, it would have taken at least three years.

(As an example of city delays: The city was asked for a radiator cover for a Morrisania office. Instead of buying one, the city had to make it. The requisition passed through several city agencies for job drawings and specifications; then the raw product had to be sent to Chicago to have the grills punched, because no punch was available in the New York City area. The cover cost about $175—and getting it took two years.)

The surgical service at Morrisania probably represented the most serious problem of all. Operating rooms were unclean and poorly equipped and there were no recovery-room facilities at all. There was no full-time surgical staff, and the vast majority of the 26 surgeons listed on the roster were inactive. Since affiliation, a virtual revolution has taken place. A full-time director and a full-time assistant have been employed, and surgical residents from Montefiore now rotate through Morrisania. Thirteen surgical specialists now insure 24-hour, seven-day coverage in the operating room. Major improvements have occurred in the surgical suite and vast amounts of surgical equipment and supplies have been purchased.

Still, even with constant and aggressive pressure from Montefiore and the presence at Morrisania City Hospital of an excellent administrator, the basic goal of high quality service there has not been fully achieved. There are simply not enough good people working for the hospital. A study by the city indicated that the security staff needed 20 more recruits—but only four have been assigned. The engineering force numbers only 14—when twice that number is needed. Basic problems still remain in purchasing, maintenance, repairs and construction. The reason is obvious: The city's budget is inadequate; red tape runs on.

Nevertheless, the Montefiore-Morrisania City Hospital affiliation has demonstrated beyond question the revitalizing effect of even a partial affiliation. (Where we were unable to move forward as well or as quickly as we should, it was because the division of professional services in Montefiore's hands and administration in the city's did not work.) The tremendous positive effect of the Albert Einstein College's commitment at the Lincoln Hospital and the extraordinary improvement in ambulatory services at the old Gouverneur Hospital by Beth Israel's intervention are also a matter of record. There is no doubt that insti-

tutions with powerful professional and administrative resources can meet the challenges of the municipal hospital system.

A look at the salient characteristics of the successful and esteemed voluntary hospitals makes quite clear what it takes to run an outstanding hospital and will also point out why proprietary, municipal and certain voluntary hospitals are just not good enough.

For a hospital to obtain quality and efficiency it must be of substantial size, generally 500 beds or more. In a recent listing of the 15 best hospitals in the United States, only one had fewer than 500 beds; eight of them had 1,000 or more beds. Adequate size is essential to make it economical to employ the professional, administrative and supportive personnel necessary to a superior operation.

Moreover, a good hospital with strong administration can increase markedly its size without deleterious effect on the quality of its service, assuming of course that its physical plant increases accordingly. A good 700-bed hospital can double the number of its beds and meet the additional top-management responsibilities with no more than half a dozen new administrative personnel. With the exception of nurses, good institutions in the United States have no difficulty in attracting professional or nonprofessional staffs. During the last 10 years, Columbia-Presbyterian Hospital, Montefiore Hospital, Mount Sinai Hospital, New York University Hospital and other outstanding institutions in New York City not only obtained the specific internes they wanted in each slot in the course of the interne-matching process but could have got many times the number they required. Even in the case of nurses, despite the shortage, good institutions tend to attract more than their fair share of the existing supply.

Quality is what determines an institution's ability to attract staff. It is probable that the single most significant factor in high quality hospital care is the presence of full-time salaried physicians who devote all their energies to patient care and to the direction of educational programs and research projects which help to keep the hospital and its staff alert to the new developments in medical science.

Finally, a quality hospital must have a lay board representing the community which serves with the willingness and ability to authorize the spending of what is needed rather than what is allotted. The public notion about compensation for government personnel is totally inadequate and makes it impossible for the city to compete in the open market for good people. There are few if any businesses as complex as hospitals, yet the Bellevue Hospital administrator is paid only $18,000 a year. He has a huge responsibility and minimum authority.

This is not meant to say that all voluntary hospitals are excellent—some are marginal. Some of the best have shown less social responsibility than they might have. Still, the best ones are where the quality is, and that is where the 18,000 municipal hospital beds should be.

