NUTRITION AND HUMAN NEEDS

HEARINGS

BEFORE THE

SELECT COMMITTEE ON
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OF THE

UNITED STATES SENATE

NINETIETH CONGRESS

SECOND SESSION

AND

NINETY-FIRST CONGRESS

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ON

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PART 15—HUMAN NEEDS IN HEALTH

WASHINGTON, D.C., NOVEMBER 3, 1969

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NUTRITION AND HUMAN NEEDS

MONDAY, NOVEMBER 3, 1969

U.S. SENATE,
SELECT COMMITTEE ON NUTRITION AND HUMAN NEEDS,
Washington, D.C.

The committee met at 10:07 a.m., pursuant to call, in room 1202, New Senate Office Building, Hon. George S. McGovern (chairman of the committee) presiding.

Present: Senators McGovern and Ellender.

Staff present: William C. Smith, staff director and general counsel; and Kenneth Schlossberg, professional staff member.

OPENING STATEMENT OF HON. GEORGE McGOVERN, A U.S. SENATOR FROM THE STATE OF SOUTH DAKOTA, CHAIRMAN OF THE COMMITTEE

The CHAIRMAN. The committee will be in order.

For the past 10 months the committee has been engaged primarily in investigations into the problem of hunger and malnutrition as it relates to the poor citizens of this country.

We have also looked at certain aspects of the food interests of the American people as a whole, but what we have not really done to date is to relate these nutritional concerns to the health needs of the American people, and that is the purpose of our session this morning.

Our witnesses for today are Dr. Lester Breslow, who is the president of the American Public Health Association, and Dr. Paul Cornely, who is the president-elect of the American Public Health Association.

We are pleased to welcome these two distinguished doctors to the committee and you gentlemen may proceed in any way you wish.

STATEMENTS OF DR. LESTER BRESLOW, PRESIDENT, AND DR. PAUL CORNELY, PRESIDENT-ELECT OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

Dr. BRESLOW. Thank you, Mr. Chairman.

We appreciate this opportunity to report to your distinguished committee the findings of a nationwide tour which we, as president and president-elect of the American Public Health Association, recently completed. We wanted to observe first hand the status of our efforts and the level of our success in meeting human needs in the field of health.

First of all, a word about our organization, the American Public Health Association, since this is our first opportunity to appear before this distinguished committee. Our 24,000 members are primarily professional health personnel whose careers are dedicated to the prevention of illness. Our Association is the largest and oldest voluntary public health association in the country.

I also want to express the deep appreciation of the American Public Health Association for the leadership that this committee has provided in combating malnutrition through legislation to improve and expand the food assistance programs of the Department of Agriculture.

FIELD INVESTIGATIONS

As we recall, it was field investigations that developed the evidence for the need to establish this committee, and also the need for the legislation approved by the Senate to improve and expand the Food Stamp Act. I mention this because we are here today to report on a field investigation of the American Public Health Association. Our tour considered nutrition as well as other aspects of human needs in health.

Following a visit to the Mexican-American barrio in Houston, we went to a rural community in the central valley of California; juvenile and adult detention quarters in Atlanta, Ga.; the Potomac River in Washington, D.C.; homes of off-reservation Indians in Great Falls, Mont.; and the inner-city community of Kenwood-Oakland on the south side of Chicago, Ill.

We wanted to investigate, firsthand, situations which cause continuing serious health problems in our country. We believed it was time for health professionals to see directly, to hear and even smell these situations which characterize the lives of millions of Americans. We are convinced that the dimensions of human needs in health are inadequately described solely in terms of health statistics, patients in clinics, and laboratory specimens.

On the tour we were joined by people from the neighborhoods, concerned professions, some health and welfare officials, and national and State legislators, as well as representatives of the news media. Their participation reflects the rising and already substantial demand for improvement of our Nation's health that is so inextricably a product of not only medical care, but also housing, nutrition, air and water environment, and jobs.

SHOCKED AND REELING

As public health physicians, Dr. Cornely and I, thought we knew pretty well the nature and extent of those conditions. But frankly, Mr. Chairman, we were shocked and we are still reeling. Circumstances that can only be called health brutality pervade the lives of millions of American people who live in communities that seem designed to break the human spirit.

The national and State programs which purport to deal with these conditions, when viewed closely, appear to represent a policy of domestic brinkmanship. These programs simply skirt disaster and do little to alleviate underlying problems.

"MASSIVE CRISIS"

President Nixon recently spoke about a "massive crisis" in health care, and warned that "we will have a breakdown in our medical system which could have consequences affecting millions of people throughout the country." In fact, the breakdown has already occurred, and the consequences are already affecting our people.

The consequences of the "massive crisis" are reflected in such facts as these:

INFANT MORTALITY

The infant mortality rate of the United States in 1950 was higher than that of 14 other countries. Today it is higher than that of 13 other countries.

The nonwhite infant mortality rate is almost twice that for whites.

Children in families with incomes under $3,000 per year see physicians 2.6 times per year as compared to 4.4 times per year in the case of children in families with incomes over $10,000 per year.

Forty-five percent of all women who have babies in public hospitals are delivered without prenatal care.

Poor families have three times more disabling heart disease, seven times more visual impairment and five times more mental illness than the more fortunate of us.

More than 20 percent of all persons in families with incomes under $3,000 a year have never seen a dentist.

This partial recitation of indices reflects the failure of "the system" in meeting human health needs in our country. Although these statistical facts were well known to us, we were not prepared for the awful conditions we observed on the tour.

We recall with pain:

The approximately 50,000 persons who reside in the Kenwood-Oakland area of Chicago, in rodent- and insect-infested housing, with burst plumbing and broken stairs and windows, for which the residents pay one-third to two-thirds of their incomes as rent; 50,000 persons who are served by a total of five physicians in their community—a physician-to-population ratio less than one-tenth that of the country as a whole—with the county hospital and clinics 8 miles away.

The 53-year old American Indian in Great Falls, Mont., veteran of the South Pacific in World War II, raising a family of six children (and one grandchild, whose father is now in Vietnam) on a pension and what he can scrounge by salvage in a junkyard, so poor that he cannot buy food stamps and cannot return to the hospital for postcancer treatment—closure of his bowel, which now opens on his abdomen—because his family would not have food while he is gone.

The farmworker in Tulare County, Calif., who said that exposure to pesticides from airplane spraying of fields, contrary to regulations and often leading to illness, was frequently not reported because "What's the use? We lose wages going to the doctor, get better in a week usually, and get no compensation, and they don't stop spraying."

The woman in Tulare County, 8 months pregnant, whose Medi-Cal (medicaid) eligibility has been canceled last month because her husband had just found a temporary job, thus forcing her to seek care in the county hospital which previous experience had taught her to hate, and to break off care provided by her own choice of physician.

The young woman in Houston, whose welfare check for a family of eight children had been cut from $123 to $23 per month.

The therapists in the Child Treatment Center, Atlanta, Ga., who were doing excellent work with youngsters in trouble, but who said, "The main difficulty is that the kids have to go right back to the same life that got them into trouble in the first place. And we can't do anything about that here." We also recall the "stockade" of the Atlanta City prison for very sick people, alcoholics, particularly what is called the "hole"—a 3-foot by 8-foot solitary confinement cell, which had been occupied the days preceding our visit by an "uncooperative" chronic alcoholic who carried a card from Grady Hospital identifying him as an epileptic.

The dead fish floating in the dirty water of the Potomac, the "Nation's River," flowing through our Capital City, so polluted by untreated and inadequately treated sewage that fish could not live there, and the spread of human disease-causing bacteria was appearing as a serious threat.

TRAPPED BY "THE RULES"

Everywhere we encountered the lamentable excuses offered by local health and welfare officials, who seemed as trapped by "the rules" as the people they were supposed to serve.

While there has been considerable improvement in the quality of life for most Americans, the fact still remains that a large proportion of the 22 million blacks, the 5 million Mexican Americans, the 500,000 American Indians and millions of others live day in and day out in conditions we would not let our animals endure; and the "system" of care for people with diseases associated with such conditions seems designed to obstruct their receiving the care that is needed.

Mr. Chairman, we would like an opportunity to present to you, within the next 2 weeks in a separate communication, a somewhat more detailed account of our tour. In the meantime, if any should think that we present in our summary an exaggerated picture, or too harsh a judgment based on "isolated" instances, let him spend, as we did, a few full days actually looking, listening, and smelling. The conditions we describe are all too pervasive.

LINES OF ACTION

Now we wish to propose some lines of action, first, for health professionals such as ourselves and then for the legislative and administrative branches of Government. We share the conviction of many in our country, often expressed these past few months, that a nation with the technological ability and governmental resources to create a satisfactory environment for an Apollo space capsule on a trip to the moon must find a way to provide healthful living conditions for the people in Houston, Tulare County, Great Falls, Chicago, Washington, Atlanta, and everywhere else in this country.

As professional public health workers, we should first recognize our own deficiencies. Like others in professional and technical fields of endeavor, some of us have become closely identified with agencies and institutions whose bureaucratic interests contradict the interest of the people who are supposed to be served.

Of course we must be loyal to the agencies for which we work, but we need not become callous in accepting the "rules" and the budgets. We develop such callousness possibly as a protection against our own feelings of guilt as workers in too feeble programs, but it can insensitize us to the point where we no longer press vigorously to achieve adequate programs.

We tend to resist the "community takeover" of health programs by people in impoverished neighborhoods, who have found that they must participate in setting the rules as a means, literally, of survival. For too long the programs have stifled their participation. The rules of these programs, often established by others who do not understand the problems, make less and less sense.

To avoid such professional myopia, we urge that public health professionals, no matter what their type of work or employment, devote some time each year to observing directly the conditions of life that generate health problems. It is one thing to treat a child in a clinic with a cut eye, but another thing to encounter him as we did in a Chicago neighborhood, with a patched eye, and to hear him describe and then see the broken stair-rail at his house which permitted him to fall from the second floor onto glass on the ground adjacent to his home.

Further, we believe that health professionals should join hands with the organizations of people that are emerging in neighborhoods throughout the country, to fight for better health conditions. Mr. Chairman, I would stress this point as one of the major conclusions of our tour. Everywhere on the tour we found that neighborhood organizations are springing up and arousing new hope. The advancement of public health today requires the development of effective alliances between such groups and those having technical competence in health work. Alliances of this sort would energize the efforts of all.

Although we knew before the tour that our health programs needed a drastic overhaul, the visits added a depth of understanding and feeling that we could not have achieved otherwise.

I know that this committee with jurisdiction over nutrition and human needs would be as shocked as we were on the tour.

What is the answer?

Perhaps I should say first that the maintenance of the status quo is not the answer. Pouring more and more money into the existing health care system is not the answer. Yet that is what we are doing.

In 1963 the health budget of HEW totaled $4 billion. The 1970 HEW budget proposes a health expenditure in the amount of $12 billion, a threefold increase. Furthermore, more than three-fourths of the $12 billion will be spent for the provision of health services, primarily through medicare and medicaid. I can assure you that, to put it plainly, "we are not getting our money's worth" out of the increased funding.

A health care program for the poor based on a month-to-month means test to determine indigency is unacceptable in a decent society. As professionals we can only begin to understand the indignity suffered by those who seek to qualify under a means test.

MEANS TEST OFTEN UNFAIR

But apart from that, the means test system requires the cancellation of eligibility for benefits because of a slight increase, often temporary, in income. This is standard practice under medicaid throughout the country. Access to medical care is thus often cut off just when it is most needed to boost a family out of the poverty-poor health-poverty cycle. This makes no medical sense.

Getting the information, keeping the records, and making the judgments each month, according to rules which are changed often with little or no notice by State and county officials, costs a substantial amount of money. That money could go a long way toward providing benefits on a yearly basis. The latter would be much more sensible from a medical standpoint and in the long run probably more economical.

One must ask whether the present arrangement is designed to aid the poor or to perpetuate a bureaucracy. Medicaid as a whole—its system of eligibility, loose budgeting, crazy-quilt pattern of benefits, and failure to set standards for care—was fashioned from the mold of old-fashioned, welfare-oriented programs. It is probably the most colossal excrescence of a welfare system that has long outlived its usefulness and, as President Nixon has indicated, must be revamped.

What better place to begin the revamping than to set free the provision of health services for the poor from a welfare system that grossly distorts its purpose? Few would deny that health care is important and that a health care system should make medical sense.

Perhaps it is time for this committee, Mr. Chairman, to assert that the human needs of the poor must be approached systematically in order to overcome the erosion of their health. Responsibility for the health care system must no longer be parceled out in an uncoordinated way among dozens of Federal, State, and local public agencies.

NATIONAL POLICY AND PROGRAM ON HEALTH CARE

With more than 6 percent of the gross national product now devoted to health care, and an increasing proportion of that paid directly out of Government funds, it does seem timely that we develop a national policy and program on health care. It is not sufficient to drift and take pot shots at drug prices and physicians' fees, horrendous as some of these may be. Our tour convinced us that health care for the poor, at least, in this country has already broken down. The crisis is not coming; it is here.

The American Public Health Association would be pleased to join in the development of a national policy and program of health care for all.

In the meantime, convinced of the urgency by our tour, we make the following recommendations as beginning—and I emphasize "beginning"—steps to relieve the chaos in health care:

RECOMMENDATIONS

1. Establishing eligibility for medicaid on a yearly basis rather than monthly.

2. Channeling funds from medicaid and other governmental health programs into comprehensive, ambulatory health care services in poverty neighborhoods, linked to hospital services for cases in which the latter are needed.

3. Offering young physicians opportunity for service in poverty neighborhoods as an alternative to military service.

We would note, however, that health care per se is only one part of what is needed to meet human health needs, and not the most important part. Again, the tour reinforced this point in our minds.

A national program to improve housing for the poor is urgently needed as a health measure. It is simply impossible to maintain health in houses that are physically unsafe and do not have elementary sanitation features. Yet millions of Americans now live in such houses.

A national housing program must do more than what "urban renewal" has meant in many places; namely, driving poor people out of dilapidated dwellings to make room for public and commercial buildings and residences for people of means, with little or no improvement in housing for the poor who are merely scattered by the "renewal."

The main public housing program for the poor really consists of welfare benefits which include an itemized amount for rent. Many hundreds of millions of this money goes to support housing that does not meet any standard. This means, in effect, that present national welfare policy subsidizes shockingly bad housing without any effort at quality control; it actually encourages landlords to continue making profits without improving the housing.

We now spend an estimated $4.2 billion of Federal funds in public assistance payments. President Nixon's welfare reform proposal would add $4.0 billion, double our current expenditures. But the welfare reform proposal does not provide for the changes that are needed to insure that Federal payments for housing do not continue to subsidize substandard dwellings.

MEDICARE

Medicare provdies that funds are not to be used to pay hospitals that fail to meet a standard of quality. Since, overall, housing may be at least as important to health as hospitals, we believe that health interests require the same approach to housing as that taken to hospitals. Poor people are beginning to see, and one can understand when visiting them how they began to see, the whole "establishment"—welfare agencies and low enforcement agencies—in support of rent payement but not decency in housing.

As a first step toward better housing for the poor, we recommend:

4. Prohibiting the use of money in individual welfare assistance budgets for payment of rent in housing that fails to meet local regulations. Unfortunately, Mr. Chairman, I must point out that in some cities in our country there are no such local regulations. Where they exist, however, welfare payments should provide that housing meet those standards.

5. Development of a national minimum standard-setting program for quality of housing in which moneys derived from Federal general tax revenues can be used as rent.

That hunger and malnutrition exist on a wide scale among the people of America is now openly acknowledged by the President and congressional leaders. Food subsidy in this country, however, has meant and still means payment to agricultural interests either for not growing food or for maintaining the price of food. The direct surplus food distribution program and the food stamp program have been relatively minor byproducts of the subsidy to agriculture, designed largely for price control.

To overcome hunger and malnutrition in this country it will be necessary to convert the current "food programs" that offer some assistance to a relatively narrow range of people into programs based on genuine need. On the tour we encountered situation after situation in which people were obviously poor, but did not qualify for the food program assistance because they lived in the wrong county or someone in the household got a temporary job last month; or they were so poor that they could not get enough cash at one time to purchase the minimum quantity of food stamps sold.

We, therefore, recommend as immediate steps, pending further proposals that may emerge from the White House Conference on Food, Nutrition, and Health, and elsewhere.

6. The continuation of the work of this committee in the investigation of food assistance programs and nutrition.

We are very much aware of the fact, Mr. Chairman, that it was the work of this committee that led to the passage by the Senate of S. 2547, an excellent piece of legislation.

INDIAN HEALTH CARE

National policies and practices toward the American Indian have continued to be one of the most shameful streams in American history. The brutality continues, for example, in forcing Indians who are struggling to live off the reservations to return to the reservations for needed medical care; and in the statements which Secretary of the Interior, Walter J. Hickel, was quoted as making at the 1969 Annual Western Governors' Conference; namely, that the Government had been a "little overprotective" of Indians and that his administration might reverse the trend because they "always have that crutch of being able to go back" to the reservations.

It is tragic that Indians must still depend for essential medical care upon "that crutch" which Mr. Hickel suggests taking away, but until something better is available, they must fall back on it even when that means traveling more than 100 miles. No policy could be better designed to drive back to the reservations those Indians who are trying to "make a go of it" in the towns and cities of America than the policy of denying them urgently needed medical care. Yet that is exactly what we do.

Since responsibility for Indian health care was transferred to the Public Health Service, tremendous improvement has occurred in the health of Indians still living on the reservations. Just when that care is most needed, however, during the transition to off-reservation life,

it is frequently denied because of the limits of the Federal program and the failure of State and local government to acknowledge Indians as citizens.

Pending further development of national social policy to assist Indians who want to achieve off-reservation life, we recommend as an immediate health measure:

7. Expansion of the Public Health Service program for Indian health care to include adequate funds to pay for medical services for Indians in need, for at least 5 years after they leave the reservation.

Degradation of our environment has become another national issue. Hardly a day passes without major reference in the news media to the demand expressed by some national political figure or concerned group that one or another aspect of the environment be cleaned up. Our tour yielded us the opportunity to see, smell, and hear the basis for this outcry: grossly polluted water, even in the Nation's river, the Potomac; garbage and debris strewn not only over the landscape, but accumulating in the vacant lots and alleys where children of the inner cities spend most of their time; air increasingly filled with physical and chemical waste, and noise, from what we call "advances" in industry and technology. This deterioration of America's living space results from our failure to respond to the collision between the growth and concentration of our population and our capacity to produce and use things. Our waste is drowning us, in the absence of control measures.

America must clean up. This will require a major alteration in our current policies on land development and use. Ineffectual rules and enforcement machinery, established for a time when air, water, and land seemed "free" and more than plentiful, must now be sharply brought up to date. We can no longer tolerate leaving these responsibilities in the hands of governmental agencies attuned to the short-term interests of industry and land developers.

We recommend:

8. Making the health of people the paramount criterion in developing and implementing much-needed national policy on the environment. Here we mean health broadly defined, not just specific disease control. As a first step, the Secretary of Health, Education, and Welfare should promptly develop and promulgate a comprehensive set of standards based on health criteria and without regard for any presumed ability to meet such standards, for the air, water, and land of our country.

Social advances such as those made in the United States bring changes in attitude toward many problems, including fundamental alteration in how we characterize problems. Not many years ago, for example, chronic alcoholics were drunken bums to be dealt with by the policeman and the jailer. Now the chronic alcoholic is a sick person, provided he happens to be in the right social class. The rich chronic alcoholic goes to a private sanitarium run by psychiatrists; the middle-class chronic alcoholic goes to the clinics that are being established under health auspices; but the poor chronic alcoholic still goes to jail, for drunkenness or some related offense.

This is true countrywide, not just in Atlanta where we saw it on our tour. I would like to emphasize here, Mr. Chairman, that we do not regard the places we saw on our tour as unique. We picked them

deliberately because they are merely typical of many other places in the country, and what we saw in Atlanta could be seen in every city of this country.

Meanwhile the judiciary, as one branch of Government, is beginning to consider chronic alcoholism as a health problem—not completely as yet, but moving in that direction.

In preparation for the social decision which will probably be manifested by some Supreme Court decision, we hope in the near future, that alcoholism is a health problem, we recommend:

9. Appropriation of Federal funds on a large scale to support community services for treatment of the chronic alcoholic as a sick person.

I was delighted just recently to read that Assistant Secretary for Health, Dr. Roger Egeberg, also called for expansion of Federal effort to treat the alcoholic as a sick person.

In conclusion, I want to emphasize again that spending more money for health care services in the absence of fundamental changes in the organization and delivering of health services is not the answer. Our threefold increase in HEW health expenditures between 1963 and 1970 is not the answer. Nor is the doubling of welfare payments the answer in the absence of fundamental changes in the welfare program. We are pouring money down the drain when we continue to subsidize substandard housing for example, with Federal welfare payments.

HUMAN NEEDS IN HEALTH

Human needs in health are not being met and much more than the provision of health care services is involved. We hope that this committee will carry out its own investigation of the conditions that interfere with meeting human needs in health. The American Public Health Association would be very pleased to provide any assistance that would be helpful.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you for your statement, Dr. Breslow.

Dr. Cornely, did you have anything you wanted to add before we go into questions?

Dr. CORNELY. Mr. Chairman, I would just like to join Dr. Breslow in expressing my thanks to you and to the committee for making it possible for us to present this testimony to you.

We would be very happy to answer any questions that the committee may have.

The CHAIRMAN. Thank you, Dr. Cornely.

(The prepared statement of Dr. Lester Breslow follows:)

PREPARED STATEMENT OF DR. LESTER BRESLOW, PRESIDENT, AMERICAN PUBLIC HEALTH ASSOCIATION

Mr. Chairman, we appreciate this opportunity to report to your distinguished Committee the findings of a nationwide tour which we, as President and President-Elect of the American Public Health Association, recently completed. We wanted to observe first-hand the status of our efforts and the level of our success in meeting human needs in the field of health.

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The national and state programs which purport to deal with these conditions, when viewed closely, appear to represent a policy of domestic brinkmanship. These programs simply skirt disaster and do little to ameliorate underlying problems. President Nixon recently spoke about a "massive crisis" in health care, and warned that "we will have a breakdown in our medical system which could have consequences affecting millions of people throughout the country." In fact, the breakdown has already occurred, and the consequences are already affecting our people.

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More than 20 percent of all persons in families with incomes under $3,000 a year have never seen a dentist.

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Everywhere we encountered the lamentable excuses offered by local health and welfare officials, who seemed as trapped by "the rules" as the people they were supposed to serve.

While there has been considerable improvement in the quality of life for most Americans, the fact still remains that a large proportion of the 22,000,000 blacks, the 5,000,000 Mexican-Americans, the 500,000 American Indians, and millions of others live day in and day out in conditions we would not let our animals endure; and the "system" of care for people with disease associated with such conditions seems designed to obstruct their receiving the care that is needed.

Mr. Chairman, we would like an opportunity to present to you, within the next two weeks in a separate communication, a somewhat more detailed account of our tour. In the meantime, if any should think that we present on our summary an exaggerated picture, or too harsh a judgment based on "Isolated" instances, let him spend, as we did, a few full days actually looking, listening, and smelling. The conditions we described are all too pervasive.

Now we wish to propose some lines of action, for health professionals such as ourselves and for the legislative and administrative branches of government. We share the conviction of many in our country, often expressed these past few months, that a nation with the technological ability and governmental resources to create a satisfactory environment for an Apollo space capsule on a trip to the moon must find a way to provide healthful living conditions for the people in Houston, Tulare County, Great Falls, Chicago, Washington, Atlanta, and everywhere else in this country.

As professional public health workers, we should first recognize our own deficiencies. Like others in professional and technical fields of endeavor, some of us have become closely identified with agencies and institutions whose bureaucratic interests contradict the interest of the people we are supposed to be serving. Of course we must be loyal to the agencies for which we work, but we need not become callous in accepting the "rules" and the budgets. We develop such callousness possibly as a protection against our own feelings of guilt as workers in too feeble programs, but it can insensitize us to the point where we no longer press vigorously to achieve adequate programs. We tend to resist the "community takeover" of health programs by people in impoverished neighborhoods, who have

found that they must participate in setting the rules as a means, literally, of survival. For too long the programs have stifled their participation. The rules of these programs, established by others who do not understand the problems, make less and less sense.

To avoid such professional myopia, we urge that public health professionals, no matter what their type of work or employment, devote some time each year to observing directly the conditions of life that generate health problems. It is one thing to treat a child in a clinic with a cut eye, but another thing to encounter him as we did in a Chicago neighborhood, with a patched eye, and to hear him describe and then see the broken stair-rail at his house which permitted him to fall from the second floor onto glass on the ground adjacent to his house.

Further, we believe that health professionals should join hands with the organizations of people that are emerging in neighborhoods throughout the country, to fight for better health conditions. Everywhere on the tour we found that neighborhood organizations are springing up and arousing new hope. The advancement of public health today requires the development of effective alliances between such groups and those having technical competence in health work. Alliances of this sort would energize the efforts of all.

Although we knew before the tour that our health programs needed a drastic overhaul, the visits added a depth of understanding and feeling that we could not have gotten otherwise.

I know that this Committee with jurisdiction over nutrition and human needs would be as shocked as we were on the tour.

And what is the answer?

Perhaps I can explain it best by pointing out that the maintenance of the status quo is not the answer. Pouring more money into the existing health care system is not the answer. Yet that is what we are doing.

In 1963 the health budget of HEW totalled $4 billion. The 1970 HEW budget proposes a health expenditure in the amount of $12 billion, a three-fold increase. Furthermore, more than three-fourths of the $12 billion will be spent for the provision of health services, primarily through Medicare and Medicaid. I can assure you that, to put it plainly, "we are not getting our money's worth" out of the increased funding.

A health care program for the poor based on a month-to-month means test to determine indigency is unacceptable in a decent society. As professionals we can only begin to understand the indignity suffered by those who seek to qualify under a means test. But apart from that, the means test system requires the cancellation of eligibility for benefits because of a slight increase, often temporary, in income. This is standard practice under Medicaid throughout the country. Access to medical care is thus often cut off just when it is most needed to boost a family out of the poverty-poor health-poverty cycle. This makes no medical sense. Getting the information, keeping the records, and making the judgments each month, according to rules which are changed often with little or no notice by state and country officials, costs a substantial amount of money. That money could go a long way toward providing benefits on a yearly basis. The latter would be much more sensible from a medical standpoint and in the long run probably more economical. One must ask whether the present arrangement is designed to aid the poor or to perpetuate a bureaucracy. Medicaid as a whole—its system of eligibility, loose budgeting, crazy-quilt pattern of benefits, and failure to set standards for care—was fashioned from the mold of old fashioned, welfare-oriented programs. It is probably the most colossal excrescence of a welfare system that has long outlived its usefulness and, as President Nixon has indicated, must be revamped. What better place to begin the revamping than to set free the provision of health services for the poor from a welfare system that grossly distorts its purpose? Few would deny that health care is important and that a health care system should make medical sense.

Perhaps it is time for this Committee, Mr. Chairman, to assert that the human needs of the poor must be approached systematically in order to overcome the erosion of their health. Responsibility for the health care system must no longer be parceled out in an uncoordinated way among dozens of Federal, state and local public agencies. With more than 6 percent of the Gross National Product now devoted to health care, and an increasing proportion of that paid directly out of government funds, it does seem timely that we develop a national policy and program on health care. It is not sufficient to drift and take pot shots at drug prices and physicians' fees, horrendous as some of these may be. Our tour

convinced us that health care for the poor, at least, in this country has broken down. The crisis is not coming; it is here.

The American Public Health Association would be pleased to join in the development of a national policy and program of health care for all.

In the meantime, convinced of the urgency by our tour, we make the following recommendations as beginning steps to relieve the chaos in health care:

1. Establishing eligibility for Medicaid on a yearly basis rather than monthly.
2. Channeling funds from Medicaid and other governmental health care services in poverty neighborhoods, linked to hospital services for cases in which the latter are needed.
3. Offering young physicians opportunity for service in poverty neighborhoods as an alternative to military service.

We would note, however, that health care per se is only one part of what is needed to meet human health needs, and not the most important part. Again, the tour reinforced this point in our minds.

A national program to improve housing for the poor is urgently needed as a health measure. It is simply impossible to maintain health in houses that are physically unsafe and do not have elementary sanitation features where millions of Americans now live. A national housing program must do more than what "urban renewal" has meant in many places, namely driving poor people out of dilapidated dwellings to make room for public and commercial buildings and residences for people of means, with little or no improvement in housing for the poor who are merely scattered by the "renewal."

The main public housing program for the poor consists of welfare benefits which include an itemized amount for rent. Many hundreds of millions of this money goes to support housing that does not meet any standard. This means, in effect, that present national welfare policy subsidizes shockingly bad housing without any effort at quality control; it actually encourages landlords to continue making profits without improving the housing. We now spend an estimated $4.2 billion of Federal funds in public assistance payments. President Nixon's welfare reform proposal would add $4.0 billion, or double our expenditures. But the welfare reform proposal does not provide for the reforms that are needed to insure that Federal payments for housing do not continue to subsidize substandard dwellings.

Medicare provides and Medicaid permits requiring that funds may not be used to pay hospitals that fail to meet a standard of quality. Since, over-all, housing may be at least as important to health as hospitals we believe that health inerests require the same approach to housing as that taken to hospitals. Poor people are beginning to see the whole "establishment"—welfare agencies and law enforcement agencies—in support of rent payment but not decency in housing.

As a first step toward better housing for the poor, we recommend:

4. Prohibiting the use of money in individual welfare assistance budgets for payment of rent in housing that fails to meet local regulations.
5. Development of a national minimum-standard setting program for quality of housing in which monies derived from general tax revenues can be used as rent.

That hunger and malnutrition exist on a wide scale among the people of America is now openly acknowledged by the President and Congressional leaders. Food subsidy in this country, however, has meant and still means payment to agricultural interests either for not growing food or for maintaining the price of food. The direct surplus food distribution program and the food stamp program have been relatively minor byproducts of the subsidy to agriculture, designed largely for price control.

To overcome hunger and malnutrition in this country it will be necessary to convert the current "food programs" that offer some assistance to a relatively narrow range of people into programs based on genuine need. On the tour we encountered situation after situation in which people were obviously poor but did not qualify for the food program assistance (they lived in the wrong county or someone in the household got a temporary job last month); or they were so poor that they could not get enough cash at one time to purcase the minimum quantity of food stamps sold.

We, therefore, recommend as immediate steps, pending further proposals that may emerge from the White House Conference on Food, Nutrition and Health and elsewhere:

6. The continuation of the work of this Committee in the investigation of food assistance programs and nutrition.

We are very much aware of the fact that it was the work of this Committee that led to the passage by the Senate of S. 2547, an excellent piece of legislation.

National policies and practices toward the American Indian have continued to be one of the most shameful streams in American history. The brutality continues, for example, in forcing Indians who are struggling to live off the reservations to return to the reservation for needed medical care; and in the statements which Secretary of the Interior, Walter J. Hickel, was quoted as making at the 1969 Annual Western Governor's Conference; namely, that the government had been a "little overprotective" of Indians and that this administration might reverse the trend because they "always have that crutch of being able to go back" to the reservations.

It is tragic that Indians must still depend for essential medical care upon "that crutch" which Mr. Hickel suggests taking away, but until something better is available they must fall back on it even when that means traveling more than 100 miles. No policy could be better designed to drive those Indians who are trying to "make a go of it" in the towns and cities of America back to the reservations than the policy of denying them urgently needed medical care. Yet that is exactly what we do.

Since responsibility for Indian health care was transferred to the Public Health Service, tremendous improvement has occurred in the health of Indians still living on the reservations. Just when that care is most needed, however, during the transition to off-reservation life, it is frequently denied because of the limits of the Federal program and the failure of State and local government to acknowledge Indians as citizens.

Pending further development of national social policy to assist Indians who want to achieve off-reservation life, we recommend as an immediate health measure:

7. Expansion of the Public Health Service program for Indian health care to include adequate funds to pay for medical services for Indians in need for at least five years after they leave the reservation.

Degradation of our environment has now become a national issue. Hardly a day passes without major reference in the news media to the demand expressed by some national political figure or concerned group that one or another aspect of the environment be cleaned up. Our tour yielded us the opportunity to see, smell, and hear the basis for this outcry: grossly polluted water, even in the Nation's river, the Potomac; garbage and debris strewn not only over the landscape but accumulating in the vacant lots and alleys where children of the inner cities spend most of their time; air increasingly filled with physical and chemical waste, and noise, from what we call "advances" in industry and technology. This deterioration of America's living space results from our failure to respond to the collision between the growth and concentration of our population and our capacity to produce and use things. Our waste is drowning us, in the absence of control measures.

America must clean up. This will require a major alteration in our current policies on land development and use. Ineffectual rules and enforcement machinery, established for a time when air, water, and land seemed "free" and more than plentiful, must now be sharply brought up to date. We can no longer tolerate leaving these responsibilities in the hands of governmental agencies attuned to the short-term interests of industry and land developers.

We recommend:

8. Making the health of people (broadly defined, not just specific disease control) the paramount criterion in developing and implementing much-needed national policy on the environment. As a first step the Secretary of Health, Education, and Welfare should promptly develop and promulgate a comprehensive set of standards based on health criteria and without regard for any presumed ability to meet such standards, for the air, water and land of our country.

Social advances such as those made in the United States bring changes in attitude toward many problems, including fundamental alteration in how we characterize problems. Not many years ago, for example, chronic alcoholics were drunken bums to be dealt with by the policeman and the jailer. Now the chronic alcoholic is a sick person, provided he happens to be in the right social class. The rich chronic alcoholic goes to a private sanitarium run by psychiatrists; the middle-class chronic alcoholic goes to the clinics that are being established under health auspices; but the poor chronic alcoholic still goes to jail, for drunkenness or some related offense.

This is true country-wide, not just in Atlanta where we saw it on our tour. Meanwhile the judiciary, as one branch of government, is beginning to consider chronic alcoholism as a health problem—not completely as yet but moving in that direction.

In preparation for the social decision, which will probably be manifested by some Supreme Court decision in the near future, that alcoholism is a health problem we recommend:

9. Appropriation of Federal funds on a large scale to support community services for treatment of the chronic alcoholic as a sick person.

In concluding, I want to emphasize again that spending more money for health care services in the absence of fundamental changes in the organization and delivering of health services is not the answer. Our three-fold increase in HEW health expenditures between 1963 and 1970 is not the answer. Nor is the doubling of welfare payments the answer in the absence of fundamental changes in the welfare program. We are pouring money down the drain when we continue to subsidize substandard housing with Federal welfare payments.

Human needs in health are not being met and much more than the provision of health care services is involved. We hope that this Committee will carry out its own investigation of the conditions that interfere with meeting human needs in health. The American Public Health Association would be very pleased to provide any assistance that would be helpful.

The CHAIRMAN. Senator Ellender has to go to another committee session, so I am going to defer questions and let him begin.

Senator Ellender?

Senator ELLENDER. Thank you very much, Mr. Chairman. I regret that I have to go mark up a rather large appropriations bill.

You have given us all the bad. Have you found any good at all?

Dr. BRESLOW. Yes, we found one important hopeful sign. Everywhere we went on the tour, we found a new spirit springing up among people who are living among even such degraded conditions as we found.

For example, in Houston we encountered a 15-year-old boy who was the leader of a youth group that was seeking by organizing the young people of the neighborhood to get some improvement in recreation. He had a rather modest objective, namely, to get some trees in a park.

In Great Falls, Mont., we encountered a man who was organizing the Indian Advancement Council, a little neighborhood group of a few families that was endeavoring to assess their own problems and make recommendations to the local officials. They were trying to build up their own situation by their bootstraps.

On the South Side of Chicago, too, we found local groups springing up. That is, I think, the most positive thing we found on our tour, the determination of the local people to get on with the job.

LOCAL PARTICIPATION

Senator ELLENDER. Don't you think that this matter should be looked into and treated by the local people?

I have been in many cities where a lot of filth exists, and unless the people themselves insist upon it, it is never changed. Would you agree to that?

Dr. BRESLOW. I would agree to that. I think the new spirit might lead to this.

Dr. CORNELY. I would like to make a comment on that.

Senator ELLENDER. What effort has your health association made to correct the conditions of which you are complaining?

Dr. CORNELY. May I make a comment on the question that Senator Ellender made that this has to be a local effort at all times?

First of all, let me say this: I think that the insensitivity and apathy shown by the agencies for human services which we find in many cities and many areas throughout the United States, have brutalized people. They have been brutalized by the welfare department, the department of sanitation, the department of recreation. These individuals have become what I would like to call "battered adults," just as we talk about battered children.

These individuals cannot continue to live in Houston, Tex., in the second ward area there, where filth is actually filtering down from the second to the first floor, and where a cement industry is spewing dirt all over the place.

I saw people who were trying to keep clean, and they just couldn't do it under these circumstances. Therefore, we have to do a great deal more than just say that the local groups can help in this particular situation. We have to have other approaches, and some of these that Dr. Breslow has mentioned are extremely important.

Therefore I wouldn't want to put all of the burden upon the local community.

Senator ELLENDER. I always felt that there should be local cooperation. You wouldn't expect the Federal Government to do all of it; would you?

Dr. CORNELY. No. I do believe that there is the opportunity here for this committee to take a good look at the relationship of the Federal Government, that is the Public Health Service, to the health departments, State and local, and see what can be done to develop a program that will really reach the local community. There has to be this kind of combined effort.

FEDERAL PARTICIPATION

Dr. BRESLOW. I think, Senator Ellender, that we could express the point of view we arrived at this way. The Federal Government has seen the necessity of assisting communities and neighborhoods in developing hospitals and other health care facilities. This has involved the commitment of Federal funds and also the insistence upon at least a minimum Federal standard in the construction of the facilities. Under medicare, also, the quality of the institutions which are participating, with the expenditure of Federal funds, must comply with a Federal minimum standard.

Just as health care per se is important to health, also housing, nutrition, and these other things of which we have been speaking are important to health. What we call for is Federal participation in just the way we have embarked upon this matter in the health facilities field; namely, reasonable controls on the use of Federal moneys.

We certainly need Federal assistance because the local and State tax resources are now overwhelmed. We must have Federal assistance to get on with the job of social advance.

Equally important at the present time is the setting of standards. We do not think it is of any value to continue pouring hundreds of millions of dollars, for example, into substandard housing. We need to set standards, and if the Federal Government is going to make the money available, it should set the standards.

Senator ELLENDER. What do you mean by the Federal Government furnishing money for housing that is not standard? Do you know of any program like that?

Dr. BRESLOW. Yes; it now commits $4 billion, and President Nixon proposes doubling that, in cash assistance throughout the country for welfare budgets, including an amount for housing. Every State has the responsibility for fixing the level of assistance, and throughout the country that includes Federal money for housing that is substandard.

Senator ELLENDER. Is that money being used to change the housing itself in order to make it a better place to live in, or is it given as a rent subsidy?

PUBLIC HOUSING AND RENT SUBSIDY

Dr. BRESLOW. It is given as a rent subsidy, in effect, with no effort whatsoever to improve the quality of the housing. That is precisely the point, sir.

Senator ELLENDER. I happen to have authored the first public housing bill in the country, back in 1937, and I found that many areas which were able to do some of this work failed to do it. They failed to create the necessary authority, but even in areas where we did assist, within a matter of a few years, the public housing became slums because the people would not keep the area clean, and would not keep the housing clean. I am sure you found some of that in your investigation.

Dr. BRESLOW. Yes; we did.

Senator ELLENDER. Who is to blame for that?

Dr. BRESLOW. It is difficult to assess blame, Senator Ellender, in a situation like this. But I would say that insofar as the Federal Government appropriates funds to support the housing without any effort whatsoever to insist upon a minimum standard for that housing, then we are unfortunately in support of what is happening.

Just as I would insist that we continue to maintain and, in fact, elevate the standards for construction of hospitals into which Federal money goes, and for the providing of services in those hospitals into which Federal money now goes, we should do the same for housing.

Senator ELLENDER. The cases I am referring to are housing constructed in accord with plans and specifications prepared in conjunction with the Federal Government and the housing authorities.

What I am complaining about is that many of the people who live there don't take care of the buildings. They don't take care of themselves, and the first thing you know, within a matter of a few years they go back to slums.

Dr. CORNELY. Let me make a statement about that, because I think we cannot solve health problems by just one approach. You cannot solve the health problem of housing by just building a physical structure. You have got to do other things to go with housing. You have to provide jobs for people who may not have any, and find themselves quite often in a situation where they have to take additional people in such housing and make it overcrowded.

You also have to provide sanitary facilities in those areas, and you also have to provide education for people. What we are saying here is that you have to have a total package whenever you are looking at health. It can't be done by itself.

Senator ELLENDER. Don't you think that those rules and regulations should be meted out by the local government?

Dr. BRESLOW. Sir, I believe, in response to that question, that local government should assume a larger and larger share of responsibility. Where the Federal Government, however, is using Federal moneys to support these services, including rent payments, then it is the responsibility of the Federal Government to insist upon at least a minimum standard for the expenditure of these funds.