As an example, let us take the city's new 1,200-bed Harlem Hospital, now under construction. It is not within the realm of possibility for this new hospital to operate with anything near the efficiency or quality of the superior voluntary hospitals. Recently, however, Columbia University's medical school, whose teaching institution is Presbyterian Hospital, announced that it will withdraw from Bellevue and concentrate more of its interest in Harlem Hospital. Would it not be magnificent if Columbia and Presbyterian were to assume total administrative responsibility for Harlem Hospital? It would be a great burden for them, but there is no doubt that Harlem Hospital would then be assured of medical care of the highest order.

Other voluntary hospitals and medical schools, in my opinion, are equally able to assume full responsibility (it is assumed that antiquated physical plants would be rebuilt or replaced) for all medical and administrative functions of designated municipal hospitals. Among these I would list: Downstate Medical Center, to be responsible for Kings County Hospital; New York University Medical Center, for Bellevue Hospital; Albert Einstein Medical Center, for the Bronx Municipal Center; Montefiore Hospital, for Morrisania Hospital; New York Medical College, for Metropolitan Hospital; Columbia-Presbyterian Medical Center, for Harlem Hospital; and Mount Sinai Hospital, for Elmhurst Hospital. Other voluntary hospitals in the city are also capable of full affiliation at the present time or will become so in the near future.

The executive talent, administrative skill and professional resources that the great voluntary hospitals have cannot be matched by the city. The medical schools and a handful of voluntary hospitals have the conjunction of brains and ability on all levels required to create a first-class medical system serving the entire

community. They must be given the opportunity to do so. The city hospital system, locked in by legalistic and bureaucratic restrictions as it is, cannot do the job—no matter how much money Medicaid and Medicare pour into it.

Recently, the whole affiliation process has come under attack. Some voluntary hospitals have been charged with mismanagement; accusers have pointed to inadequate public accountability from these institutions, and have even accused some of shirking their responsibilities by selecting interesting and affluent patients to treat.

It is true that there have been abuses. These have occurred for a variety of reasons. Some of the voluntary hospitals were not yet strong enough rapidly to improve conditions in their affiliated municipal hospitals. Nevertheless, while the contracts between the city and the voluntary hospitals may have been hastily drawn, there is no reason why the city could not have kept the affiliation program under more careful supervision. If the voluntaries take over municipal hospitals, there is no reason why there cannot be full public accountability of their stewardship. Voluntaries are going to be subject to more public scrutiny, in any case, because of the role tax funds will play in their financing.

Public accountability would be essential under any new system. If examination showed that city money was being inappropriately handled by a voluntary hospital, I would expect the city to remedy the situation. If a voluntary hospital did not demonstrate a reversal of the downward trend in its city-hospital affiliate, extension of the contract should be carefully considered. Not all voluntary hospitals have the strength necessary to help others; many are in great need of help themselves. Affiliations must be selective. But it would be irresponsible to prevent the better voluntaries from raising medical standards because of the inadequacies of a few.

It is also true that the voluntary hospitals in the past have been very uneven in their assumption of responsibility and often have been too selective, seeking "interesting" patients for "teaching" rather than because of their need for care. But the answer, it seems to me, is precisely such a unified system as I have suggested, so that it will be impossible for one group of hospitals to slough off patients and responsibilities onto another.

Of course, turning over certain municipal hospitals to carefully selected voluntary hospitals will not alone create a single hospital system. There are also the city's proprietary hospitals, operated for profit, which generally provide only acute inpatient care with little or no ambulatory care or other desirable communal hospital services. In addition, many voluntary hospitals are of marginal quality, some too small to be efficient, others cut off from the teaching which makes for good care. Finally, our hospitals now compete more than is in the community's interest, creating a duplication of resources and services with consequent higher than necessary hospital bills and poor utilization of highly skilled professionals.

But the immediate problem remains the municipal hospitals. Sentimental attachment to an outmoded system of hospital operation in the name of a charitable commitment to the poor and underprivileged will not solve that problem.

ITEM 5: ARTICLE FROM THE WALL STREET JOURNAL, AUGUST 8, 1967

Diagnosis of "Medicaid"—New York State's Huge Medical Care Plan for the Indigent Is Plagued by Many Ills

(By Jerry E. Bishop)

New York.—How do you begin the broadest and perhaps one of the most expensive Government medical programs in the nation's history?

Start with a total lack of preparedness, move quickly into chaos, add a little apathy and then stir up some fights with the doctors, dentists and pharmacists. After 14 months, you'll find yourself in somewhat the same position as New York City as it struggles to administer its huge, Federally backed medical-care-for-the-indigent program, commonly known as "medicaid."