For example, in Chicago we found a woman who was paying $100 a month for rent out of a welfare assistance check of $143 per month. More than two-thirds of her welfare assistance went to pay for housing, which I am sure that anyone in this room would quickly designate as grossly substandard.

That is the kind of thing to which we are objecting, and for which we think the Federal Government carries some responsibility.

Senator ELLENDER. We found many cases in which a large percentage of the welfare payment goes for rent, but I am speaking of the sanitary conditions which you have talked about in your paper here.

It is my belief that it not only requires assistance at the local level, but also from the people themselves.

Now, in respect to hospitals, you talked a lot about that in your statement. Have you examined any in Louisiana? Have you been in Louisiana to examine our hospitals there?

Dr. BRESLOW. No, sir.

Senator ELLENDER. It is a pity you didn't go there, because Louisiana leads the Nation in the hospitals that are available for the poor. We have nine State-operated hospitals that give assistance to all people, irrespective of the disease they have, and they remain there as long as the doctor states that they should. It is different from medicaid and these other programs to which you refer. In addition to that, we have in practically every parish—county to you—taken advantage of the Hill-Burton Act, which I helped to sponsor back in the early 1940's. I think a good job has been done in that way. Of course, it has been done with the cooperation of our local health department, as well as the State government. Also, we have in each parish clinics that are operated by the State, and in many States such do not exist. Those may be the areas in which you find all this difficulty to which your refer.

HOSPITALS IN LARGE URBAN CENTERS

Dr. CORNELY. I would like to make a statement in terms of hospitals. Although we didn't have the opportunity to go to Louisiana to look at the hospital program there, nevertheless when one looks at hospitals throughout the United States, particularly hospitals in the large urban centers, one sees a pattern which is quite characteristic in terms of the outpatient departments of these hospitals, in the manner in which people, poor people, have to wait long hours, in the manner in which they have to travel long distances to get to the hospitals, and many other characteristics in the care provided by these hospitals.

So I would say that even though Louisiana may have a wonderful hospital system, I would like to emphasize the fact that if you look at the urban centers throughout the United States, you will find that the city hospitals are in great need of reorganization.

Senator ELLENDER. I am sure that is true, because of the increasing population. Many of these hospitals were constructed years ago when the population was much less than it is now. I grant that you find some deficiency there, but it strikes me that the burden lies more on the local people than it does on the Federal Government. Your health organization should be at the forefront in seeing to it that the health organizations in the States carry out what you are now proposing. More could be effected by your health organization in that field, and I think we would get better results.

Dr. BRESLOW. We do have, Senator Ellender, State affiliates of the American Public Health Association, and regional branches taking in the public health workers in a group of States. Our members are concerned with these matters. As a national organization, we recognize the value of your remarks, that this is not a job exclusively for the Federal Government, and so we do call on our organization, State and regional affiliates as well as the national organization, to take a firsthand look at these problems.

We are very much heartened in one respect; namely, by what we see as a new spirit arising in the neighborhoods. People themselves are demanding that the sanitary inspectors make the rounds to see what kind of meat is being sold in the meat market, and what kind of fruits and vegetables are being sold in the grocery stores. They feel they must do this because we have abandoned large numbers of people to very degraded conditions, including food that is sold in their stores.

So we think it is a job for everybody, including the Federal Government.

Senator ELLENDER. I do hope this cooperation can be accelerated. At the local level, your organization is in the forefront, and I am sure that a lot of good can come from it.

I regret that I have to leave. I am half an hour late now, I am chairman of the subcommittee, so I have to leave.

Dr. BRESLOW. We appreciate your being here, Senator Ellender.

FIELD INVESTIGATION

The CHAIRMAN. Dr. Breslow and Dr. Cornely, I want, first of all, to express my personal appreciation that you have taken this investigation into the field.

I quite agree with you that no amount of reading of statistics and reports ever gives one the insight into the deeply human problems that you get when you go out into the field. The members of this committee, I might say, began our investigation somewhat skeptical of the extent of the need that had been reported in the field of nutrition, and after 1 day in the field, looking into some of these filthy homes and seeing the conditions under which people lived, and the terrible diets they had and, as you say, smell the smells and see the sights, it gives you a new perspective.

So I want to add my appreciation to the effort you have made. I wonder a little bit more about your tour. What dates did the tour take place, and who went on it? Was it just the two of you, or what was involved in your effort?

Dr. BRESLOW. We made the tour during July and early part of August of this year in three legs. We visited two places on each leg of the tour, a total of six places.

Dr. Cornely made the complete tour. We had the assistance of some staff who made arrangements locally in advance for us to go on a walking tour of the neighborhoods at each of these locations, usually in the morning. In the afternoon we would typically sit for several hours in a neighborhood house to talk with the people about their problems.

So we saw people on the streets, in their homes, and at neighborhood gatherings. Likewise, we met with officials, usually for breakfast, and often stayed into the evenings with medical societies and other groups.

FEDERAL AND STATE COOPERATION

We were joined in every place by either Federal or State, sometimes both, legislators.

In Houston, Tex., Senator Yarborough, Congressman Bob Eckhardt, and State Senator Lauren Cruz accompanied us. Elsewhere we had either Federal or State legislators with us.

In addition, we had the news media. They were extremely interested, and went right along with us on the streets, and into the homes oftentimes. We had with us on the tour local officials, health, welfare, and other officials, who were encountered by neighborhood people and asked questions about the services they provided.

The CHAIRMAN. Is this tour part of a larger citizens group that is looking into the problems of health, or was it strictly an operation by the Public Health Association?

Dr. BRESLOW. It was strictly an operation by the American Public Health Association. I happen to be personally identified with another longer continuing study of health care for Americans, and we did have some staff cooperation from that group, but this was specifically an American Public Health Association undertaking.

The CHAIRMAN. In reading your statement, you paint a very dark picture, and I think legitimately so, of the breakdown of our health system in this country.

Whose fault is that? Is it the fault of the medical societies, or the Government, or the local communities? Where do we find a responsibility for this shocking fact that you cite that the United States is 13th from the top in infant mortality rates, that we lag behind other countries with less monetary resources than we have in the health field. Why is that?

Dr. BRESLOW. Well, sir, on matters like this I do not think it is helpful to go about pointing the finger. I believe profoundly, Senator McGovern, that all of us, including you and me, share in the guilt.

I would rather look not at who is to blame, but rather who is to take the initiative in responding to the situation, who is going to lead us out of the crisis.

NATIONAL LEADERSHIP

That is the question. I think that our national leaders, persons in the administration and persons like yourselves, sir, you and the distinguished colleagues that serve with you on this committee, are the ones who can take the initiative.

Nothing so mobilizes this country as leadership from the national level. Of course, we must have grassroots effort. Medical societies must participate. Our association has been guilty of not being sufficiently aggressive. We are looking for leadership now, and I think that this committee is one place where we might achieve it.

Our effort in the tour was to pinpoint some of the problems and to make some specific recommendations, not with the notion that they are a total program, but with the expectation that we can take some immediate, concrete action. This is not something to be discussed and subjected to "policy review" for years and years. We must have a national health policy, but beyond that we must get on with the immediate tasks.

Dr. CORNELY. Mr. Chairman, the point that Dr. Breslow made concerning the need for some national priority, I think, is extremely important. I think we have allowed ourselves in this country to just go haphazardly about health, without certain goals.

For instance, we in this country have never said our infant mortality is extremely high for a technologically advanced country. Why can't we bend our resources to reducing this? The British Ministry of Health has asked that question of themselves, and I think this is the sort of thing we need to do.

At the present time, as I see it, health has been given quite a low level of priority, and I think we need to really establish certain specific priorities.

The CHAIRMAN. Dr. Cornely, with reference to this matter of priorities, how do you line up the various human needs that are covered both by the scope of your statement and Dr. Breslow's statement, and also by the scope of this committee?

For example, we have a mandate under the resolution that created this committee, "to study the food, medical, and other related basic needs among the people of the United States." That is a very broad mandate. I don't know of any committee in the Congress that has that broad an instruction from the Congress to look at the whole range of human needs.

There are a few things about that I would like to ask you to comment on, whether you think we can make much progress on any one of those if we take it up singly instead of through an overall approach and, second, where do you see the priorities within that rather broad range of human needs?

Dr. CORNELY. This is a broad question, and certainly off the top of my head, it would be a little difficult to try to set priorities.

QUALITY OF LIFE

It would appear to me that all of us today have to be concerned about the quality of life in this country. It is really going down the drain, and if we don't do something about it, we are a lost society, in terms of environment, in terms of medical care and all the other facets.

Now, if we are going to look at the quality of life, then we have to begin to take a look at some of the important needs. So, first of all, it would appear to me that people have to be given a way of life that will assure an income, proper nutrition, and good housing. These are basic needs.

Second, they have to have adequate medical care, and this medical care has to be provided in a way that can be helpful to them.

As Dr. Breslow said in the statement, medicaid is an abomination, and we can't continue to go on like this. Then, third, it seems to me that we would like to try to pinpoint certain specific problems which are of concern to each of the many diverse populations in our country.

We, unlike Norway or Sweden, don't have a homogeneous population. We have to pinpoint certain specific approaches. Therefore, I would see it as an overall, broad concept that all of us have to be concerned about.

I would also make this last statement, that we are going to have to listen to our communities in terms of their needs, and I don't think that we have done enough of this.

The CHAIRMAN. Thank you.

With reference to a national medical policy, there has been some discussion, as you know, for years about a national medical insurance program to cover not just those over 65, but all of our citizenry.

NATIONAL HEALTH PROGRAM

I would be interested in any comment that either of you doctors would care to make on that proposal.

Dr. BRESLOW. We are strongly in favor of a national health program which would provide good health care on an equitable basis to all persons in the country.

The major defect in our present governmental approaches to health care still is that we have a dual system of health care. We still earmark funds to pay for health care for the poor in public facilities which are devoted exclusively to health care of the poor. Whenever there is a segregated, a dual, system, whether it is in health or education or any other feature of our social life, one is better and one is poorer. In the case of health care we believe it is important that all individuals in our Nation should have the right to a single and high standard of health care.

There are several ways in which this can be achieved. The American Public Health Association, before the passage of medicare, advocated the use of the social security mechanism as one means of achieving better health care for persons over 65.

In Philadelphia at our meeting next week, we are going to be giving consideration to the extension of this principle. We join with you, as I take it from your question, Senator, in looking toward the development of a national health program. We would emphasize that we cannot afford to have the kind of a program that medicaid represents; namely, the perpetuation and consolidation of a dual system of health care.

MORE PHYSICIANS NEEDED

We found five physicians serving about 50,000 persons on the South Side of Chicago. When the rest of our country has more than one physician per thousand persons, that community has only about one physician per 10,000 persons, with the people compelled to go 8 or 10 miles to the county hospital for outpatient clinic care, as well as inpatient care.

That is not unique. A similar situation exists even in my own community of Los Angeles, where there is one community, Venice, with six physicians for more than 60,000 people. These are the kinds of discrepancies that we must tackle.

The CHAIRMAN. Thank you, Dr. Breslow.

I notice in your statement that you recommend that this committee be continued. As you know, we are operating under a 1-year mandate. In the absence of some further action by the Senate, the committee would expire at the end of next month, the end of December.

RECOMMEND FURTHER STUDY

Does your recommendation refer to extending the committee beyond that date? Are you suggesting that the Congress extend the life of the committee beyond its present authorized date?

Dr. BRESLOW. Yes; we would favor that, Senator McGovern. We are very much heartened by the broad mandate given by the Senate to this select committee. We think it is a very appropriate mandate to study human needs, of which nutrition is an important one, but only one.

We endeavored in our tour to look at nutrition and other aspects of life that are important to health. We would like very much to see your committee extended, to carry on the same type of investigation into the whole quality of life important to health that you have already accomplished in the field of nutrition.

The CHAIRMAN. I was going to get to that question, to ask you whether you have suggestions as to what the committee ought to do, where it ought to concentrate its attention, or any other suggestion that you might have that you think might be helpful to us in formulating further investigation.

Dr. BRESLOW. I would say that a guiding principle should be that the criterion for the evaluation of the various aspects of the quality of life should be health. Perhaps you would expect us to say that because we are public health workers. In any event we believe that health should be the paramount criterion in the quality of life, in considering human needs. As your committee looks at other human needs, beyond nutrition; as you look at housing; the quality of the air which people breathe; the water—not just the drinking water——but the recreational water, and all the types of water in our country; as you look at the jobs that people have and the incomes that people have, we hope you will consider health to be the paramount criterion. It is unfortunately true that in National, State, and local approaches to these problems—for example, that of environmental health—the criterion often adopted is the so-called practical; namely, what is "reasonable," or what would the industry involved be agreeable to.

We do not think that this should be the determining factor. We can do much more with our technology than we are now doing, if a health criterion is accepted as the guide to the way in which we should move.

Dr. CORNELY. Mr. Chairman, could I make a couple of comments?

I would join with Dr. Breslow about the continuation of this committee, and I would hope that at the APHA meeting a resolution to this effect would be made.

I would like to make another plea, since you asked for some suggestion. I would like to make a plea for the minorities of this country.

When I left Chicago, I was really depressed, because by the time that I got to Chicago, I had seen the Mexican-American in Houston, the migrant workers, mostly Spanish-Americans, in Tulare County, I had seen the Indians in Great Falls, Mont., and I saw the situation in South Side, Chicago.

Now, these number from 35 or 40 million people who are really being brutalized daily. I would hope that your committee would really take a good look at this particular area along with its broad perspective. For instance, I think that the exploitation of blacks is almost reprehensible in our country. I have said to Dr. Breslow that the poor represent a gold mine in this country. They are exploited by absentee landlords. They are exploited by grocers who sell substandard food. They are even exploited by physicians under the medicaid system, who are able to get fees, and this sort of exploitation, I think, has to stop in our country, and I would hope that you would give some thought to this area.

The CHAIRMAN. We appreciate these suggestions, Dr. Cornely and Dr. Breslow. The committee is meeting in executive session on Wednesday of this week. We have a number of things to discusss, and I am sure that one of the things that members of the committee will want to look at is the possibility of extending the committee, or staying with our present mandate, which would permit it to expire at the end of this year.

I quite agree that there is a big agenda of unfinished business before the committee. We have been somewhat successful in the Senate in passing a food assistance program, but that measure is stalled in the House of Representatives, apparently on the grounds that we can't afford to fund that kind of program. It seems to me to be very strange reasoning when we have documentation out of the Budget Bureau that it costs us perhaps three or three and a half times as much to permit malnutrition to continue in this country as it would cost to put an end to it under the kind of modest proposals that have already cleared the Senate.

But there is no question that our committee has barely scratched the surface on health, housing, and community conditions, other than nutrition.

The more I look at these problems, the more I think they can't be separated. You can't really have a healthy person if he doesn't have proper food, and you can't have a person who is well fed if the worms are getting the food.

So the problems are tied together. This housing situation when you described it, I think perhaps that shocked me even worse than the food conditions that we saw on some of the tours that this committee took, the incredible conditions under which some people live.

I appreciate the point my distinguished colleague makes, Senator Ellender, about the importance of people carrying some sort of responsibility themselves. On the other hand, when you jam a family of 12 or 14 people into one little room inadequately ventilated, with inadequate sanitation facilities, it is very difficult to provide an attractive living space under those conditions, no matter how responsible you are.

So I do think these problems are related and your testimony has been most helpful to the committee.

I am going to personally see to it that other members of the committee have it called to their attention. I do want to thank you for your observations here today.

Dr. CORNELY. We certainly thank you.

Dr. BRESLOW. Thank you very much.

The CHAIRMAN. The committee will stand adjourned.

(Whereupon, at 11:25 a.m. the committee adjourned, to reconvene at the call of the Chair.)

APPENDIX

WASHINGTON, D.C., *December 5, 1969.*

Mr. WILLIAM C. SMITH,
Staff Director and General Counsel, Select Senate Committee on Nutrition and Human Needs, 134 Senate Office Building, Washington, D.C.

DEAR MR. SMITH: Enclosed is a copy of the Report of the American Public Health Association Tour of Health Conditions that Mr. Barclay asked me to send you.

We appreciate having this included in the Committee's report.

Sincerely,

JANE KATZ,
Staff Director.

Enclosure: As stated above.

HEALTH CRISIS IN AMERICA

A REPORT BY THE AMERICAN PUBLIC HEALTH ASSOCIATION

INTRODUCTION

In the summer of 1969, as President and President-elect of the American Public Health Association, we undertook a tour to examine in microcosm health conditions in the United States.

The tour started in a Mexican-American barrio in Houston. From there, we went to a rural community in the Central Valley of California; juvenile and adult detention quarters in Atlanta, Georgia; the Potomac River in Washington, D.C.; homes of off-reservation Indians in Great Falls, Montana; and the inner-city community of Kenwood-Oakland on the Southside of Chicago, Illinois. Our aim was to investigate, firsthand, typical environmental and medical care situations which give rise to serious health problems in our country. We believed it was time for health professionals to see directly, to hear and smell these situations which characterize the lives of millions of Americans, rather than to limit our view of the problems to health statistics, patients in clinics and laboratory specimens.

ACKNOWLEDGMENT

This work was supported in part by participation of staff of the Citizens Board of Inquiry Into Health Services For Americans and by a grant for publication from the Field Foundation, for all of which deep appreciation is expressed.

People from the neighborhoods, concerned professionals, some health and welfare officials, national and state legislators, and representatives of the news media joined our tour. Their participation reflects the rising and already substantial demand for improvement of health conditions in our country—improvement in housing, nutrition, air, water, jobs, and medical care.

As public health physicians, we thought we knew pretty well the nature and extent of those conditions. But frankly, we were shocked, and are still reeling. Circumstances that can only be called health brutality pervades the lives of millions of American people who live in communities that seem designed to break the human spirit.

When viewed closely, the national and state programs which purport to deal with these conditions appear to represent a policy of domestic brinkmanship. They simply skirt disaster and do little to ameliorate underlying problems. President Nixon recently spoke about a "massive crisis" in health care and warned that we will have a breakdown in our medical system "which could have consequences affecting millions of people throughout the country." In fact, the breakdown has already occurred, and the consequences are already affecting our people.

We recall with pain:

Approximately 50,000 persons of the Kenwood-Oakland area of Chicago, who live in rodent- and insect-infested housing, with broken plumbing, stairs and windows. Today, these people pay from one- to two-thirds of their income for rent and are served by a total of five physicians in their community—a physician-to-population ratio less than one-tenth of the country as a whole—with the county hospital and clinics eight miles away.

A 53-year-old American Indian in Great Falls, Montana, veteran of the South Pacific in World War II, raising a family of six children (and one grandchild, whose father is now in Vietnam) on a pension and what he can scrounge by salvage in a junkyard. He can neither afford to buy food stamps nor return to the hospital for post-cancer treatment—closure of his bowel, which now opens on his abdomen—because his family would not have food while he is gone.

The farmworker in Tulare County, California, who said that exposure to pesticides from airplane spraying of fields, contrary to regulations and often leading to illness, was frequently not reported because "What's the use?" she asked. "We lose wages going to the doctor, get better in a week usually, and get no compensation, and they don't stop spraying."

The woman in Tulare County, eight months pregnant, whose Medi-Cal (Medicaid) eligibility had been cancelled last month because her husband had just found a temporary job, thus forcing her to seek care at the County Hospital which previous experience had tought her to hate.

The young woman in Houston, whose welfare check for a family of eight had been cut from $123 to $23 a month.

A therapist in the Child Treatment Center, Atlanta, Georgia, where excellent work with youngsters in trouble was underway, but "the main difficulty is that the kids have to go right back to the same life that got them into trouble in the first place, and we can't do anything about that here."

The "uncooperative" chronic alcoholic who carried a card from Atlanta's Grady Hospital identifying him as an epileptic, but who, a few days before our visit, had occupied the "hole"—a 4 feet by 8 feet solitary confinement cell in the Atlanta City Prison.

Dead fish floating in the dirty water of the Potomac, the "Nation's River," which flows through our capital city so polluted by untreated and inadequately treated sewage that fish cannot live there, and the spread of human disease-causing bacteria appears as a serious threat.

Everywhere we encountered lamentable excuses offered by local health and welfare officials, who seemed as trapped by "the rules" as the people they were supposed to serve.

While there has been considrable improvement in the quality of life for most Americans, the fact still remains that a large proportion of the 20,000,000 Blacks, the 5,000,000 Mexican-Americans, the 500,000 American Indians, and millions of others live day in and day out in conditions we would not let our animals endure; and the "system" of care for people with disease associated with such conditions seems mainly to obstruct their receiving the care that is needed.