The big medical program was supposed to have gone into effect in May 1966 here in New York City as well as throughout the state; it actually got started in October. Ten months later, no one is yet sure how many of the city's residents are eligible for aid under the program, though estimates range from 2,000,000 to 3,000,000 persons. About 1,500,000 have signed up for the program.

Those who have signed up for help under the program are having trouble finding a doctor or dentist who will provide care; a majority of the physicians and dentists are so upset about the program they refuse to take medicaid patients. The doctors and dentists who do take medicaid patients are threatening to stop filling prescriptions for medicaid patients because they don't like the program's rules or the method of payment. And private nursing homes say they are about to be forced out of business by handling medicaid patients.

"It's just beginning," says one city official. "It's going to be two or three years before we can get this thing (medicaid) set up."

FAR-REACHING IMPLICATIONS

New York's travails with the medicaid program are of far more than just local interest. Although 30 states and territories now have some form of medicaid, none approach the current New York program in scope, with the possible exception of California.

Medicaid stems from a sleeper section of the same Federal law that established "medicare." Under this statute, every state in the union will have to institute a medicaid program within the next 2½ years or face the loss of Federal funds for a variety of programs medicaid is designed to replace. These programs currently provide medical aid for the disabled, the indigent, the blind, dependent children and others.

In New York, a family of four with a total annual income of $6,000 or less is eligible to have all its medical and dental expenses paid by the program, whether it's a matter of a vaccination or a month's stay in the hospital. An estimated 6 million of the state's 18 million residents are believed eligible for the program; in the current fiscal year, it is expected to provide aid to almost 3 million New Yorkers at a cost of about $738 million, according to state estimates.

Under a proposal attached to the Social Security bill recently approved by the House Ways and Means Committee, limits would be placed on the rapidly mounting costs of medicaid. In terms of New York's program, eligibility would be reduced by 1970 to families earning $3,900 or less annually. The bill is expected to reach the House floor in several weeks and then it will go to the Senate.

Whether or not the bill is signed into law unchanged, it's estimated there will still be substantial increases in cost from present programs. And nowhere are the pitfalls of instituting medicaid more dramatically apparent than in New York City.

MEDICAID WAS A "SLEEPER"

Much of the trouble with medicaid, say both its administrators and its critics, stems from the fact that almost from its inception it has been a spur-of-the-moment program with few of those involved realizing its vastness. Those familiar with its history trace its origins, ironically, to the American Medical Association. In an eleventh hour attempt in 1965 to defeat the medicare-for-the-aged program, the AMA proposed a substitute "eldercare" program. Basically, it would have been a state-Federal sharing program, using tax money, to buy health insurance for the needy and, more important, the near-needy elderly—those who weren't technically indigent but would still require help to pay medical bills. The insurance would have covered a wide variety of medical costs, not just the hospital and nursing home bills covered by medicare. Determining who was needy and near-needy was to have been left up to the states. Basic to the concept was that those eligible would be free to choose their own doctors and to go into hospitals as private patients rather than charity cases.

The concept so intrigued legislators then pushing the medicare bill through Congress that instead of substituting it for medicare (Title 18 of the bill) they broadened it beyond just the elderly and slipped it in as Title 19. It is aimed at covering a full range of medical care for the indigent and "medically indigent," the latter being those who may not be on welfare but whose incomes are so low that the cost of a major illness might put them on welfare. Determination of eligibility is left to the states. The Federal Government pays 50% of the cost of the program for the richest states and more than 80% for the poorer states.

With the spotlight focused on medicare, little attention was paid to Title 19 until the late spring of 1966. That's when New York State realized Title 19 would bring increased Federal funds to defray the expenses of the state's already broad medical welfare program.

A New York family of four already was eligible for hospital care if it had an annual income of $5,200. Thus, the legislators could hardly do less than raise the income limit to $6,000 and broaden the services covered to include all medical care. The bill whisked through the state legislature with little discussion. Gov. Rockefeller signed it on April 30 to become effective the next day, May 1. In other words, health and welfare officials theoretically had less than 24 hours to get the program in operation.

Actually, the program had to be given the final stamp of approval by health and welfare officials in Washington. They were so taken aback by the extent of the program that approval was delayed many weeks. Where Federal officials previously had estimated the Federal share of Title 19 for all states at $238 million in its first year, New York's program alone would cost the Treasury $217 million its first year. (Even this estimate proved low; the Federal contribution to New York for medicaid's first year amounted to $276.9 million.)