We visited the particular places mentioned because they are typical, not unique. The gross pollution of the Potomac exemplifies what is happening to the rivers and lakes of America. Atlanta treats her alcoholics essentially the same way such very sick people in cities across the land are treated, and Atlanta provides facilities for juveniles in trouble that are better than in many other places. These conditions characterize the lives of millions of Americans; they are not just isolated pockets of disaster.

The following separate reports of each of our visits indicate these disgraceful situations that millions of Americans now endure.

LESTER BRESLOW, M.D.,
President, APHA, 1969.
PAUL CORNELY, M.D.,
President, APHA, 1970.

A MEXICAN-AMERICAN BARRIO, HOUSTON, TEXAS

"The average Mexican-American lives ten years less than the average Anglo. There is no biological reason why this should be so. The only reason is because the Mexican-American is starving and does not have enough medical care"—Senator Ralph Yarborough, D-Texas.

In Houston—the space-age city with world renowned heart transplant facilities as well as astronauts and the Astrodome—we visited a community of 80,000 Mexican-Americans who live in the center of the city.

We walked through the Canales Courts area in the western portion of the Second Ward and visited the homes of residents there. In this five-square-block area, approximately 2,000 Mexican-Americans live in 432 apartments. Rents average between $40 and $60 a month, not including utilities. Neighborhood people informed us that the day before our visit the city had paved their street and made one of its infrequent attempts to pick up the garbage and cut the weeds. The Canales Courts area is typical of the neighborhood in which most of Houston's 80,000 Mexican-Americans live.

The first person with whom we spoke was a 50-year-old Mexican-American grandmother. She lives with her mother and 2-year-old grandson, left by a daughter who was unable to care for him. The building containing their tiny two-room apartment once might have comfortably housed a single family but now has been divided into eight cramped apartments in which eight families, 40 people, live. The two rooms of her apartment were about ten feet by 12 feet. There were no closets. Over sagging beds, clothes hung on lines strung in each room. The kitchen appliances, such as they were, were awkwardly crammed into what apparently once served as a hallway.

"I'm tired," she told us, "tired of being without money and having no way to earn any money for my children and my mother." Her only support for her mother and her grandson, as well as herself, is what a son, married and with his own family, sends. This is generally $10 a week for rent, from his weekly salary of $50, plus whatever food he can spare. She applied for social security benefits, but was turned down. She gets no welfare assistance since her son works.

Seeing us looking at the plaster dust which was sifting through her ceiling into the pots on her stove, and at her grandson who was sleeping on what served as a bed while flies and mosquitoes rested on his face, she said, "It's such a struggle to just keep things where they are without them getting any worse."

This stooped, grey-haired woman had watched four of her twelve children die from diarrhea, a common disease in children who suffer from malnutrition. Her hand was in a clumsy bandage she had fixed to protect a burn wound suffered over a month ago. The burn had never been treated by a doctor, and its effects may have been aggravated by the diabetes from which she suffered. The diabetes requires continuing medical attention, but "sometimes it is just impossible for me to get to the hospital for medicine since I can't even pay for the bus."

When she does have busfare, the visit to the hospital for the necessary treatment is likely to take most of the day. The only bus routes which serve the Second Ward run to and from the downtown area. To travel by bus from the Canales Courts area to Ben Taub County Hospital at the Texas Medical Center, she has to catch an eastbound bus for a 15 minute, 2 mile ride to downtown and then transfer to a southbound bus for a 25 minute, 6 mile ride. She may wait at each bus stop for as long as a half hour. Thus, every time she leaves to visit the hospital, she faces the possibility of an hour and 40 minute trip each way, in addition to the usually long wait for treatment at the hospital itself.

For the people of the Canales Courts area, Ben Taub Hospital is the closest of the two county hospitals which serve welfare recipients. Since there are almost no bilingual personnel on the hosiptal staff, Mexican-American patients often receive reproachful lectures about their inability to speak English. "Our children get sicker than most," one lady told us, "but they don't like to go to the doctor, because nobody speaks Spanish."

Those who try to use the hospital's facilities may find themselves turned away for lack of space. We met a lady on the streets of the Canales Courts area who reported she had suffered from a hernia for 10 years. About a month before our visit, she had sought treatment at Ben Taub. "They told me there were no beds and they would call me sometime, but I still haven't heard from them."

The Second Ward begins about one mile east of the Houston City Hall in the center of town and follows the Buffalo Bayou east for about five miles to the Port of Houston. Most of the land in the Second Ward is owned by absentee landlords. Being close to downtown Houston, the land is valuable—too valuable for developing low-cost, single-family residences. The value lies in prospective appreciation, and because the City of Houston has no building codes, the landlords have no incentive to keep the buildings in the Second Ward from running down. The houses and apartments of the Second Ward are indeed run down, and every available inch of these dilapidated buildings seems carved out for use to maximize the rental income of the absentee owners.

Another person complained, "We are choking from the air, yet nothing is done to stop the industries from polluting it." Someone else remarked, "If a person runs through a stop sign he is fined. If he pollutes the air on a big scale, he is put on the Air Pollution Control Commission." Congressman Bob Eckhardt, D-Texas, told the man that the way to control air pollution is to "tighten up the Air Quality Act of 1967 which permits states to drag their feet because it does not set standards." Air pollution in the Houston area is "discomfitting, sickening, and killing," especially to persons with respiratory or heart disease, according to Doctor Jan Jenkins, Houston physician and Past-President of the National Tuberculosis Association.

Besides industrial air pollution, the waters of the nearby Houston Ship Channel have a full two feet of pollution-laden silt, scientists estimate. According to one observer, the Channel is "one of the most polluted bodies of water in the world." About 40 per cent of the Galveston Bay Complex is off-limits to oyster production. "The bottom of the Bay is so full of chemicals that it will take generations to bring it back to anything like what it ought to be to provide food and recreation for people," State Representative Lauro Cruz said.

Despite the near 100-degree heat, residents of the Second Ward came out of their homes to tell about mosquitoes "which eat you alive" and rats that are "'this big' and scare away the cats." Mrs. H. said her 2½-year-old neighbor had been bitten two days before by a copperhead snake in her own yard and it took 45 minutes to drive the child to the county hospital. Another resident told how he kept his children inside his home because of rats and snakes. Some children must stay outside while their parents are at work. They may go to a park which was described by one young man as "a place where we have to play all day with the rats and mosquitoes and we don't even have any trees or shade."

Several residents described problems with rats. "There are rats even in the rectory here, but the church can pay for cheese and traps," Father Emile Farge reported. "Many of my neighbors cannot afford even traps." Dr. Charles A. Pigford, City Health Department Director, responded that the city has a rat control program, but not sufficient funds to conduct an adequate program.

Mrs. V. described her experience raising eight children on welfare assistance. A few days before the tour her welfare check was cut from $123 to $23 a month. Mrs. V. was not certain about the reason for the cut; others mentioned that two of her children had later been identified as participants in a children's hunger demonstration. Asked how she was feeding her children at the present time, Mrs. V. replied, "They're not eating right now."

Another problem of the young in Canales Courts is gross tooth decay. "A great number of Mexican-Americans lose their teeth at an early age," said Dr. Mervin Mergele, Director of Houston's Dental Health Division. "Dental care is too expensive for most of these people and they can't afford the foods which help build good teeth." Ripley House, a private settlement home in the Mexican-American neighborhood, conducts a small-scale dental program for children. Ben Taub Hospital, one of two sources of care for welfare residents, has only an oral surgery program for adults. "Although a few extractions take place here, much more could be done than just taking out teeth," Dr. Mergele asserted.

The typical Mexican-American does not expect to go to college. Most drop out of high school, if not before. "They drop out because of the money which is not in their pocket, the food which is not on their table, the schooling which forces them to learn in English, the laws which they cannot understand, and the knowledge that no Mexican-American on their block has been a success," explained Abraham Ramirrez, one of the few Mexican-American attorneys in the city.

"Our walk through the Canales Courts area in Houston set out in bold contrast what this country can do in the field of health and what it doesn't do. Senator Yarborough, Representative Cruz and I drove directly from the dedication of spectacular facilities at the M. D. Anderson Hospital Center and Tumor Institute in the Texas Medical Center to the Canales Courts area. In those few miles, we went from space-age health care to virtually no health care. Our advances in such areas as heart transplants and sophisticated cancer research are overshadowed by our failure to deliver health services to the people."—Congressman Bob Eckhardt, D–Texas.

TULARE COUNTRY, SAN JOAQUIN VALLEY, CALIFORNIA

"The poor child in a rural community may grow up hungry while surrounded by food he cannot eat. He leaves school too soon because his labor is needed to support his family. He lives in crowded, broken down housing, and is denied

educational, medical, and recreational services that are taken for granted among the urban poor. Rural America needs her young people, yet we are wasting a generation by driving them into the urban ghettos."—Assemblyman Gordon W. Duffy, R-California.

Hidden behind the peaceful green of the San Joaquin Valley with its productive farmlands and plentiful fruit groves live thousands of farm families—in another world, of poverty and poor health.

Many of the Anglos whose fathers came from Oklahoma to find work in Tulare County a generation ago are foremen in the fields. The laborers are mainly Chicanos who came from Mexico to follow the crops and are now gradually forming more or less settled communities.

The use of pesticides in the fields is one of the most worrisome health problems of the workers. "When they use the pesticides, they spray us too," a worker said. "Sure we get sprayed, and we get sick. Sometimes you see people going around with headaches all the time and getting dizzy and they wonder what the matter is. It's the pesticides, the spray."

State regulations require that no airplane spraying be done while workers in the fields may be exposed, and that after spraying, signs be posted to keep workers out. But one worker told us: "We get red eyes many times from the sulphur the planes spray. The planes cover your clothes with sulphur and when you get home your kids hug you and they get sick too. Twice I was thinning peaches and pickling oranges and the plane came over, spraying. We never knew it was coming. I took the number of the plane and told the foreman. Nothing happened."

An official from the County Agriculture Commission gave this response. "If there are violations, all people have to do is give us a call." When pressed as to how many prosecutions there had been for violations, he replied; "We've placed a number of operators on a year's probation, but you must remember that it's a very hard thing to take away a man's livelihood by taking his spray permit."

But what about the livelihood of workers who get sick in the fields? The official conceded however, that his inspectors have little time for anything beyond checking spray rigs and investigating a few complaints. Dr. Erwin Brauner of the Tulare County Medical Society disclosed that between 100 and 200 Tulare workers are reported to suffer from pesticide poisoning each year. Workers claim most cases are never reported. "What's the use?" one laborer asked. "We lose wages going to the doctor, get better in a week usually and get no compensation, and they don't stop the spraying."

Spraying abuses are only a dramatic part of a general disregard for the lives and dignity of the farm workers in Tulare County. David Perlman, a reporter for the *San Francisco Chronicle* who was with us on the tour, summarized it well when he wrote of one woman who lives in the town of Woodville in Tulare County: "Jenaida Arellano's good humor, patience and love for the world around her are often strained by a system that seems designed to diminish her self-respect and her family's access to good health."

Because there was little work around Woodville in June, Mrs. Arellano's husband had left to pick cherries in King City, some 130 miles away. The two oldest children, aged 12 and 10, went with their father to work on the lower parts of the trees. "While they are away, they are saving money by living under the trees," she explained. The family's income, which must support Mr. and Mrs. Arellano and their eight children, is about $2,500 a year, mostly earned during the summer months.

The groceries for the family when all were at home the week before our visit consisted of a 25-pound bag of flour, eight-pound bag of beans, four or five pounds of rice, a few green peppers, a few tomatoes, and a chicken. "The regular milk we can't afford and I only buy skim milk for the baby, Johnny. He is 2 years old and needs it."

Mrs. Arellano's husband is making $120 a week now, and so the Tulare County Welfare Department has cancelled his Medi-Cal card. As in most states, Medi-Cal, the California version of Medicaid, determines eligibility on a month-by-month rather than a year-by-year basis. A single month of earnings higher than the allotted income cancels eligibility until earnings again drop below the cut off level. Because her card had been cancelled, Mrs. Arellano expressed worry about how she would pay for her ninth baby, expected in less than a month. She was told by an official to appeal, but an appeal normally takes 105 days.

"With no Medi-Cal card, I have to go to the county hospital. I feel so terrible to go there and say I cannot pay. I feel so ashamed." The county hospital does

not require poor patients to pay in advance, but if a patient cannot pay the bill when it comes due, his property will be attached. The last time she traveled the 20 miles to the county hospital, she left at 7 a.m. because she had a morning appointment. "I didn't get home until one o'clock the next morning. We waited and waited."

We met another family who had taken a loan to buy a house, but later found out the amount for monthly payments was raised above the supposedly agreed upon amount. "We had to buy a home large enough for seven children because we couldn't afford rent for a big enough apartment," the father said. He had expected to pay $47 every month, but the bank now collects $63. In the winter, he earns only $19 per week. During the spraying season, the father has been able to get jobs with a spray company for $130 a week. "I tell welfare to take us off the rolls as soon as he earns enough," the mother said.

Her oldest son quit school at the end of his junior year, "He quit because the other kids called him a welfare leach and a bum, and that people like you shouldn't be on welfare," she said. "When you are treated like that, you can't concentrate, can't study." She noted that most of the welfare children in her neighborhood had similar experiences.

When the family is not on welfare, however, they cannot use their Medi-Cal card. "Without our card, we can't afford to go to any doctor." During emergencies, she said it was difficult to get care because the county hospital was 30 miles away and was understaffed.

In each of the homes we visited, we heard about problems in traveling to the county hospital and then often having to wait 12 hours and more to obtain care.

Fortunately for Tulare County, though, the Salud (Health, in Spanish) Clinic opened in Woodville in 1967. It is a unique institution that operates for the poor and does so without government subsidy. Each staff member, including the two physicians, draws a monthly subsistence allowance of $250.

"We all work equal hours—hard, long hours—and there is no reason why one should make more than the other," a staff member said in explanation of the policy. The cost of a medical visit to the clinic varies between $4 and $6, depending on the employment status of the patient and the number of people in his family. The clinic has only outpatient facilities and thus is unable to handle cases which require hospitalization.

Residents of Tulare County have grown attached, almost too attached, to the clinic. Some feel such a sense of responsibility toward the clinic they are reluctant to use its facilities when they have no money or Medi-Cal card with which to pay. Charles Cummings, a veteran member of the County Board of Supervisors, spoke for the people of Tulare County when he said of the founder of the clinic: "Dr. Brooks may look like a beatnik. But he's a dedicated man, and folks around Woodville wouldn't have a doctor at all if it wasn't for Dr. Brooks and Salud."

A Child Treatment Center, and the "Stockade" Atlanta, Georgia

The Child Treatment Center

"These children have committed no crime except to have no home," an official of the Child Treatment Center said of the children in the area of the Center which is reserved for neglected or abandoned children. Also in the Center are detention facilities for boys and girls charged with delinquency of all degrees of severity, ranging from violation of the curfew ordinance to murder-manslaughter.

"These children all have one thing in common," a staff member remarked. "Their lives are filled with people who don't care, or with people who care but who cannot do anything to improve the situation."

In the neglected children's section of the Child Treatment Center, the usual length of stay is several months. "We have to fight to get these kids a home," explained Judge John Langford, presiding judge at the Fulton County Juvenile Court. In the babies' ward, only youngsters over 12 months old are accepted. Infants are taken to Grady Hospital for care. "When the boys become sexually aware, we have to move them out," Judge Langford said. When removed, young boys who are detained merely because of being neglected or abandoned are placed in the same rooms with active delinquents.

In the girl's section for delinquents, an 11-year-old pregnant girl was locked in with others who were there for a variety of offenses. Pregnant girls traditionally drop out of Atlanta schools: "So they often end up here," and official reported.

"These girls need a great deal of education in a very short time." Girls are sometimes kept there as long as one year, although an average stay is about 30 days.

Life for delinquent males in the Center can be brutal. One boy had recently been stabbed with the handle of a toothbrush that had been converted into a knife by sharpening on the cement wall.

Despite such harsh difficulties, the staff members were remarkably keen and dedicated to improving the lives of the youngsters placed in their hands. The educational facilities were excellent. Good liaison was maintained with public schools. "During the winter, the rooms are too crowded to be conducive to learning" one teacher reported, "but generally we can do good work."

A nurse is available in a well-equipped facility at the Center all day, and is backed up by a physician who visits daily and is on call.

In another Center room, the art teacher showed her materials and described her methods of gaining interest and participation. She mentioned one 16-year-old boy she had recently taught. This boy had been sent to the Center because he had argued with his foster mother. Although he had not broken a law, his foster mother had decided she could not cope with him any longer. After being locked up for a month, he was sent back to the same home. The teacher expected him to return soon.

"Many of the children here will return again and again," one official said. "Most of these children are from low-income families, if they have families, and most of these families are Black." In 1968, according to one official, 60 percent of the children in the Center were Black. "You've seen how they live here. It's much worse for them outside the Center. What chance do they have?"

Care for alcoholics

"Alcoholism is the third major public health problem in the United States today. It is an extremely serious illness, involving some six million people in the United States. Contrary to public opinion, only 15 percent are 'skid row bums'. The remaining 85 per cent are 'nice people'—garden variety citizens—typically a 40-year-old white collar worker with a wife and children and a member of a church." Vernelle Fox, M.D., Medical Director, The Georgian Clinic.

"Every Monday morning we have a crowd and it's usually the same bunch," was the opening statement by an officer in the Fulton County Jail in Atlanta, Georgia.

Individuals accused of drunkenness are delivered to the jail's back door. After being admitted, they are searched. All valuables (such as glasses) are taken, marked, and returned upon departure. After being fingerprinted, the prisoners are taken to the jail where, on bare floor without beds or chairs, for the next four to eight hours, they "dry out."

When the prisoner is reasonably sober, he gets an opportunity to put up $25 bail. If he cannot pay or obtain the $25 immediately, he is held until the next session of the General Division of the Municipal Court, known as "drunk court." Lower class prisoners usually cannot pay and hence must appear in court for having been drunk.

Despite a recent decision that chronic alcoholism is a defense to a charge of public intoxication (*Dunlap* v. *City of Atlanta*), police officers are still finding ways to treat alcoholics as criminals. Rather than arresting them for drunkenness, the police arrest them for related violations which do not permit alcoholism as a defense. According to a report recently issued by Atlanta's Steering Committee on Treatment and Rehabilitation of Chronic Alcoholic Court Offenders, sentences for these other violations are more severe. The report stated, "Ironically, since the rendering of the decision in the *Dunlap* case, the plight of persons certified . . . as "chronic alcoholics" seems to have worsened. It appears that many of the people so certified are being arrested and convicted for violations of City Ordinances other than plain drunkenness and, instead of the 13 to 27 day sentences they were formerly receiving, they are now being given consecutive sentences on separate counts (e.g. cursing, loitering, etc.) which frequently total 60 to 90 days or more."

State Representative Julian Bond who accompanied us on the tour remarked, "Whites are charged with the minor crimes and sent to the city jail, whereas Blacks are charged with major crimes and sent to the county jail."

On the day of the tour, 18 prisoners appeared in "drunk court." Any who agreed to participate in a private rehabilitation program were sent there for 30 days. Of the 18 offenders, six men and one woman volunteered to accept this program. The remaining group, ranging from a shriveled, old and obviously ill

man to a healthy looking teenager, were sentenced to 13 days at the City Prison farm, locally called the "Stockade."

At the time of our visit to the Stockade, 363 men and 32 women were in the facility which has room for 600 people. "Our load is seasonal," the superintendent reported. "Right now, people have more work and so we have fewer prisoners."

When a prisoner arrives at the Stockade, he receives a blue and white uniform. All personal belongings of any value are taken for safekeeping until his departure. He then finds an empty bed in one of the wards, approximately 300 feet by 36 feet, two wards for male prisoners and one for female prisoners. There is no locker for the prisoner, not even a spot for a toothbrush. If he wants to read, he can carry a book into his ward, but the only place to keep it is under his mattress.

Each prisoner is assigned to work detail. "Work is therapy," explained the superintendent. A prisoner receives $1 for each day of work, the major type being farm work. When the superintendent was asked what he would like most to improve the Stockade, he answered, "A bigger farm."

If a prisoner thinks he should see a doctor, he can ask for the prison physician who spends about 45 minutes a day at the Stockade and during this time sees an average of 13 prisoners. Prisoners can receive more care if the doctor decides they should go to sick bay where typically two to five patients are kept, except during the winter when many patients are admitted with "flu." Two practical nurses are in charge of the sick bay.

"If prisoners fight or disobey rules, we send them to the 'hole'," a guard said, The "hole" is an isolation room measuring about 4 feet by 8 feet. During the summer, temperatures soar near 100 degrees. There is a fan, but no ventilation. One light is turned on constantly unless a prisoner expressely requests it be turned off. The room has one board, about 6 feet by 2 feet, which serves as a combination bed and chair.