Here in New York City, where the program is administered by the city health and welfare departments, medicaid has been in operation since Oct. 1, with benefits retroactive to May 1, 1966.

For the 630,000 persons who were already on the city welfare rolls, medicaid is providing a drastic change in how they obtain their medical care. Before, these persons received hospital care either in the city's huge but worn hospitals or else in the charity wards of the voluntary nonprofit hospitals. Outpatient care was provided through city clinics and emergency rooms while home care was received from a panel of 650 physicians.

FOOT CARE COVERED

Medicaid, however, is supposed to provide the medically indigent with the same quality of care as the financially better off people receive. Thus, the welfare clients, as well as all other medicaid patients, are supposedly free to go to the doctor of their choice and obtain a semiprivate room in a hospital and all other services in the same manner as anyone else. Welfare clients under medicaid for the first time also receive private dental care. They are supposed to be able to have drug prescriptions filled by any corner pharmacy, obtain eye glasses and even the services of a pediatrist. The only difference from any other patient is that the bills are sent to the welfare department.

A random glance at the mound of bills in the welfare department finds one for $6.50 from a Brooklyn doctor for an office visit from a six-year-old girl diagnosed as suffering from poor nutrition; another for $320 from an ophthalmologist for treating a "senile cataract"; another for $56 from an anesthesiologist for anesthesia during a finger amputation, and a $105 bill from a psychiatrist for visits by a 44-year-old woman suffering from "schizoid character, addictive personality, LSD."

So far, say city officials, more than 500,000 persons have received some sort of care under medicaid and the program costs are running between $30 million and $40 million a month. Most of this is going for hospital care; the voluntary hospitals receive up to $69 a day per medicaid patient (compared with $42 a day they were receiving for a city welfare patient), while the municipal hospitals are receiving $64 a day, both figures being based on the hospitals' costs.

But, say both city administrators and doctors, such figures tell little of the administrative nightmare that has bogged down the program.

For one thing, medicaid patients are having a difficult time finding doctors and dentists who will accept them. So far, it's estimated, only about 10% to 15% of the city's 18,000 physicians are taking medicaid patients regularly. And only about half the city's 7,500 dentists are participating in the program.

Disgruntled doctors and dentists charge that the program was hastily set up with little or no dialogue with the professions—with the result that most doctors and dentists find some features so objectionable they don't want to bother with it.

Fees, for example, are established on a statewide basis, notes Dr. George Himler, spokesman for the five county medical societies within the city. Since the rural and upstate areas traditionally have lower fees than New York City doctors, the city physicians are receiving far less than the "customary and prevailing" fees they receive from regular patients—and, incidentally, from the medicare program. Thus, for a first visit to the office, medicaid pays $6.50 whereas the prevailing fee in the city is around $10.

The uproar caused by the situation in New York City prompted the state health commissioner earlier this week to say that medicaid fee schedules "might" be revised. The commissioner, Dr. Hollis S. Ingraham, wouldn't say how much extra New York City doctors might receive, however, and indicated that no change could be expected for at least six months.

In any case, doctors' objections run deeper than the question of fees. At the moment, any licensed physician is considered qualified to take care of a medicaid patient. By next March 1, however, a doctor eligible to treat patients under medicaid will have to be a specialist, have a hospital appointment, be a member of the American Academy of General Practice or else complete 150 hours of post-graduate work within three years.

The qualifications would bar a large number of the city's general practitioners from medicaid. More important, say the doctors, is that the state health department, which sets the qualifications, is arbitrarily usurping the province of the state's medical licensing agency, with the result there are now dual standards to determine who is qualified to practice medicine. "It's our thesis that the education department (which licenses doctors and the medical societies) should determine qualifications," Dr. Himler says.

And the doctors are casting an apprehensive eye at requirements that medical records of medicaid patients be kept and made available for later "evaluation." This is aimed at making sure medicaid patients are getting good quality care and is no different from a health insurance company asking the doctor to justify his bill and treatment of a patient, says a city health department official. But, charge the doctors, no one knows who is going to do the evaluation and who is going to say what is "quality" care and what isn't; and, as yet, there are no standards by which to measure quality medical care. "The medical audit is an embryonic science and, in this case, it is a premature business," says Dr. Himler.