One Stockade prisoner with a card from Grady Hospital certifying he was an epileptic said he had been arrested during an epileptic attack in front of the hospital where he was seeking care. In the Stockade, he had been placed in the "hole" for being uncooperative. He acknowledged that he had been in the Stockade several times previously for intoxication.

After seeing the Stockade, we had an opportunity to talk with Dr. Bernard Holland of Emory University. He described a highly successful pilot program for 1,200 "hard-core" alcoholics, but the program had ended July 1, 1969, when the Federal funds supporting it expired and local or state money could not be raised to continue it. An excellent staff was now being dispersed from this major effort in a University-directed program to treat alcoholism as a disease.

The Georgian Clinic for alcoholics, in direct contrast to the prison farm, was conducted in an old southern mansion located in an upper class, white neighborhood. The wide-carpeted stairway leading to small rooms with large closets, windows and pictures created a strikingly different atmosphere from that of the Stockade.

For the 35 participants in the Clinic's regular program, activities extend over a period of from one to eight weeks. The clinic also cares for about 700 patients irregularly, whenever the patient decides he needs help.

"The idea of our program is to substitute people for the bottle," said Dr. Helen Dedham, Assistant Staff Director of the Georgian Clinic.

Very few lower class people or Blacks participate in the program of the Georgian Clinic, since "the Clinic does not have the staff to seek patients and poor people are not apt to hear about it from their neighbors. Also, Blacks would be uncomfortable because the programs are geared to the upper-classes," Dr. Dedham said.

At the end of the day, John Bagge, Director of the Southern Regional Council on Crime and Correction, remarked that upper-class alcoholics go to private sanatoria, middle-class alcoholics go to clinics, lower-class whites go to jail for a few days and lower-class Blacks get longer sentences in jail.

POTOMAC. THE NATION'S RIVER WASHINGON, D.C.

"Picture a city, bordered by clean rivers and operating an effective solid waste disposal program that removes the breeding grounds of rats. That might not make it a good place to live, but it would be better than it is now. Environmental success can bring dividends throughout our entire social fabric."—Senator J. Caleb Boggs, R–Delaware.

Dead fish, floating sewage, and rotting plant-life constitute much of the Potomac River flowing through the Nation's Capital. Down the river, a large sign warns, "Polluted Water, Bathing Hazardous." According to marine scientist Dr. Donald Lear, this means, "Anyone who comes in contact with this water should see a doctor."

Our visit to the Potomac was highlighted by a laboratory demonstration of the nature and extent of pollution in the river, prepared by the Federal Water Pollution Control Administration. Chemical, physical and biological tests of specimens of water from various places in the river show the severe degradation of the water.

The major contribution to the Potomac River's pollution comes from untreated domestic sewage. More than 400 million gallons of partially treated and raw sewage, mostly from homes in the Metropolitan Washington area, flow into the river each day. "Unlike other rivers of the country which are polluted by industrial wastes, this river's problem is people," Dr. Lear said. "We just have too many people for the treatment plants we have."

A 1969 report, "Potomac River Water Quality," by the Federal Water Pollution Control Administration of the U.S. Department of the Interior, notes:

> Despite the advances, the Potomac River Estuary in the Washington Metropolitan Area remains grossly polluted due to inadequate sewage treatment. . . .
>
> Decomposing organic matter in the water and sewage sludge deposits on the bottom of the river reduced the dissolved oxygen (DO) content of the river to levels that would not support a sport fishery. Near the point of the District of Columbia treatment plant discharge, the DO has been so low that it would not support even the most tolerant pollution-resistant rough fish, such as carp and catfish.
>
> . . . The sludge deposits have blanketed fish spawning grounds and destroyed the bottom aquatic life on which fish feed. In areas along the margins of the estuary, sludge deposits released obnoxious odors when uncovered at ebb tide. Floating sludge masses, lifted by gases of decomposition, added to other debris on the water's surface.
>
> Repulsive debris, including solid materials from raw sewage, defiled the surface of the estuary in the vicinity of combined sewer overflows during and following periods of rainfall. These overflows also contributed to bottom deposits, high bacterial densities, and low DO concentrations. Nutrients from upstream sources added to those in sewage treatment plant discharges to the estuary supported excessive growths of algae. These minute suspended plants may turn the water green, add to DO depletion problems and cause fish kills and offensive odors.

In addition to the reduction of dissolved oxygen in the water of the Potomac which makes fish life in many parts of the river impossible, a new problem of even greater urgency has recently come to light. The water carries a high bacterial count and Salmonella have been isolated throughout 15 to 20 miles of the river. The latter type organism causes human disease, usually in the form of food-poisoning, and some varieties can be fatal. Other agents of human disease, including the virus causing hepatitis, may be present in sewage-contaminated water.

More than 42,000 acres of shellfish grounds in the river already have been closed by health authorities. These authorities fear human disease may occur from eating shellfish grown in waters with gross sewage contamination.

Also, fish may become infected with disease-causing organisms in the polluted Potomac and then swim to clean waters. When caught, these infected fish may cause disease to unsuspecting people.

"Probably we are not doing enough by just declaring certain waters unsafe," Dr. Werner Janssen, a medical microbiologist from Ft. Detrick, warned. Contaminated or infected fish can, of course, infect anyone handling the fish directly through wounds or abrasion. But the biggest danger from fish exposed to contaminated water is the possibility that they may become actively infected with the human disease-producing organisms associated with sewage and spread them to areas thought to be safe.

Pollution from untreated sewage not only strangles fish life in the Potomac and threatens to spread human disease. It also substantially impairs use of the river for recreation because of the stench and unsightliness. Those who want to use the river for boating are beginning to protest more vigorously each year against the conditions. Once a promising location for sailing and other recrea-

tional use of surface water that has become so popular throughout America, the Potomac is rapidly losing its attractiveness for such sport. Further loss will seriously restrict the opportunities for enjoyment of a once-beautiful river.

While domestic sewage is the greatest factor in the pollution of the Potomac, other sources also contribute. These include: dumping chemicals into the river, soil erosion, pesticides, sewage from ships and poor septic tanks of waterfront homeowners. "These problems continue to exist," one resident complained, "because the developers of the land don't consider for one moment the results of their development, and the government just lets them keep on building and polluting."

At an afternoon session, we heard representatives of local citizens' groups aided by interested scientists, as well as spokesmen for local, State and Federal governmental authorities.

For years, residents and public officials have been making recommendations and plans to clean up the Potomac. A series of Federal Enforcement Conferences since 1957 has led to some improvements in sewage treatment plants but effective treatment has not been accomplished. The District of Columbia, along with Alexandria and Fairfax County of Virginia have failed to meet the schedule to improve treatment plants, as set out by the 1957 Federal Enforcement Conference. Spokesmen for citizens' groups at our session demanded clean-up, and particularly assailed the unwillingness of local government to control land developers. Federal authorities insisted that local people were putting the sewage into the river and hence local government carried responsibility for treatment facilities. Spokesmen for local and state governments, however, called greater Federal participation in financial support of treatment facilities and noted that the Federal government is the "big industry" of the metropolitan area. Since industry generally is called upon to pay for pollution control, local officials say the Federal government should assume responsibility in large measure for cleaning up the Potomac.

This discussion emphasized governmental failure to solve a problem for which technical solutions are available, in spite of the fact that it has been under continuing official consideration for 12 years. "It does seem a shame," one observer remarked, "that men can't enjoy, and fish can't live, in the nation's river."

INDIANS WHO LEAVE THE RESERVATION, GREAT FALLS, MONT.

"Indian reservations should never be terminated. But Indians should have a choice whether to stay on or leave the reservation. Now they have no choice because of the lack of programs to ease the transition to off-reservation life. It is probable that a majority of Indians will be forced to seek work in urban areas within the next decade. Unless we provide some programs for them, we are just sending them to the city to suffer abuse and to starve. Indians are legally entitled to better treatment"—John Vance, Chairman, Indian Claims Commission.

"While significant improvements have been made in the health status of reservation Indians served by the Indian Health Service since 1955, it is recognized that many Indians living in urban and non-reservation communities have not fully shared in these advances. Constraints of Federal policy and the limitation of resources do not permit the service to provide them with the comprehensive health services which are available to Indians on reservations"—Emery A. Johnson, M.D., Acting Director, Indian Health Service.

The Indian who has left the reservation is in many ways a forgotten man. He has cast aside the dependent status of a reservation Indian to make his way in a world for which he is basically unprepared. Yet in making this transition, he can expect little, if any, help from the very institutional system which preordained his lack of preparation. Federal programs designed to serve reservation Indians can no longer meet his needs. State and local health and welfare programs, ill-conceived to meet the general needs of the poor, are utterly unequipped to deal with the special problems arising from the Indian's prior dependent status and from his culture and language. Caught in this institutional gap, he may if he is lucky come to eke out a marginal existence off the reservation, but more likely he will return to the reservation where at least he can get the bare necessities of life.

We met with off-reservation Indians in Great Falls, Montana, a town of some 60,000 people. About 3,000 are Indians. Situated on the Missouri River just

northwest of the center of the State, the town is a natural first settling place for Indians leaving the seven Montana reservations. Indeed, the tradition of Great Falls as a home for off-reservation Indians was established over a century ago when the ancestors of many of the town's present residents came to settle along nearby riverbanks rather than be herded onto reservations.

Once an Indian leaves the reservation, he becomes ineligible for subsistence benefits. The Welfare Department of Cascade County, where Great Falls is located, requires a year of residency in the county before an applicant is eligible for state or county welfare benefits. Thus, for the first year after coming from a reservation, an Indian has no access to any welfare assistance, county, state, or Federal, even though it is then that his need may be most acute. As the Indians we met knew only too well, "It takes time to find a job, and it takes longer to have enough money for food and a place to stay." So the Indian must start his new life away from the reservation on the brink of economic disaster.

During this initial period off the reservation, an Indian's health care needs are supposed to be met by the Indian Health Service (IHS). Indians who have left the reservation ordinarily remain eligible to receive care at IHS facilities. But because the IHS was established primarily to serve reservation Indians, almost all of its facilities are located on reservations. From Great Falls, the nearest reservation is Rocky Boys, which is well over 100 miles away. To expect people to travel over 100 miles in a nonemergency situation is unrealistic. To ask people to travel that far in an emergency situation is inhumane. For many the trip is still longer. One young mother told us of taking her child to her home reservation, Fort Belknap, for extensive medical attention, since there would have been no place for her to stay at Rocky Boys while the child was convalescing. Besides, she said, friends and relatives at the reservation could take her in. Fort Belknap is nearly 200 miles from Great Falls: if she had been from Fort Peck or Northern Cheyenne, she would have had to travel 350 or 400 miles before her child could receive care.

For an Indian in his first year off the reservation, the IHS has made some attempt to mitigate the harshness of this situation. It has established a policy of reimbursing local hospitals or doctors for emergency care given an Indian who is less than one year off the reservation. But the relief provided by this policy is largely illusory. According to Emery A. Johnson, M.D., Acting Director of IHS, constraints of Federal policy and the limitation of resources do not permit the Service to provide them with the comprehensive health services which are available to Indians on reservations. While significant improvements have been made in the health status of reservation Indians served by the Indian Health Service since 1955, it is recognized that many Indians living in urban and non-reservation communities have not fully shared in these advances."

Thus, if an Indian, newly arrived in Great Falls, receives treatment from a local doctor, he may well discover that he is stuck with a bill the IHS refuses to pay. Under these circumstances, many Indians choose not to risk responsibility for a large medical bill and simply do not seek help. In an emergency, others may discover the IHS will not cover their expenses and, as a result, suffer the humiliation and inconvenience of having to leave the local facility and make the long trip to an IHS facility. We met an Indian girl who told of being turned away from the county hospital when she was ready to have her baby. Presumably, the hospital learned the IHS would not cover the costs of the delivery. "They told me that I didn't qualify for welfare and should go back to my reservation." Her baby was born over 100 miles away at the Rocky Boys Reservation.

Recent court decisions, however, indicate some relief may come. Similar residency requirements elsewhere have been struck down as unconstitutional. If the Cascade County requirement could be proven invalid, newly arrived Indians would have the same opportunity as older residents to qualify for welfare benefits, and some health care services might then become available under government programs.

Long-term residents, too, have serious problems qualifying for welfare assistance. Many cannot meet the arbitrary eligibility requirements promulgated by the County Welfare Department. Others are able to obtain coverage on only a fluctuating basis.

Families with able-bodied men, for instance, are able to receive general assistance payments only during the winter months. The county presumes able-bodied men can find at least ranchwork during warm weather months. Consequently, it stops payment during this period. Machines, however, now do

much of the ranchwork. Several Indian families, who receive general assistance during the winter, told us of being unable to find ranchwork—or any other work—during the summer. Yet under the County's presumption, they are ineligible to receive general assistance.

Those who do qualify for welfare, however, must settle for the health care provided by the County Welfare Department. We met few who relished the thought of having that Department responsible for meeting their health care needs. They saw the County clinic as being understaffed and overcrowded. The care provided, they said, was poor and neglectful. "If I had to go to the County doctor, I just wouldn't go," a 35-year-old Indian mother told us. "I went once because both my baby and I had a fever. When the doctor called my baby a brat, I bit my tongue because I wanted the medicine. Then he just looked at my eyelids and told me I had syphilis. I went home and cried." The next day she was able to scrape together enough money to go to a private doctor. He treated her for an abscessed tonsil, which he removed a few weeks later.

Even those Indians who are fortunate enough to get construction work or a job at the Anaconda Company plant are far from secure in their ability to obtain health care. Several who were so employed told of having to declare bankruptcy as a result of medical bills. One Indian obtained employment as a construction worker for $115 a week shortly after leaving the reservation. He hurt his leg, however, and was unable to work for several months. During those months, his wife had a baby. His unpaid medical bills soared to $2,200. "As soon as I started to work, my creditors pounced on me. Without more time to earn some money, I couldn't pay my bills and buy food for my children. But they wouldn't give me more time, so I had to declare bankruptcy."

We visited an Indian ghetto called Wire Mill Road, just outside the city limits of Great Falls. The 12 families comprising this small community live on a hill overlooking the smokestacks of a large industrial complex. The side of the hill is used as a junkyard by city residents; year by year the pile of junk automobiles and other trash grows bigger and moves closer to the homes of the Indians.

One of the residents of Wire Mill Road is a 53-year-old World War II veteran of the South Pacific. He receives a monthly veterans' disability pension, which covers only his rent and utilities. His utilities include a pit privy situated 50 feet from the house near an enclosed cistern which contains the entire water supply for a month. The cistern pump was defective when we were there. For the 500 gallons of water delivered each month, approximately the amount used in one day by the average family of four, he pays $3. A waterline runs under the hill, but is controlled by the neighboring industrial complex. Residents of Wire Mill Road are not permitted to use it.

In the winter, it is nearly impossible for him to remove the garbage because the road to his home is not graveled. On the day of our visit, in the middle of summer, no garbage had been removed for a week because his only truck needed repair.

He does not qualify for general assistance because of his veterans' pension. Nine years ago, he had a colostomy for cancer of the bowel. He has never returned for the second operation, to close the colostomy, because he cannot afford the time away from work. Work for this World War II veteran is salvaging auto parts from the junkyard on the side of the hill. On a good day, he earns about two dollars. "If I can find junk to sell, then I can feed my family. If I can't find any. . . ."

Feeding the family has become more expensive since the wood-burning oven broke down and it became necessary to purchase bread. His family includes a wife, six children—one of whom is partially blind—and one grandchild whose father is in Vietnam. Food stamps are an impossible dream; he cannot afford the lump sum payment of $36, the monthly amount required to purchase stamps for a family his size.

We asked his most pressing health problem. "A job," he replied.

Indians who have no ancestral ties with reservations have been given even less recognition by government programs than those who have left the reservation. In the middle and late 1800's, when treaties were signed setting up the reservations, some Indians refused to be confined to reservation lands. "My fathers believed the land belonged to God and should be used by everyone," an Indian explained to us. Many of these Indians came to Great Falls, some from as far away as Wisconsin or the West Coast. At first, they camped along the Missouri River. As Great Falls grew, the Indians retreated to a hill near the

river. The only employment many of them knew was clearing rocks in ranch fields. In the spring, entire families would settle on a ranch to clear the field and, as a result, many Indian children would leave school before the school year would end. As time went on, many residents left the hill to live in the heart of Great Falls or to venture elsewhere into the outside world. Many others died of extreme poverty. Those who stayed were beaten down by decades of discrimination and deprivation.

Today, the hill, liberally strewn with junk from the city, is called "Hill 57" in recognition, legend has it, of the wealth of empty "Heinz 57" cans that once could be found scattered on the grounds. Across town from Wire Mill Road, Hill 57 is inhabited by a small, determined band of 15 Indian families, proud of their heritage and culture and unwilling to lose their identity by complete assimiliation into the white man's world. They live in small dilapidated shacks, seven or eight members to a family. Most of the Hill's residents are children. Until two years ago, these children suffered serious, recurring bouts of diarrhea; they had no running water. Now there is one faucet to serve all the families. Electricity was brought to the Hill only within the past decade. In the last year, the residents raised enough money selling Indian crafts to replace their wood-burning stoves with propane gas ranges, but only after a five-year-old girl died from an explosion caused by burning battery boxes in old stoves.

We visited the residents of Hill 57 and met with a group of about 15 in the Hill washhouse, the only building large enough to accomodate us. Most of the parents had dropped out of school when they were young because they could not speak English and were embarrassed to attend school dressed in shabby clothes. One man spoke for the group, explaining he had learned English by reading newspapers. He told how discrimination in getting jobs and promotions had robbed his people of incentive. "Even though we worked hard at the same job for several years, we were not even considered for a better job. We were just there to do the dirty work." But he also told how the residents of Hill 57 were fighting back: they had banded together in a group for concerted action to improve conditions relating to their employment, housing, and health and at the same time to preserve the culture so dear to them.

"Off-reservation Indians live in a kind of limbo where nearly everyone disclaims responsibility for helping them meet their needs. Their greatest liability is their feeling that they are not part of a community that really cares about them. It is necessary for the larger community to realize that a social illness in any part of the community is an illness of the total community. When we are willing to help these people, they then will have the confidence to learn how to help themselves."—Congressman John Melcher, D–Montana.

THE KENWOOD-OAKLAND AREA, CHICAGO, ILLINOIS

"When a community changes from white to black, city officials lose interest in it, except for law and order."—State Representative Robert Mann, Chicago.

The streets of the Kenwood-Oakland community are an unforgettable profile of destitution and deprivation. On every block, childern play on crumbling sidewalks, amid rotting garbage and trash—much of it thrown there by commercial trash companies—and in condemned apartment houses with broken sewers.

Fifty thousand or more people, 85 percent Black, are packed into the tenements lining the streets in the two square miles of the community. At least two people live in almost every room often, two or three to a bed. "One family moves into a small apartment in the area, then they are joined by another family, and another," says Dr. Joyce Lashof, Director of Community Medicine at Presbyterian-St. Luke's Hospital.

About half of the tenements are substandard. Many have no hot water, no air conditioning for the summer, no heat for the winter, poor lighting, falling plaster, peeling paint, roaches and rats.

Residents reportedly live here largely because they are faced with racial discrimination in real estate in other parts of the city. "You can't always prove there is discrimination," one woman said, "but you can tell by seeng how few black faces are permitted to live in the Federal housing projects for families with low incomes."

Each apartment costs more than $100 a month, although the average monthly rent in other parts of the city is $88. "This neighborhood, like other Black, urban areas, is the biggest gold mine since the California goldrush," one doctor said.

Residents estimate that they pay a "color tax" of $20 a month to live in Kenwood-Oakland. Yet residents have less space, and much of it is substandard.

There is no library or park in the entire Kenwood-Oakland area. "The schools here are rotten," one child said. More than half of the residents have not finished high school. One elementary school had every single window broken and replaced by plywood sheets. No natural daylight entered the building. Indeed, sun barely penetrates into the dank, dark apartments or into the lives of the countless children living in Kenwood-Oakland. Recreation is in the alleys, the streets, the occasional fields of rubble where buildings once stood. The tour crossed one such "urban park," where perhaps 20 small children were playing in and around a rusting, abandoned car. This is their "playground."

Most of the children growing up in this environment are hungry. If their families depend on welfare, high rents consume most of the monthly budget. For at least 54,000 hungry Chicago families, food becomes a second priority. "At the end of the month, our children usually survive on candy bars," one woman told us. "After all, it is energy food and cheap."

Most food is not cheap, and much of it is inferior. We walked through a major grocery store and saw moldy melons, grossly discolored meat, overpriced and fatigued vegetables. Missing were foods familiar to Black people, but tempting were costly frozen desserts, for which few in the community have home freezers, and a shining liquor display as you enter the store. A study of the Senate Select Committee on Malnutrition and Hunger revealed at least 54,000 hungry Chicago families. "Hunger is not a hurting thing. It is a halting force with respect to the progress of a nation toward goals of unity, cohesion, and growth," stated Reverend Jesse Jackson of Operation Breadbasket.

Depression and despair greeted us in each house we visited. We spoke to a woman whose apartment just recently had been condemned by city officials. She had to relocate herself and her seven children within four weeks. She had no place to go nor any idea how to seek housing she could afford. "But I guess anything will be better than living here," she said. Each time she goes to sleep, she fears fire. There have been numerous fires in her building because of poor wiring. "There is no janitor to keep drunks and other riff-raff out of the empty rooms here. The doors won't lock and there is nothing here but women and children." When it rains, she said, everything gets wet because the roof leaks. "And it doesn't just leak in certain places where it could be caught with pans. It leaks all over. Even my beds get wet." Reeking sewage was backed up in her toilet. She showed how she flushed the waste with a hose from the sink to the toilet. "It's not as bad now as it was last winter," she said. "Then I had to even go without water for two weeks." On some winter days, there is no heat.

One of her neighbors also told of plumbing problems. "My children can't flush toilets or take baths," she said. The toilet, located just next to her apartment for the use of several families, floods daily. She has attached a hose leading from the toilet to a nearby sink to prevent flooding, but water still overflows.

This tiny, extremely nervous lady also described her attempts to get care for her 2-year-old child who weighs only 23 pounds and is frequently feverish. "I just don't know what to do for him. I keep taking him to the doctors, but they can't find out what's wrong." She and her five children reside in a four-room apartment filled with the stench of uncollected garbage. She pays $100 a month in rent. We noted that her baby had passed one of Kenwood-Oakland's most critical tests—living past his second week. About 45 of every 1,000 babies born in Kenwood-Oakland die in early infancy, it was reported.

Another woman told of being unable to have a colostomy repaired because she could not repay 11 pints of blood she had received during a previous operation. The supervisor of the Cook County Hospital's blood bank explained that patients are normally asked to repay blood before being given any additional surgery, except during an emergency.

One lady told how she watched her baby die while waiting three hours for care in an emergency room at Cook County Hospital. "They expect you to wait hours for emergency care there." Most of the Black residents of Chicago, however, still use this hospital. Black people occupy 85 per cent of the beds there.

The hospital's clinic handles more than two-thirds of the outpatient care for the city's Black citizens. Why do the Blacks go there? A recent University of Chicago survey revealed that Blacks continue to depend on Cook County Hospital because it is the one institution where they know they will not be refused care—if they can tolerate the time to travel there and wait for service. A more pressing reason is the paucity of physicians in Chicago's Black ghettos. There

were five physicians for the 50,000 or more residents of Kenwood-Oakland until the community itself closed down the business of a pair of unsanitary, disreputable doctors.

"We can't be expected to bus white doctors into the city by day and send them home by night," explained Doctor Risher Watts, who represents the Cook County Physicians Association. "We need to train more Negro physicians to serve the people of the inner city. Even more important is learning how to keep the few physicians we have now." He said that the few specialists who had practiced near Kenwood-Oakland moved away because they could not be assured prompt and full payment by the State for the many welfare patients they were expected to treat. "Rather than fight the system, they just moved out." Consequently, as Pierre DeVise, DePauw University urbanologist, concluded: "We have very separate and unequal facilities and services that pass for health care."

Who is to blame in this degradation of life and health? Is it the penalty of being poor or being Black? Or both? "I think in the list of active enemies of health in this community, we have already identified, first, the political structure and City Hall," stated a community practitioner. "Second, we have to identify organized medicine, with its platitudes, and third, the health care system, which is guaranteed to make shortages by rewarding those who go to the affluent parts of the system instead of into places of grave need."

In an effort to achieve a health care system responsive to the needs of the local communities, the residents of Chicago in 1966 voted for a $5 million dollar bond issue to be used in conjunction with Federal grants to build 10 neighborhood health centers. The bonds have been floated, but the city has so far refused to release the money. Two neighborhood centers have been built, but solely with Federal money. Most residents are pessimistic that the City will release the funds in the near future.[1] "The people have spoken, but who are the people?" one resident asked.

If someone had decided to design a system to break people's spirit, and to break them as human beings, they couldn't have done a better job.

Conclusion

If any should think that we present an exaggerated picture, or too harsh a judgment based on "isolated" instances, let him spend, as we did, a few full days actually looking, listening, and smelling. The conditions we describe are all too pervasive.

They speak for themselves and require no discussion. They are the basis for the disillusionment of millions of Americans with the "Establishment," especially with agencies of government that fail to take effective action on glaring health difficulties that deeply depress the whole quality of life.

We were struck by the utter inadequacy of our social response. The agencies that are supposed to deal with the problems appear to exist mainly as enforcers of rules that are carefully framed legalistic subterfuges to avoid providing needed services. Often these rules, of course, are there to guard against expenditures from the grossly insufficient budgets that are appropriated by legislative bodies.

The apathy of professional personnel in practically all the agencies of human services, with a few striking exceptions, was particularly disconcerting. Most of them seemed weighted down to the point of indifference by the system in which they work. The major challenge comes from professionals who are outside the official system linked up with grass roots organizations of people. Those in governmental agencies generally do not even seem concerned with the severe inadequacies of health information, especially among the poor.

As physicians knowing something about Medicaid's shortcomings, we were appalled to see how harshly it works against the medical interests of individuals. Termination of benefits without reasonable notice and by arbitrary application of welfare rules that completely ignore medical realities is especially outrageous.

Overshadowing in health consequence even the problems in medical care for the poor was the lack of attention to environmental conditions. While adverse

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[1] Morgan J. O'Connel, M.D., Commissioner of Chicago Board of Health, sent the following telegram to Dr. Breslow: "Myself and staff have had numerous meetings with citizens of Kenwood-Oakland communities. See little benefit our attendance at meeting to investigate South Side health via tour. Would welcome you and Doctor Cornely here at Board of Health offices for briefing on Chicago problems."

environmental conditions affect all persons to some extent, as in the case of the Potomac, the living conditions of the poor in America constitute an ever-greater national disgrace when one considers the capability of our country and the living conditions of most people in the country. Housing literally not fit for animals, residences in sections of the cities marked for future industrial or commercial development and hence really abandoned for human habitation—these are typical. Enforcement of local zoning and housing codes, if these even exist, is not seriously attempted. In fact the only rule that seems to be systematically enforced is that the people continue to pay rent. The regulatory agencies do defend the interest of those who derive income from the property and the environment in which the poor live so miserably.

Now we wish to propose some lines of action, for health professionals such as ourselves and for the legislative and administrative branches of government. We share the conviction of many in our country, often expressed these past few months, that a nation with the technological ability and government resources to create a satisfactory environment for an Apollo space capsule on a trip to the moon must find a way to provide healthful living conditions for the people in Houston, Tulare County, Great Falls, Chicago, Washington, Atlanta, and everywhere else in this country.

As professional public health workers, we should first recognize our own deficiencies. Like others in professional and technical fields of endeavor, some of us have become closely identified with agencies and institutions whose bureaucratic interests may contradict the interests of the people we are supposed to be serving. Of course, we must be loyal to the agencies for which we work. But callousness in accepting the "rules" and the budgets, developed possibly as a protection against our own feelings of guilt as workers in too feeble programs, has insensitized us to the point where we no longer press vigorously to achieve adequate programs. We tend to resist the "community take-over" of health programs by people in impoverished neighborhoods, who have found that they must participate in setting the rules as a means, literally, of survival. For too long the programs have stifled their participation; and the rules, established by others who do not understand the problems, make less and less sense.

To avoid such professional myopia, we urge that public health professionals, no matter what their type of work or employment, devote some time each year to observing directly the conditions of life that generate health problems. It is one thing to treat a child in a clinic with a cut eye, but another thing to encounter him as we did in a Chicago neighborhood, with a patched eye, and to hear him describe and then see the broken stair-rail at his house which permitted him to fall from the second floor onto glass on the ground adjacent to his house.

Further, we believe that health professionals should join hands with organizations of people that are emerging in neighborhoods throughout the country, to fight for better health conditions. Everywhere on the tour we found that neighborhood organizations are springing up and arousing new hope. The advancement of public health today requires the development of effective alliances between such groups and those having technical competence in health work. Alliances of this sort would energize the efforts of all.

Although we knew before the tour that our health programs needed a drastic overhaul, the visits added a depth of understanding and feeling that we could not have gotten otherwise.

A health care program for the poor based on a month-to-month means test to determine indigency is unacceptable in a decent society. We can only begin to understand the indignity suffered by those who seek to qualify under a means test. But apart from that, the means test system requires the cancellation of eligibility for benefits because of slight temporary increases in income. This is standard practice under Medicaid throughout the country. Thus, access to medical care is often cut off just when it is most needed to boost a family out of the poverty-poor health cycle. This makes no medical sense. Getting the information, keeping the records, and making the judgments each month, according to rules which are changed often with little or no notice by state and county officials, costs a substantial amount which could go a long way toward providing benefits on a yearly basis. The latter would be much more sensible from a medical standpoint and in the long run probably more economical. One must ask whether the present arrangement is designed to aid the poor or to perpetuate a bureaucracy.

Medicaid as a whole—its system of eligibility, loose budgeting, crazy-quilt pattern of benefits, and failure to set standards for care—was fashioned out of the mold of old fashioned, welfare-oriented programs. It is probably the most colossal

excrescence of a welfare system that has long outlived its usefulness and, as President Nixon has indicated, must be revamped. What better place to begin the revamping than to set free the provision of health services for the poor from a welfare system that grossly distorts its purpose? Few would deny that health care for the poor is important and that a health care system should make medical sense.

It is time for Congress to assert that health care for the poor must be approached systematically; responsibility for the health care system must no longer be parcelled out in an uncoordinated way among dozens of Federal, state, and local public agencies. More than six percent of the Gross National Product now is devoted to health care. With an increasing proportion of that directly out of government funds, it does seem timely that we develop a national policy and program on health care, instead of drifting and taking pot shots at drug prices and physicians' fees, horrendous as some of these may be. Our tour convinced us that health care for the poor, at least, in this country has broken down. The crisis is not coming; it is here.

The American Public Health Association would be pleased to join in the development of a national policy and program of health care for all.

In the meantime, convinced of the urgency by our tour, we make the following recommendations as beginning steps to relieve the chaos in health care:

1. Establishing eligibility for Medicaid on a yearly basis rather than monthly.

2. Chaneling funds from Medicaid and other governmental health care programs to build comprehensive primary medical care services in poverty neighborhoods, linked to hospital services for cases in which the latter are needed.

3. Offering young physicians opportunity for service in poverty neighborhoods as an alternative to military service.

We would note, however, that health care *per se* is only one part of what is needed to meet human health needs, and not the most important part. Again, the tour reinforced this point in our minds.

A national program to improve housing for the poor is urgently needed as a health measure. It is simply impossible to maintain health in houses that are physically unsafe and do not have elementary sanitation features, such as the houses where millions of Americans now live. A national housing program must do more than what "urban renewal" has meant in many places, namely driving poor people out of dilapidated dwellings to make room for public and commercial buildings and residences for people of means, with little or no improvement in housing for the poor who are merely scattered by the "renewal."

The main public housing program for the poor consists of welfare benefits which include an itemized amount of rent. Many hundreds of millions of this money goes to support housing that does not meet any standard. This means, in effect, that present national welfare policy subsidizes shockingly bad housing without any effort at quality control; it actually encourages landlords to continue making profits without improving the housing. We now spend an estimated $4.2 billion of Federal funds in public assistance payments. President Nixon's welfare reform proposal would add $4.0 billion, or double our expenditures. But the welfare reform proposal does not provide for the reforms that are needed to insure that Federal payments for housing do not continue to subsidize substandard dwellings.

Medicare provides for, and Medicaid permits regulations that funds may not be used to pay hospitals that fail to meet a standard of quality. Since, overall, housing may be at least as important to health as hospitals we believe that health interests require the same approach to housing as that taken to hospitals. Poor people are beginning to see the whole "establishment"—welfare agencies and law enforcement agencies—in support of rent payment but not decency in housing.

As a first step toward better housing for the poor, we recommend:

4. Prohibiting the use of money in individual welfare assistance budgets for payment of rent in housing that fails to meet local regulations.

5. Developing a national minimum-standard setting program for quality of housing in which monies derived from general tax revenues can be used as rent.

That hunger and malnutrition exist on a wide scale among the people of America is now openly acknowledged by the President and Congressional leaders. Food subsidy in this country, however, has meant and still means payment

to agricultural interests either for not growing food or for maintaining the price of food. The direct surplus food distribution program and the food stamp program have been relatively minor byproducts of the subsidy to agriculture, designed largely for price control.

To overcome hunger and malnutrition in this country it will be necessary to convert the current "food program" that offers some assistance to a relatively narrow range of people into programs based on genuine need. On the tour, we encountered situation after situation in which people were obviously poor but did not qualify for the food program assistance (they lived in the wrong county or someone in the household got a temporary job last month); or they were so poor that they could not get enough cash at one time to purchase the minimum quantity of food stamps sold.

We, therefore, recommend as immediate steps:

6. Increasing by at least 50 per cent the amount of moneys available for food stamps, and eliminating the requirement of a minimum quantity of food stamps to be purchased at any one time.

7. Establishing for all persons in the nation a guaranteed annual income sufficient to insure opportunity for adequate nutrition and other essentials for healthful living.

National policies and practices toward the American Indian have continued to be one of the most shameful streams in American history. The brutality continues, for example, in forcing Indians struggling to live off the reservations to return to the reservations for needed medical care; and in the statements which Secretary of the Interior, Walter J. Hickel, was quoted as making at the 1969 Annual Western Governor's Conference; namely, that the government had been a "little overprotective" of Indians and that his administration might reverse the trend because they "always have that crutch of being able to go back" to the reservations.

It is tragic that Indians must still depend for essential medical care upon "that crutch" which Mr. Hickel suggests taking away, but until something better is available they must fall back on it even when that means traveling more than 100 miles. No policy could be better designed to drive those Indians who are trying to "make a go of it" in the towns and cities of America back to the reservations than the policy of denying them urgently needed medical care. Yet that is exactly what we do.

Since responsibility for Indian health care was transferred to the Public Health Service, tremendous improvement has occurred in the health of Indians still living on the reservations. But just when that care is most needed during the transition to off-reservation life, it is frequently denied because of the limits of the Federal program and the failure of State and local government to acknowledge Indians as citizens.

Pending further development of national social policy to assist Indians who want to achieve off-reservation life, we recommend as an immediate health measure:

8. Expanding the Public Health Service program for Indian health care to include adequate funds to pay for medical services for Indians in need for at least five years after they leave the reservation.

Degradation of our environment has now become a national issue. Hardly a day passes without major reference in the news media to the demand expressed by some national political figure or concerned group that one or another aspect of the environment be cleaned up. Our tour yielded us the opportunity to see, smell, and hear the basis for this outcry: grossly polluted water, even in the Nation's river, the Potomac; garbage and debris strewn not only over the landscape but accumulating in the vacant lots and alleys where children of the inner cities spend most of their time; air increasingly filled with physical and chemical waste, and noise, from what we call "advances" in industry and technology. This deterioration of America's living space results from our failure to respond to the collision between the growth and concentration of our population and our capacity to produce and use things. Our waste is drowning us, in the absence of control measures.

America must clean up. This will require a major alteration in our current policies on land development and use. Ineffectual rules and enforcement machinery, established for a time when air, water, and land seemed "free" and more than plentiful, must now be sharply brought up to date. We can no longer tolerate leaving these responsibilities in the hands of governmental agencies attuned to the short-term interests of industry and land developers.

We recommend:

9. Making the health of people (broadly defined, not just specific disease control) the paramount criterion in developing and implementing much-needed national policy on the environment. As a first step the Secretary of Health, Education, and Welfare should promptly develop and promulgate a comprehensive set of standards based on health criteria and without regard for any presumed ability to meet such standards, for the air, water, and land of our country.

Social advances such as those made in the United States bring changes in attitude toward many problems, including fundamental alteration in how we characterize problems. Not many years ago, for example, chronic alcoholics were drunken bums to be dealt with by the policeman and the jailer. Now the chronic alcoholic is a sick person, provided he happens to be in the right social class. The rich chronic alcoholic goes to a private santarium run by pschiatrists; the middle-class chronic alcoholic goes to the clinics that are being established under health auspices; but the poor chronic alcoholic still goes to jail, for drunkenness or some related offense.

This is true country-wide, not just in Atlanta where we saw it on our tour. Meanwhile the judiciary, as one branch of government, is beginning to consider chronic alcoholism as a health problem—not completely as yet but moving in that direction.

In preparation for the social decision that alcoholism is a health problem we recommend:

10. Appropriating Federal funds on a large scale to support community services for treatment of the chronic alcoholic as a sick person.

In concluding, we want to emphasize again that spending more money for health care services in the absence of fundamental changes in the organization and delivering of health services is not the answer. Our three-fold increase in HEW health expenditures between 1963 and 1970 is not the answer. Nor is the doubling of welfare payments the answer in the absence of fundamental changes in the welfare program. We are pouring money down the drain when we continue to subsidize substandard housing with Federal welfare payments.

Human needs in health are not being met and much more than the provision of health care services is involved. A strategy for health progress must be based upon improvement in the quality of life for all people—improvement in housing, nutrition, medical care and all the factors that determine health. As a nation, we must decide whether freedom in the pursuit of narrow economic advantage or devotion to the common good, health for all, is to be the guiding force of social life.

PRESS REPORTS ON HUMAN NEED IN HEALTH

[From the New York Times, Oct. 14, 1969]

3 Health Groups Combine To Fight Commercialized Medicine

(By John Sibley)

Three health organizations, fighting the "reactionary leadership of the American Medical Association," have formed a coalition to transform national purposes "from support of the military-industrial complex and of commercialized medicine to the fulfillment of human needs."

Physicians who head the three groups announced the coordinated effort yesterday at the New York Academy of Medicine, Fifth Avenue at 103d Street. Their goals include the following:

Federally financed universal comprehensive health services.

A fundamental improvement in the organization and delivery of health care, including a shift in emphasis toward preventive aspects.

A decisive voice for the medical consumer in planning and operating health facilities.

A team approach to care, rather than fragmentation and domination by physicians.

An end to the war in Vietnam and the international arms race, with transfer of funds to health, education and social services.

A halt to the development of chemical and biological weapons.

An end to the defilement of the environment.

OTHER GROUPS WELCOMED

The coalition, which calls itself the Council of Health Organizations, now consists of the Medical Committe for Human Rights, the Physicians Forum and Physicians for Social Responsibility. The organizers emphasized that they would welcome the support of other groups in the health field.

The Medical Commitee for Human Rights was formed in 1964 to provide medical services for civil rights workers in the South. Since then, its doctors and other health workers have been on the scene at Columbia University's student riots and have treated persons injured in demonstrations during the Democratic National Convention in Chicago.

Last July, members of this group joined in noisily disrupting the annual meeting of the American Medical Association in the Americana Hotel here. The group has chapters in 25 cities. Its national headquarters is in Philadelphia.

The Physicians Forum, founded in the late nineteen thirties, has, during the last decade supported social security for physicians, health insurance programs (including Medicare) and community control of health activities. Its national office is at 510 Madison Avenue.

7,000 MEMBERS

Physicians for Social Responsibility was organized in 1961 by doctors concerned with their role in war and peace issues. It opposes American involvement in the Vietnam war and the production of chemical and biological weapons. Its headquarters are in Boston.

The Medical Commitee for Human Rights claims a membership of 7,000 health workers. Each of the other organizations in the coalition claims about 1,000 members. There is considerable overlapping, however, and a number of those at yesterday's conference are members of all three groups.

The new coalition's steering committee consists of three representatives of each of the member organizations. They are:

Medical Committee for Human Rights—Dr. Paul Lowinger, associate professor of psychiatry at Wayne State University; Dr. T. G. G. Wilson of the Temple University Health Sciences Center, and Jane Kennery, a registered nurse and professor of medicine at Loyola University.

Physicians Forum—Dr. Lewis M. Fraad, professor of pediatrics at the Albert Einstein College of Medicine; Dr. John L. S. Holloman Jr., past president of the National Medical Association, and Dr. Eli Messinger, a New York psychiatrist.

Physicians for Social Responsibility—Dr. Victor W. Sidel, chief of the division of social medicine at Montefiore Hospital; Dr. Bennett Gurion, a Boston psychiatrist, and Dr. Sidney Alexander, specialist in internal medicine at the Lahey Clinic in Boston.