Even more disgruntled are the dentists, although a greater percentage of them seem to be participating in medicaid. Since there has been little experience with government-paid dental care on this scale, the program's authors apparently were worried that some dentists might take undue advantage of it, launching into expensive but unnecessary care of medicaid patients on a wholesale basis.

Thus, except for simple dental work, such as a single tooth extraction, or emergency care, dentists have to submit a plan to the welfare department detailing what they intend to do for each patient. They can't undertake the dental work until they receive approval of the department's dentists.

"The authorization request goes to someone in the welfare department who has never seen the patient," explains one dental society official. "All he ever sees is the X-ray. You might have a young person in whom you want to save a tooth by root canal therapy but someone down there can say 'No, you have to take the tooth out.'" If the dentist and the patient agree to go ahead and do the root canal therapy, the dentists cannot collect for it. Moreover, the official explains, since medicaid is supposed to pay for all dental work, the dentist cannot bill the patient for any part of it. Thus, he has to either take the tooth out, if he wants to collect anything from medicaid for other dental work on the patient, or do the root canal therapy free.

"The government is getting involved with individual dental care in a way it has never done before," says Dr. Robert L. Fisher, head of a special committee on medicaid for the city's three dental societies. The preauthorization requirement, he says, "may be wasting time and money." He suggests that state medicaid officials could easily substitute guidelines for the dentists, outlining what will be paid for and what won't. "But the program has been in operation for almost a year now and the state still hasn't set any guidelines," despite pleas of the dental societies, he says.

The State Dental Society charges that its recommendations to the state have been ignored, and medicaid is "plagued with indecision and confusion." Therefore, it says, the society can't be expected to urge dentists to participate in the program.

Pharmacists are equally vocal in their complaints. One bitter battle over pharmacy charges for filling medicaid prescriptions has been settled by allowing druggists a maximum 66⅔% markup on the prescriptions with a minimum $1.50 fee per prescription.

DRUGGISTS' NEW COMPLAINT

Now the pharmacists are balking at a medicaid notice that it will pay only for prescriptions filled with the low-priced drugs sold under their generic names as opposed to the allegedly higher-priced drugs of major drugs makers promoted and

sold under a manufacturer's brand name. The only exceptions are prescriptions for children or when the doctor specifically states on the prescription that it is to be filled only with a certain brand with no substitutes allowed. The profit on the lower-priced drugs would be lower, of course. Since pharmacy economics are pegged to the doctors' habit of writing the vast majority of their prescriptions by brand name, rather than generic, the rule could eat heavily into pharmacy profits. Medicaid officials say they're sympathetic but they've got to hold down medicaid costs as much as possible.

By far, the most immediate storm, however, is raging over the payment of doctors, dentists and pharmacists for medicaid patients. Because medicaid was put into effect by the state so swiftly, with little preparation, the city welfare department had neither the manpower nor the procedures to pay the flood of bills that started pouring in. City welfare officials say it will be late this summer, 15 months after the program became effective, before they will have the automated processing equipment available to pay medicaid bills within 60 days.

Meanwhile, unpaid medicaid bills are piling up. The department says it is desperately trying to pay at least 50% of the amount of each bill immediately, without processing; the remainder is paid after fiscal auditing of the bill.

Despite this, "I know doctors who say they haven't gotten a single cent from medicaid yet," says Dr. Himler. This is especially hard on physicians practicing in or near slum areas. He notes that one doctor near Harlem, 95% of whose patients are now medicaid patients, has received little or nothing from the program for months.

A dental society official cites the complaint of a Harlem dentist with an office that handled 50 patients one day recently. "Only four of them were private paying patients, the rest were medicaid for whom he won't be paid for months," he says. "You can't make a living on four patients a day." Moreover, while the dentists wait for medicaid payments, their expenses for dentures, orthodontic equipment, filling material, X-rays, nurses, receptionists and rent continue.

At one point, some desperate physicians started selling their unpaid medicaid bills to a factoring concern at 90 cents on the dollar. This ceased when the welfare department said its payments could go to no one except the doctors.