[From the New York Times, Oct. 15, 1969]

UNIVERSAL U.S. HEALTH INSURANCE PLAN PROPOSED AT PARLEY HERE

(By Richard D. Lyons)

A comprehensive health insurance program that would be a type of Medicare for most Americans of all ages was proposed yesterday by a group of influential medical, union, political and civil rightsleaders.

The proposed system would be similar to Medicare in the range of benefits and the method of payment, which would include payroll deductions and Federal taxes.

Walter P. Reuther, head of the United Autoworkers Union, outlined the universal health insurance proposal. Mr. Reuther said such a system was needed because the nation's current "nonsystem" of health care cost too much and gave too little in service.

"The United States is the only nation in the world," he said, "that does not have a national health system," with built-in incentives to help "eliminate waste and inefficiency" in the delivery of medical care.

Mr. Reuther addressed the opening of a two-day conference on universal medical plans that was convened at the Statler Hilton Hotel by the Committee for National Health Insurance, of which he is chairman.

The committee's vice chairmen are Dr. Michael E. DeBakey, the heart surgeon; Mrs. Albert D. Lasker, who is influential in medical affairs; and Whitney M. Young, Jr., executive director of the National Urban League. Other committee members include businessmen, clergymen and Congressmen, as well as medical, labor and civil rights leaders.

About 150 delegates representing 57 national groups, including Blue Cross and the American Medical Association, heard Mr. Reuther term that current system of health care services "inadequate," "unacceptable," and "second-rate."

In urging a national health insurance system, Mr. Reuther emphasized that he sought a "uniquely American" program, inferring that he was not seeking to set up a National Health Service such as the British formed 20 years ago.

During a news conference Mr. Reuther and Dr. I. S. Falk, the committee's technical consultant, who is professor emeritus of public health at Yale, set forth an outline of a national insurance system, which they said would be subject to modification.

PROPOSED COVERAGE

As envisioned, the system would cover costs of personal health care, but might not include drugs and dentistry. The insurance would cover most Americans, but might exclude military personnel, patients in Veterans' Administration and mental hospitals, Federal wards, such as Indians and Eskimos, and persons in schools, custodial and correctional institutions.

Insurance premiums would be financed by a payroll tax shared by employers and employees, together with Federal taxes that would cover about one-third of the system's cost.

Dr. Falk estimated that the United States currently spends about $60-billion on health care and that about $40-billion would be covered by the proposed insurance system.

Under the proposal, general tax revenues would pay about $13.5-billion of the estimated cost, including some premiums for those unable to afford them. This amount is at least several billion dollars more than the Federal Government is now paying for the delivery of health care services.

While the proposed insurance system would cost more Federal money than is now being spent on health care, Dr. Falk noted that it was intended that the system should cover many health-related expenses now being met by state and local funds. The new system would absorb Medicare and Medicaid.

Financing would be channeled through a system similar to Social Security using the Treasury Department. It would be administered by an Office of National Health Insurance Administration at the Department of Health, Education, and Welfare. An administrative and a National Advisory Council would oversee operations.

Dr. Falk and Mr. Reuther said it was hoped that all existing dispensers of health services, from the neighborhood doctor to giant medical centers, would take part in the delivery of care.

An important part of the system, they said, would be the providing of fiscal and other incentives to make health care delivery more efficient.

Mr. Reuther said the meeting's purpose was to discuss and examine details so that a final proposal could be incorporated into legislation that would be introduced early next year in Congress, which has two other insurance proposals already before it.

[From the New York Times, Oct. 19, 1969]

RX FOR BETTER HEALTH CARE: NATIONAL INSURANCE

(By Richard D. Lyons)

WASHINGTON.—The setting last week was a Congressional committee hearing; the issue was the rapid rise in medical care costs; the witness was a Harvard University economist, Dr. Rashi Fein. Said Dr. Fein: "Things have gotten out of hand.'"

That view of the situation is being echoed across the country by labor leaders, consumer groups and even the American Medical Association. Dr. Gerald D. Dorman, the A.M.M. president, said in a statement from Chicago last week that "one major illness or accident can be a financial as well as physical tragedy." Dr. Dorman urged Congress to adopt a health insurance system based on tax credits.

And in New York, 150 doctors and other persons concerned with rising costs met to try to work out not only a health insurance program based on a new payroll tax but also a revamping of the national health care system. A more efficient system, they argued, would give better medical care, and help prevent the huge price increases in medical care that have occurred in recent years.

Dr. Fein, an expert in the finances of medical care, ticked off some statistics to the Congressional Joint Economics Subcommittee on Fiscal Policy: In the three years since the start of Medicare and Medicaid, health care costs have risen by 22.2 per cent, with hospital charges ballooning more than 50 per cent and doctors' fees rising by almost 25 per cent.

"When the Federal Government decided to start paying medical bills through Medicare programs," Dr. Fein said, "the medical community was gracious and accepted the offer, and prices—discretionary prices—rose. Prices will continue to climb," he warned, "unless we, the public intervene."

It was the quality rather than the cost of health care that particularly rankled another witness, Dr. John M. Knowles, the general director of the Massachusetts General Hospital in Boston. Earlier this year the Nixon Administration extended to Dr. Knowles, and then witdrew, the offer of the Nation's top health post.

"Our health statistics in certain areas are frankly embarrassing," Dr. Knowles said. "The health of some 30 million poor people is abysmally bad and almost totally neglected." He then cited statistics showing that the United States ranks behind most of the world's industrial nations in infant mortality and adult longevity.

Dr. Knowles predicted that a system of neighborhood health centers could cut hospital admissions by up to 80 per cent by catching disease problems before they became serious enough to warrant hospitalization. He said improvement could be made in the use of the critically short supply of medical manpower, and ended by calling for the complete restructuring of the nation's medical services and the health-care system.

While Drs. Fein and Knowles were testifying here, Walter P. Reuther was telling a news conference in New York that the American system of health care is a "non system" that is "inadequate," "unacceptable" and "second rate." The auto workers president is the head of a committee whose aims seem almost utopian: not only to reduce the nation's health care bill through a massive insurance program but also to revamp the medical system by providing incentives for efficiency.

Mr. Reuther's group, the Committee for National Health Insurance, consists of almost 100 prominent Congressmen, businessmen and clergymen as well as medical, labor and civil rights leaders. The group's aim is to refinance American health care and in doing so to improve the system, using the obvious leverage that Federal control of the purse strings would bring.

The committee's paramount aim, as its name implies, is an insurance system whose cost would be borne by a new payroll tax to which employers and employes would contribute. General tax revenues would pay the insurance premiums for those too poor to afford them.

While the final touches have yet to be put on the committee's proposal, which is to be introduced in Congress next year, the health insurance plan would cover the personal medical expenses, aside, possibly, from drugs and dentistry, for almost all Americans. As currently envisioned the only exceptions would be members of the Armed Forces, wards of the Government such as Indians and Eskimos, and the institutionalized.

Funds would be collected and dispensed through the Social Security Administration, which now directs the Medicare program. Both Medicare, the insurance plan for persons over the age of 65, and Medicaid, a program using Federal, state and local funds to cover the health expenses of the needy, would be absorbed by the program. Persons covered would be free to select their doctors and hospitals.

Delegates representing doctors, nurses, hospitals and other special interest groups indicated that they were concerned about the consequences of such a massive insurance system for them. Would an inefficiently run hospital, for example, be penalized for its shortcomings by a national health system, and if so, how? The American Medical Association, which sent two representatives to the meeting, again may be preparing to battle what could potentially evolve into an American version of the British national health service. In this system, all doctors work for, and all hospitals are run by, the Government.

Mr. Reuther emphasized that he was not advocating such a system, but some doctors remain skeptical. If a national insurance system were established they wonder whether the Government could regulate fees as a method of holding down rising medical costs.

Many knowledgeable persons here believe that a national health system, however it evolves, is going to be one of the major social reforms of the 1970's. Some even feel that health insurance—rather than merely being an issue in the 1972 Presidential campaign—may actually be a program that both parties might support.

[From the New York Times, Oct. 19, 1969]

U.S. HEALTH INSURANCE—REUTHER GROUP IS LATEST TO PROPOSE A COMPULSORY SYSTEM FOR THE NATION

(By Howard A. Rusk, M.D.)

Last week in New York City a group of union, health, political and civil rights leaders sounded the opening gun of a long-planned program directed toward the enactment of national compulsory health insurance.

The group which calls itself the Committee for National Health Insurance, is headed by the United Auto Workers union president, Walter P. Reuther.

Mr. Reuther and his colleagues have proposed that the nation should have a compulsory health insurance "as an integral part of the national social insurance system." The cost would be paid by the employe and employer with the aid of public and private contributions. Strong emphasis would be placed on prepaid group medical practice and preventive health insurance.

The plan would be compulsory but patients would have a free choice of physicians.

The proposed program would be similar to Medicare in the range of benefits and the methods of payment.

CURRENT SYSTEM SCORED

In opening the two-day conference attended by about 150 delegates representing 57 national groups, Mr. Reuther declared the current system of health care services "inadequate," "unacceptable," and "second-rate."

Mr. Reuther's group includes businessmen, clergymen and Congressmen. Its vice chairmen are Dr. Michael E. DeBakey, the cardiovascular surgeon from Houston; Mrs. Albert D. Lasker, an influential advocate of greater Federal participation in health affairs; and Whitney M. Young Jr., executive director of the National Urban League.

Final details of the proposal are now being drafted by Dr. I. S. Falk of Yale University, the committee's technical consultant.

Legislation will probably be introduced early in the next session of Congress.

The system, according to Dr. Falk, would cover costs of personal health care but might not include drugs and dentistry. The insurance would cover most Americans but might exclude persons who are now Federal beneficiaries of medical services.

Among these are military personnel, certain veterans and American Indians and Eskimos. Patients in mental hospitals, institutions for the retarded and correctional institutions might also be excluded.

OPERATION UNDER HEW

Financing would be administered through the Treasury Department, through a system similar to Social Security. The program would be administered by an office within the Department of Health, Education, and Welfare.

Dr. Falk has estimated that the United States currently spends about $60-billion annually on health care, of which $40-billion would be covered by the proposed insurance system.

The proposals of Mr. Reuther and his associates are not new. As far back as 1914 an effort for health insurance through the states was proposed but not enacted by a single state.

Since then various plans have been advanced from time to time. Most attention was attracted by Legislation introduced in 1943 by Senator Robert Wagner, Democrat of New York; Senator James Murray, Democrat of Montana, and Representative John Dingell, Democrat of Michigan.

Because of the costs and preoccupation with World War II the proposal attracted little support.

A major push came when another version of the Murray-Wagner-Dingell bill received the strong backing of President Truman in 1948. The bill, however, failed to get past committee in the House of Representatives. Nor was the proposal that has been advanced by a number of groups.

Senator Jacob K. Javits, Republican of New York, has also proposed a compulsory health insurance plan patterned after Medicare. The full cost for coverage for employed persons would be borne by employe-employer contributions. The Government would pay the costs for the indigent. The program would be administered by the states with help from private carriers.

Governor Rockefeller has proposed a compulsory health insurance program utilizing insurance purchased from private carriers. The plan would have Federal controls aimed at lowering costs.

A UNION PROPOSAL

The American Federation of Labor and Congress of Industrial Organizations has proposed a system offering benefits with costs paid by employe, employer and the Federal Government.

The American Medical Association also has its own plan. Under its proposal the Government would help defray the costs of private insurance by a system of graduated income tax credits. Families with lower income would get higher income tax credit for insurance premiums. The plan would be administered through private carriers with the approval of the state.

Thus far the A.M.A. proposals, which have been introduced by Representative Richard H. Fulton, Democrat of Tennessee, and Senator Paul J. Fannin, Republican of Arizona, are the only proposals for which legislation has been introduced and is pending before a Congressional committee.

The American Hospital Association has also announced the appointment of a committee to study proposals for a national health program. It is expected to announce its program early next year.

Although about 80 per cent of the nation's population has some form of health insurance, there is no doubt that the proposals for compulsory national health insurance are gaining momentum.

One factor is, undoubtedly, the constant rising costs of medical care and health and hospital insurance premiums. Health care already represents the third largest expenditure in the United States.

With its preoccupation in Vietnam, inflation, and the other major problems facing the nation, the Nixon Administration obviously is not anxious to face another major controversy, such as national compulsory health insurance.

Dr. Falk has commented that such a program is "socially inevitable, whatever political winds blow most strongly on the domestic scene." He adds that "no partial and ineffectual compromises will long withstand the pressures of public need, demand, and expectation."

He is undoubtedly right, but the big question is not only if but when this public demand will be great enough to achieve its objective.

[From the New York Times, Oct. 26, 1969]

GRAVE CRISIS OVER RISING COSTS

(By John A. Hamilton)

The nation's health care system is now itself gravely sick, suffering from an acute shortage of facilities and personnel, congenital inefficiency in galloping costs that rise like a runaway line on a fever chart. Secretary of Health, Education and Welfare Robert H. Finch and his assistant for health, Dr. Roger O. Egeberg, reported the debility to President Nixon not long ago. The state of the health system was, in Dr. Egeberg's words, "grave tending to be critical."

Since then, new complications have set in. Medical care costs have continued to climb almost twice as fast as the general cost of living and both the Federal and state governments have cut back on aid vital to hospitals and to the research institutes and medical colleges associated with them. In New York State some 16 medical schools and research centers reported the other day that their programs were imperiled. Dozens of centers across the country have reported program curtailments, caused by a 20 per cent cutback in Federal research grants.

TEETERING ON THE BRINK

New York City's hospitals have been severely affected and, owing to the state's cutback in medical aid to the disadvantaged under the Medicaid program, some facilities situated in slum-areas are in danger of having to close down. According to First Deputy Hospital Commissioner Robert A. Durzon, the city's municipal hospitals are now "teetering on the brink of disaster."

Medical care costs increases have been astonishing. In the period 1965–68 the general cost of living rose 3.3 per cent annually, but medical costs rose 5.8 per cent annually and, within the medical field, hospital daily care service charges rose 13.9 per cent annually. Doctor fees, relatively stable for some time, have also begun to spurt upward, causing the Social Security Administration to warn last week that Medicare premiums will have to be increased about 25 per cent to cover them. Such an increase would follow recent increases averaging 43.3 per cent in Blue Cross premiums on community-related contracts in New York State.

The reasons for the steeply rising costs are complicated and varied. They include the Government's own extension of medical care benefits to million of Americans without any comparable increase in medical personnel or facilities. The medical profession has generally been compensated on a cost-plus basis which offers little incentive for economy. Personnel and facilities have been inefficiently utilized. Labor costs of all sorts have soared. Private hospitals in New York City recently signed a contract calling for a 23 per cent increase in wages for nonmedical workers for the next year. Other hospitals are expected to have to match, or at least approach, this contract.

These costs have been met with funds from different sources. Private individuals have made out-of-pocket payments, some money has come from charity and philanthropy some from insurance programs and an increasing portion from the Government through grants and programs aiding the elderly and the medically indigent. Medical schools and research institutes have used Federal grants to underwrite the salaries of doctors who often also work in hospitals. Grant cutbacks can have grim implications.

One New York medical college, which prefers anonymity, anticipates a multimillion-dollar deficit this year because of cutbacks in Federal grants. With a $16-million budget, it will receive only $10-million in Federal grants, which it says is about 10 per cent below what it had been receiving and actually represents an effective reduction of close to 25 per cent when the steeply rising cost of providing medical instruction and running a hospital are taken into account.

WRONG PLACE TO CUT

"Something must be done about inflation," says Dr. Frederick Eagle, dean at the New York Medical School and president of the Associated Medical Schools of Metropolitan New York. He questions, however, whether the Federal Government ought to trim medical school grants as part of its fight against inflation. "If you turn off medical education and research," he warns, "it will take a decade or more to start them up again."

Another major area of Governmental reimbursement comes in the form of Medicaid payments for the care of the medically indigent. The New York State Legislature froze Medicaid reimbursement levels at its last session. No matter how high costs rise, it will permit only certain levels of reimbursement under this program, which is vital both to the needy and to the slum-area facilities that serve them. At St. Mary's Hospital in the Bedford Stuyvesant section of Brooklyn, some 55 per cent of its patients are under the Medicaid program. It calculates that it now costs $105 a day to provide a patient with care: Medicaid provides only $68 a day reimbursement. It anticipates a $1.1-million deficit in its current $3.5-million annual budget and it has brought suit to enjoin the state from continuing to enforce the Medicaid cutbacks.

An effort by the New York State Legislature to moderate the rise in costs may only backfire and cause additional difficulties for hospitals. It ordered the State Department of Health to secure the "efficient production" of health care services and the department has promulgated an arbitrary formula to take effect in January governing reimbursements under all Governmental programs and private insurance, such as Blue Cross, as well.

CAUGHT IN SQUEEZE

Under the formula, hospitals will be grouped by type, size and area and their cost increases will be averaged over the past several years. They will be allowed reimbursement not for 100 per cent of this average increase in the years ahead, but for only 75 per cent of it. Thus, where costs generally have been increasing about 16 per cent, the formula will limit reimbursements to cover only a 12 per cent increase.

In short, hospitals are caught in a cost-price squeeze and no one sees any effective answer at this point.

[From the Washington Post, Oct. 22, 1969]

MEDICARE PREMIUM TO GO UP 25 PERCENT

(By Eve Edstrom)

The $4 monthly Medicare premium that 19.3 million aged Americans pay for coverage of doctors' fees will be increased by more than 25 per cent beginning July 1, the Nixon administration told Congress yesterday.

Social Security Commissioner Robert M. Ball said the premium must be raised to "somewhat over $5" to catch up with explosive doctors' fees.

No final decision has been made on the exact amount which, under law, must be set by Secretary of Health, Education, and Welfare Robert H. Finch before Jan. 1.

The fact that it would go over $5 was revealed by Ball during questioning before the House Ways and Means Committee as hearings resumed on the administration's welfare reform measures and its proposed 10 per cent boost in Social Security cash benefits.

Rep. Jacob H. Gilbert (D-N.Y.) insisted that the cash benefits should go up higher than 10 per cent to more adequately reflect cost-of-living increases and to absorb the Medicare premium increase.

The monthly premium was $3 when the program began in 1966 and was increased to $4 in 1968. Former HEW Secretary Wilbur J. Cohen refused to authorize an additional increase last December in a move to restrain doctors' fees.

Ball said yesterday that the initial $4 rate was too low. It should have been $4.20 and then increased to $4.40 last December, he said.

Therefore, the new premium must make up for the low premiums of the past in addition to covering anticipated costs, he added.

Benefit payments under the plan have shot up from $664 million in the 1967 fiscal year to $1.6 billion during the last fiscal year.

The premium increase to cover doctors' bills will come on top of an increase in the amount that the aged will have to pay for Medicare hospital benefits.

Currently, the aged pay the first $44 of a hospital bill. But under a previously announced change, they will be required to pay the first $52 beginning Jan. 1.

House Democrats argue that the upward costs of hospital and medical care, along with other cost of living increases, make it imperative that Social Security cash benefits go up by at least 15 per cent.

In discussing the possible extension of Medicare benefits to cover out-of-hospital drug costs, Finch indicated that the administration may make such a recommendation in 1971.

Ball said initial coverage would be limited, possibly restricted to drugs needed to control chronic illnesses or to cover drug charges above a certain dollar amount paid by the patient.

"If we move into it, we'll want to move into it gradually," Ball said.

Much of yesterday's testimony centered on the administration's welfare reform proposals to provide $1600 minimum annual payments to poor families of four.

Finch and Rep. Martha W. Griffiths (D-Mich.) tangled verbally as Finch insisted that the plan was the soundest way to redirect the nation's welfare system by providing strong work incentives, and incentives to prevent family breakups.

"The real problem is that you are putting all your money on a myth," Mrs. Griffiths told Finch. ". . . The place to put money is on the people who are creating the problem."

Mrs. Griffiths said it was not intact families but young girls with illegitimate children who are causing relief rolls to spiral. She added that "marriage is becoming rather unpopular" with them.

She said the administration's plan does nothing to reduce illegitimacy and does nothing to help young mothers to return to school and acquire training they need, although young men would receive such opportunities.

"What have you got against women, Mr. Finch?," she asked.

"I'm very much for women," he replied.

Mrs. Griffiths pressed for a provision that would force young mothers to return to school.

"I'm not sure where she gets pregnant but I suspect probably a lot of mothers get pregnant in school," Finch said.

Social and Rehabilitation Service Administrator Mary E. Switzer agreed with Mrs. Griffiths that numerous services are needed to help young mothers, and that a "very aggressive birth control" program should begin because many young people don't "understand the facts of life."