Medicaid seems to have created the least problem with the city's prepaid group health plan, Health Insurance Plan of New York. Members of HIP pay a monthly fee for which they receive all medical care from the plan's network of clinics around the city. For medicaid enrollees who so specify the program will pay HIP $5 a month for an individual, $10 a month for a couple and $15 a month for a family. HIP, in return, provides full physician and clinic services with no further billing of medicaid. So far, more than 60,000 medicaid eligibles have chosen HIP (it has a total membership of 755,000).

The only difficulty, say HIP officials, is that some of the plan's clinics have reached their capacity and have had to stop medicaid enrollment temporarily until more physicians can be hired.

NEW YORK CITY POSITION

The city, meanwhile, is pushing to get as many persons enrolled in medicaid as possible, despite the difficulties in trying to get the program off the ground. One major reason is that the influx of Federal and state medicaid money is taking over a major share of the cost of the city's burgeoning expenses for medical care for the indigent.

In fiscal 1966, Assistant Welfare Commissioner Henry J. Rosner recalls, the cost of medical care for the indigent, including expenses of the welfare, hospitals and health departments, ran more than $426 million. The city had to pay more than half of this, or $260 million, out of its own tax revenues.

In the current fiscal year, the bill for such medical care is expected to zoom to $747 million. But, as a result of medicaid, Mr. Rosner explains, the Federal Government will pay about $200 million and the state will pay more than $228 million. The city's share will amount to slightly more than $317 million, or less than half the total cost.

"Our expenses have been going up by leaps and bounds," Mr. Rosner says, as a result of both rising costs and broadening services. If it hadn't been for the state and Federal medicaid funds, he says, "the burden would have been too great for the city."

There are signs that medicaid is accomplishing its purpose of eliminating "charity medicine." In an attempt to encourage enrollment in medicaid, city

hospitals have eliminated free services in their outpatient clinics and emergency rooms. Where care once was free to anyone walking in, the patients now must either pay $8 a visit or show a medicaid card. The city, of course, bills medicaid for the latter patient.

ITEM 6: ARTICLE FROM THE LONG ISLAND PRESS, SEPTEMBER 21, 1967

Threat to 900,000 Seen if Medicaid Is Restricted

(By Richard F. Long)

The New York State Commissioner of Social Services yesterday said if Congress should pass restrictive legislation in regard to Medicaid, about 900,000 New Yorkers would not be eligible for the free medical services in 1970.

George K. Wyman, the commissioner, testified before the Senate Finance Committee, which is holding hearings on amendments to the Social Security Act.

The House Ways and Means Committee amended the act to limit Medicaid to persons whose incomes are 33⅓ per cent above state welfare limits.

"This proposal," Wyman said, "seems utterly unrealistic to us in New York State. It is unrealistic because it proposes to reduce the eligibility standard at the same time the cost of medical care is escalating at a very rapid rate."

Under the current state-federal Medicaid program a New York State family of four with a net income of $6,000 would be eligible to receive a variety of free medical services.

Some officials have indicated that if the restrictive legislation is passed, the New York limits could drop to $1,000 or $2,000 for a family of four.

Wyman said the gradual reduction of federal participation the amendments call for could render ineligible 900,000 New Yorkers by 1970.

Wyman was the third prominent New Yorker to criticize the Medicaid restrictions before the committee. Sen. Jacob K. Javits and Sen. Robert F. Kennedy have also voiced objections.

The commissioner said that if the restrictions are passed, the expenditures on the program will be reduced by $150 million by 1970.

"The reason for this very substantial reduction," Wyman said, "is that when one federal dollar is eliminated from the program, one matching state and one matching local dollar are also reduced. Therefore the real impact of the federal reduction will be tripled."

The Senate Finance Committee is expected to finish hearings on the amendments soon. The amendments bill will then go to the floor of the Senate for a vote. The bill, including the restrictive amendments, has already passed the House.

ITEM 7: THE WILLIAM HODSON COMMUNITY CENTER—A DAY CENTER FOR OLDER PERSONS

> "Hodson Center is the triumph of a vision—a place where our older citizens engage in fruitful work, where they develop their talents, where they pursue their education and partake of recreational facilities."—Mayor Robert F. Wagner, Dedication Ceremonies, September 22, 1964.

In 1943 staff members of the Department of Welfare saw the need for a place where older people could be together other than in welfare or clinic waiting rooms. They started Hodson Center, and it became the first Day Center for older people in the world.

Today Hodson Center is operated by the New York City Department of Welfare. We are located in Claremont Village, a complex of four public housing projects built by the New York City Housing Authority. Staff is provided by both of these agencies and augmented by the Board of Education, the Health Department, and by salaries from private funds raised by the Board of Directors.

We recognize that the varied needs of older adults require diversified skills. Specialists give expert supervision to groups, and guidance to individuals. All of our staff is sensitive to the special problems created by age and retirement. Some of our members need services entirely new to them. Others simply want the assurance of a warm reception in a friendly place.

After the staff implemented the idea of the Center, a Board of Directors was incorporated, and later the Women's Auxiliary was created as a volunteer corps. Today the Auxiliary manages and staffs the Thrift Shop, helps with birthday and holiday parties, and has representation on the Board of Directors.

The Board of Directors cooperates with the city agencies to set policy, and has often initiated features which have been continued by the public agencies—our music program, the addition of an occupational therapist, and the cafeteria. The Board raises funds from the community to enrich the program, and has made possible the many pilot projects for which Hodson is famous: the first "camping" for older people, the first student training in gerontology, a nationwide television show filmed at the Center, a widely distributed film strip about day centers, and the planning of the building in which we now operate.

Many members of the Board are also volunteers—in the office, in planning publicity, or with the members. Every dollar the Board raises is augmented by the service it gives!

All people want to be helpful to others, but older citizens are often deprived of the opportunity due to loss of former contacts, lack of mobility, economic deprivation, or simply the inability to find an outlet.

Some members find satisfaction in helping others at the Center. Our barber shop, cafeteria service, and repair work grew from this need. Other people, because of their past experience or ability, provide leadership in program planning, guidance to the membership council, or act as hosts to visitors.

Our members also serve the broader communty. Sometimes they work at the Center, rolling bandages and converting shirts into hospital gowns, making toys for nurseries, or creating articles for sale. Other services are arranged outside the Center; visiting the homebound or those in hospitals, and entertaining at public schools and homes for the aged.

An experimental project is under way to find other opportunities in the community for volunteer work. The results will be published and made available to day centers throughout the world—another pioneering effort!

Hodson Center has 1100 members, men and women over 60 and *usually* under 90! A large number find satisfaction and relaxation in developing skills; some pursue old hobbies or trades, while others find completely new fields of creativity.

Materials and machinery are available for our staff to offer expert instruction in ceramics, woodworking, sewing, painting, weaving, sculpture. Sometimes a member's own interest starts a group and teaches the staff—a stamp collector or a photographer! But facility alone is not as important as the effect a "mere" hobby can have on emotional well-being. This is dramatically apparent when a piece of work stimulates the surprised admiration of children or grandchildren. Or when an object is sold for the benefit of the Center. Or when visitors admire a one-man show in the corridors.

Music is an important part of our program because, of all the arts, it provides the greatest variety of satisfactions. Some of our members study instruments, some sing solo parts or in choral groups, some play in the orchestra or rhythm band. And everybody sings!

Education is pursued in many ways at Hodson Center. The Board of Education supplies an English teacher, since many of our foreign born members never had time to learn to read and write English. This class often supplies some of the material for our monthly publication, "Hodson Voice," which is written, illustrated, and distributed by the members.

The Department of Health provides public health nurses to give advice and instruction on an individual basis. Nutrition classes supplement health information, and our cafeteria serves a balanced meal each day for about 30¢.

It would be hard to find a place of interest in New York City that our Trip Group has not visited. The broadened horizons of those who are able to travel stimulates the discussion groups for those who are not so agile. Topics vary, from Current Events to Family Living or perhaps Poetry. The knowledge gained is often secondary to the give-and-take of a group experience, so important to those who are deprived of being with others by retirement and old age.

The facilities are indeed available at Hodson Center: a pool table, cards, shuffle board, outdoor game tables, film projectors, television—even a garden. But facilities are only tools, and their value is as varied as the individuals who use them.

We know that our American society has favored work and youth—understandable for a young nation with frontiers to open and industry to build. But today

lengthened years, shortened hours, a growing population, and an expanding economy are creating new attitudes toward aging and retirement. Above all our approaches to leisure must be re-examined, and this generation must set patterns for its use. Sometimes people have to be *taught* to enjoy themselves?

At Hodson Center we are just beginning to grasp our role in this changing world, and appreciate that programs such as ours will slowly teach the generations, one by one, that a human being's days on earth will not only lengthen, but can broaden as well.