"You've got to work with the boys, too," she said. "It takes two to make a baby. At least it used to."

[From the Washington Post, Oct. 29, 1969]

GARDNER ASKS REFORMS TO CUT MEDICAL COSTS

(By Eve Eldstrom)

Average daily hospital costs will skyrocket from this year's record high of $67.59 to almost $100 in 1973, the American Hospital Association estimated yesterday.

This testimony before the House Ways and Means Committee was given at about the same time that Urban Coalition chairman John W. Gardner was describing the "terrifying inflation" of health care costs to a news conference.

Gardner made public the coalition's 76-page booklet, "Rx for Action," which urges local coalitions to become catalysts for sweeping medical reforms aimed at bringing more efficient and economical health care to more people.

WASTE ASSAILED

"The plain truth is that much of the $53 billion which we spend annually on public and private health programs is wasted," Gardner said.

While calling for local action programs, Gardner also said there must be a national system of financing health care for all age groups. But he emphasized that a financing mechanism to pay for health does not produce health services.

"Something else besides money is needed," he said. "We've got to tackle the rigidity of the system and the way to do it is at the grass roots."

Medicare and Medicaid, the coalition report states, "have resulted in a massive inflation of the cost of medical care, with only a small improvement in service availability" because adequate facilities and medical manpower have not been available.

Dr. Roger O. Egeberg, the Nixon administration's top health official who also spoke at the coalition's news conference, said he did not agree that a national health insurance plan should be adopted now.

"If we suddenly say everybody has a right to health care, it does something psychologically," he said.

He later explained it would be unfair for everyone to think they would receive health care when the nation's health care systems were not equipped to deliver it.

The Assistant Secretary for Health and Scientific Affairs said a national plan might be possible in four or five years but "give us a chance to get the (health) house in order. Don't push us with that yet."

In the meantime, Gardner urged local coalitions to work with community organizations to change patterns of delivery of health services, to make better use of existing health manpower, and to increase the use of well-trained subprofessionals.

STUDY BY COMMITTEE

Meanwhile, the House Ways and Means Committee is examining the high cost of health care to determine whether Medicare taxes must be increased.

Dr. George W. Graham, president of the American Hospital Association, attributed rising costs to salaries, additional services, inflation and administrative costs of Medicare.

Daily average hospital costs, Dr. Graham said, will go up from the current $67.59 to $74.24 in 1970, $81.52 in 1971, $89.56 in 1972, and $98.37 in 1973.

[From the Washington Post, Oct. 31, 1969]

THE WASHINGTON MERRY-GO-ROUND

HOSPITALS ACCUSED OF PROFITEERING

(By Jack Anderson)

The high cost of dying is not a monopoly of the undertakers. The nation's 7,200 hospitals are taking in their share of the profits from sickness and death.

The sprawling, unsupervised hospital industry has been under quiet, coast-to-coast study for nine months by Sen. Phil Hart (D-Mich.). His findings are so explosive that he has ordered his Senate Antitrust and Monopoly subcommittee to prepare the most exhaustive hearings in history on zooming hospital costs. The January hearings may run for weeks.

Under Hart's direction, government accountants have studied the finances of hundreds of hospitals to find out why costs jumped as much as 35 per cent since last January. The unpublished computations show average, per-patient costs vary from $28 to $135 a day, depending on the hospital.

POCKETBOOK SURGERY

• A 23-year-old New Yorker, his life ebbing after a violent auto crash, was brought into North Shore Hospital in Manhasset, Long Island. A few hours later, he died. The hospital and doctors billed his family and estate for $2,683—more than $300 an hour.

• A union man with a better-than-average insurance policy was admitted to University Hospital, New York City. His ills kept him there for two months. The health insurance paid $14,054, but he was still swamped with a personal bill for $8,094.

• Another patient at University Hospital, a woman, was treated for nine days. The cost: $800 a day. After insurance, her personal bill was still $4,454.

• In Florida, a prominent newspaperman was ordered by his doctor to a hospital for emergency treatment of a bleeding ulcer. The hospital refused to admit the anguished man because he couldn't produce $250 advance payment on the spot. Only the intervention of his doctor got him admitted.

Hospital costs are multiplied by the featherbedding practices of the American Medical Association. The AMA-controlled accrediting groups, for instance, require a pathologist on every hospital staff.

These "circuit riders," as they are called by bitter hospital administrators, may lend their names to several institutions. They generally take a third of the gross pathology and lab charges—for work done by lower-paid technicians.

DOCTORS GET RICH

A distinguished physician, head of a chain of hospitals, wrote Hart that pathologists have "a costly stranglehold on American hospitals. . . .

"In a hundred-bed hospital," explained the disenchanted doctor, "the pathologist will take $100,000 a year or more out of that hospital for a few hours' work. If 5,000 hospitals could just cut their donations to pathologists in half, it would save one quarter billion dollars a year or more."

This extra $250 million, of course, is added to the patients' bills. Thus the diseased, the disabled and the dying have been keeping the pathologists in Cadillacs and draping their women in mink.

Much of the blame for bewildering hospital costs comes from the cheek-to-jowl love affair between the Blue Cross and the hospitals.

It works this way:

Blue Cross pays its portion of the hospital costs, no questions asked, without pressing the hospitals to change their inefficient, antique ways. Since the hospitals are assured of payment, they don't reform on their own.

Most other health insurance firms are equally indifferent to the interests of their customers, who must pay for the rising costs—either in sky-rocketed health premiums or backbroken bank accounts.

HOSPITAL PROFITEERS

The hospital mess is complicated by a bitter feud—outside of the public's earshot—between the profit and non-profit hospitals. The profit seekers, many of them physicians trying to scalpel the patient's payroll two ways, have set up hospital holding companies that run or are building some 200 institutions.

The nonprofit operators have complained to Hart's investigators that the profit-takers are pushing off the poorer patients on the non-profit hospitals. The doctor-businessmen have also cut such money losers as pediatrics, obstetrics, emergency rooms and training programs from their hospitals. This enables them to undercut the non-profit institutions with lower fees.

Unhappily, the hospitals haven't been able to reform from within. Inefficiency is rampant, as almost every patient knows from experience. There is also plain thievery—of blood, drugs, hypodermic needles, even bedsheets.

Sen. Hart, meanwhile, wants to hold hearings and study the symptoms before he prescribes remedies.

Note: The costliest hospitals are found in California, Connecticut, Massachusetts and the District of Columbia. The cheapest operate in the Dakotas, South Carolina and Wyoming. Not surprisingly, big city hospitals charge more than do small town institutions.

[From the Washington Post, Nov. 2, 1969]

SUITS RAISE MALPRACTICE INSURANCE

(By William Endicott)

LOS ANGELES.—In the 18th century before the birth of Christ, a Babylonian king by the name of Hammurabi developed a simple code for dealing with medical malpractice:

Accidents or injuries beyond reasonable possibility of prevention were not regarded as legal offenses; on the other hand, carelessness and neglect were severely punished. Thus, a clumsy surgeon might lose his hands as the penalty for a maiming operation.

But times change. The barbaric principles of almost 4,000 years ago have given way to a more sophisticated means of dealing with erring doctors—the malpractice lawsuit.

ANTITRUST SUIT

In Southern California, for instance, one in every 10 doctors is the target of a malpractice claim.

The result has been to send malpractice insurance premiums skyrocketing and create a volatile issue between two of the country's oldest and most respected professions—medical and legal.

[United Press International reported last week that attorney Melvin Belli filed a $200 million antitrust suit in San Franciso against 13 insurance companies, charging that the companies allegedly conspired to overcharge for malpractice insurance and to keep physicians from testifying for injured persons.

[The suit asked that any money awarded by the court be paid into a trust "to be used in the payment of claims of citizens and residents of the state of California who are injured and damaged as the result of professional negligence on the part of uninsured doctors and hospitals.]

LAWYERS BLAMED

Doctors contend the lucrativeness of the malpractice field for attorneys is driving up the number of suits and that many of them are not justified. Attorneys contend that to blame them for malpractice suits "is like blaming the doctors for all the deaths."

It could mean:

• Higher fees for medical care. Some physicians already have announced an increase of $1 per office call and others are considering going even higher.

• A change in the approach to treatment. Patients sometimes may receive less than the best care because the doctor is afraid he'll be sued if he does what is indicated medically; in other cases, he may go beyond what is indicated simply to protect himself in the event of a suit.

• Fewer physicians. Spokesmen for the Los Angeles County Medical Association contend many senior physicians are planning an early retirement because of the increasing expense of practicing medicine.

STATUTE OF LIMITATIONS

Doctors invariably turn to the malpractice attorneys as the persons most responsible for their problems.

"Attorneys are becoming involved because they recognize that there is big money available through this," said a spokesman for the County Medical Association.

Doctors also blame the laws themselves:

• The doctrine of *res ipsa loquitur*, which in Latin means "the thing speaks for itself." Basically, this philosophy assumes that a patient suing a doctor need not produce expert testimony to show that he had been damaged by the treatment. His injuries would speak for themselves.

• The absence of an adequate statute of limitations on malpractice cases. The law in most states is that a suit must be filed within a year after the discovery of an alleged injury. In some cases, this could be many years after treatment.

[From U.S. News & World Report, Nov. 3, 1969]

GROWING CRISIS IN HEALTH CARE

INTERVIEW WITH DR. JOHN A. D. COOPER,[1] PRESIDENT, ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Doctors are among the first to agree that all is not well with medical care in the U.S. today. The question is: Can anything be done?

For an informed assessment of the problems—and possible solutions—"U.S. News & World Report" invited the head of the Association of American Medical Colleges to its conference room for this exclusive interview.

Dr. Cooper on nursing shortages: *"Nurses have been underpaid, but pay is rising. Jobs are more attractive."*

Q Dr. Cooper, how do you account for the criticism that is being leveled at the medical profession in this country?

A There are several reasons. The principal one is that people are expecting more health care from a system that is not arranged to furnish it.

Then, too, we do not have the manpower to meet the growing expectations. A proof of all this is the fact that between 20 and 40 million people in the lower income brackets are not receiving adequate care.

Q What do you mean by "adequate" care?

A The medical profession is not discharging its responsibilities to the patient unless he receives the benefits of all the modern approaches, techniques, scientific advances that we have made in the laboratory.

Q What is the problem basically? Too few doctors?

A There is a health-care crisis in this country. It arises from a number of changes. People expect more from the medical profession because they know it can do more for them. People have more money to spend on health. We have an elaborate system of private and public health insurance and Government benefits that makes it possible for more people to pay for medical care. That increases the demand for service.

The problem is that we have no efficient and effective mechanism for delivering the health services that people need and can pay for. Certainly we have not had, in the health field, the kind of technological innovations that have had such a remarkable effect on other industries. We need to develop a system that will much more effectively use very precious manpower.

I just don't think we can afford the cost in brains and money of increasing the size of the present system to take care of the millions who are not getting proper care.

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[1] Dr. John A. D. Cooper, 50, is a biochemist as well as a medical doctor. Before moving into his present job this year, Dr. Cooper was dean of sciences at Northwestern University. He has served on a number of governmental committees and is still special consultant to the National Institutes of Health.

Q Is part of the problem that there are fewer doctors than there used to be, relative to our population?

A The ratio is about one physician for every 700 people. This figure has remained more or less constant since the late 1920s and early 1930s.

Q How many doctors are being trained?

A The medical schools are taking in about 10,500 this year, and we have about a 10 per cent attrition rate.

Q That means about 9,500 new doctors yearly—

A Yes.

Q Is that enough?

A No. I believe the intake of medical students should—and will—increase by 50 per cent by 1975, either through the opening of new medical schools or the expansion of present schools.

TRAINING DOCTORS IN LESS TIME—

Q Could you produce the needed doctors more quickly by shortening the time it takes to train a physician?

A There are many experiments under way for decreasing the time involved. I started such a program at Northwestern University in 1961, in which specially selected students are admitted from high school to a program which permits them to obtain the M.D. degree in six years instead of eight. This has been very successful. The students who have participated have competed very well for internships and other positions on graduation.

Q Why wasn't this six-year program offered to all medical students?

A There is no question that we can extend it to other students. How far we go depends on some experimentation.

Stanford University has instituted a complete elective course for the M.D. degree. This takes into account what knowledge the student brings into the school with him and what his interests are. Then the school lays out a program that will bring him to the level of training and experience he needs to reach his goals.

Q Does the Stanford program also reduce the time required for medical training?

A This experiment is just beginning. I think there is no doubt that a considerable number of students will go through medical school in less than the usual four years.

Q Then there's a year of internship after graduation, isn't there?

A At present all students are required to have a year of internship, but a lot of questions are being asked by the medical schools about the necessity for this. The student now gets much of the clinical training and experience in medical school that he used to get as an intern. I think that ultimately—and it's in the not-too-distant future—the internship will probably be abolished as a requirement.

Q. Isn't there also a requirement that a young M.D. spend a year or two as a resident in a hospital before going into practice?

A. A residency is not required for a license to practice. However, because medicine is becoming more scientific, more sophisticated, it is not appropriate for a person to practice as a "family physician" without at least two years of advanced training in internal medicine and pediatrics.

Q. Does the student then end up with eight years of training, even if you reduce the number of years in college and medical school from eight to six, and eliminate the year of internship?

A. Right, but that is less than the 10 or 11 years that is usually required to train the same "family physician" under the present setup.

You have to remember, too, that just producing more doctors does not guarantee that they will go into the "ghettos" or into the rural areas that lack physicians. They may end up in the suburbs of our big cities. With the increasing demand for medical care, there are plenty of opportunities for these new physicians to practice there.

Q. Don't your students feel they have a responsibility to provide care in areas that are not so plush?

A. We have a noticeable increase in the number who are interested in dedicating themselves to helping solve some of the problems of society. However, we must provide them with a way to do this.

There was one group of 120 medical students who spent a summer in Appalachia on a grant. Only 18 said they would be willing to return to this area to practice medicine. The president of the Student American Medical Association said Appalachia did not furnish proper opportunities.

Q. In what way?

A. I think the students felt there was no effective way to deliver health care in that region.

Q. They felt they wouldn't be able to achieve much?

A. That's right. You see, you not only have to have committed students; you have to provide them with the way to fulfill their commitments.

What we really need is a new system for delivering medical care in this country for a large segment of the population. Some people claim that we have a "nonsystem." I have called it the last of the cottage industries.

We need to organize on a team basis to provide medical service over wide areas.

Q. How might that be done?

A. I think that ultimately the system will grow out of the larger teaching hospitals, probably very much like the Swedish system in which you have three levels, all interrelated: You have one group in the local community. This is largely an outpatient operation with very few hospital beds. Then you have the district hospital covering a larger area, and, behind that, the teaching hospital and medical center.

With that setup, a doctor in a remote area or in the "ghetto" would have the benefit of working with a large professional group. In an area of 20,000 inhabitants, the local team might consist of 20 physicians and 100 to 200 nurses and technicians. A doctor on the team would be tied in with the larger medical center, so that he would not be a forgotten man. There would be a continual traffic of personnel between the local clinic and the district and regional centers.

Q. A rural doctor might be rotated back to the big city after a couple of years—

A. Right, and the team he is working with would probably include some highly trained people, not doctors, who could take over much of the physician's routine work—pediatric practitioners and midwives, for instance. Almost every country in the world, aside from the United States, uses trained midwives working under the supervision of obstetricians. This is much less demanding on highly trained talent than what we do.

Q. Wouldn't a good many American wives feel that that was a risky policy, relying on a nurse with special training to deliver their babies?

A. The Netherlands has an infant-mortality rate of 16.8 per 1,000 live births, compared with our 24.8. Yet, in the Netherlands, much of the delivery of mothers is done in the home, because there is a well-organized team of obstetricians, trained midwives and specially trained health personnel who give prenatal and postnatal care to the mother on a much more frequent basis than is possible when you rely entirely on the obstetrician.

U.S.: How Healthy—

Q. Just how does the U.S. stack up against the rest of the world in terms of health?

A. Unfortunately, the figures compiled by the World Health Organization have been getting worse for us over the years, not better. We now rank fifteenth among the nations in infant mortality. There are 22 countries where the life expectancy of males at birth is greater than in the U.S., and nine in which the life expectancy of girl babies is greater than here.

Q. We spend more money on medical care than any other country, don't we?

A. Not in a relative sense. Sweden probably spends a larger proportion of its gross national product on health care than we do. I think the real difference is that these other countries have a much more highly organized medical-care system. Care is paid for and the facilities are easily available to all.

Q. Is the team setup you suggest being used anywhere in the United States?

A. Harvard Medical School has plans under way to go out into the community, setting up clinics to deliver medical care throughout the city of Cambridge, Mass. Temple University Hospital is reaching out into Philadelphia, working with established institutions and also setting up new facilities to provide care to a lower economic stratum.

Q. Do you face a shortage of nurses and technicians, as well as doctors, for your health teams?

A. Yes. I believe the medical centers and teaching hospitals, in making plans for these teams, should also be determining what education is needed for the

people who will function in them and should help prepare teachers. In many cases, the professional courses would then be offered in the community colleges.

The number of courses for health professionals is already increasing very rapidly with the development of these colleges.

The big university with its medical school can use its peculiar talents and resources more effectively in giving guidance than in trying to train all of the health professionals required.

Q. Is low pay a deterrent to getting people to go into nursing and other work in this field?

A. This is changing rapidly. These people have been underpaid compared with people with similar education and responsibilities in other industries. But this is being corrected. Pay is rising, and these jobs are becoming more attractive.

Q. Don't people who work in hospitals and clinics complain about lack of advancement—a nurse's aide can't become a nurse, a nurse can't become a doctor, and so on?

A. You have brought up an extremely important point. Upward mobility is going to be an absolute necessity.

Q. How can it be developed in the medical profession?

A. By taking into account what the student brings with him, what his goals are, the kind of program needed to advance him from one level to another.

A nurse, with the education she has, shouldn't have to do everything that the average college student has to do, if she wants to train to be a doctor. A nurse's aide should get credit for some of the things she has already learned in a hospital, if she decides to become a nurse. We have to give people in this profession the view of being able to improve themselves.

Q. Will State boards give licenses to people who move up in that manner, without going through the full routine of medical or nursing school?

A. We have seen a great change in the State boards in regard to licensing. They are going to be much more flexible.

Q. If we get the setup you propose and someone wants attention on a weekend, he won't have a family doctor to call, will he?

A. In some instances, some other member of the health team—not a doctor—may make the contact with the patient. We have to educate the public about the capabilities of the people working in these groups.

In Colorado, where the University of Colorado has had a program using nurse-pediatricians, these people have been accepted, because people now recognize their capabilities. They are not clamoring to see the pediatrician every time they bring the baby into the clinic.

Q. Aren't you really predicting the end of the doctor as we know him today—the individual practitioner?

A. I am really talking about a change in his functions. The technological changes in medicine require a more sophisticated administrative setup.

Q. So that the physician, in effect, has to be part of a hospital-oriented health-care team—

A. Right. He already has a heavy dependency on the hospital, not only for the patients he sends there but also for his outpatients. Physicians in many areas send their patients to the hospital for laboratory tests, X rays, radiation therapy and so on.

Q. Who would provide the buildings and equipment your health teams would need?

A. That gets into the question of how to pay for medical care. Some requirements will be met through individual payments of fees, insurance benefits and voluntary charity. Others will be covered by public funds. If we approach the problem this way, we have a better chance of maintaining the voluntary aspect of medicine.

If you study the history of the development of the health-care system in other countries, you find that it changes gradually from the individual contract between the patient and the physician, plus a certain amount of charity, to a period in which some services are supplied on that basis, and some are paid for with public funds. The system generally evolves from there to a situation where you have the Government supplying more and more of the services, until you reach the third stage where the Government takes over 100 per cent. That is the tradition. But you don't have to go as far as that third stage, if you provide enough public funds to satisfy those needs of society that cannot be met in other ways.

BILLIONS FOR MEDICAL CARE—

Q. What is the Federal Government spending for health care?

A. We now have a federal expenditure of almost 14 billion dollars a year in the health field, of which a substantial part is related to the delivery of medical services, either directly or indirectly.

Q. Is the expense increasing rapidly?

A. The Government was paying about a billion dollars for health services in 1940. From there the outlay increased to 3 billion in 1950, to 7 billion in 1960, to 9 billion in 1968 and about 14 billion in 1969. Part of that is related to research, but a relatively small amount.

Q. Dr. Cooper, you said recently that the Government has been dragging its feet in the delivery of health care. What did you mean?

A. I pointed out that President Nixon, in presenting a White House report on health-care needs, said there was a severe crisis in health-care delivery, and that part of this crisis was the lack of an adequate number of physicians and other manpower in this field. The President said that unless corrective measures are taken, we face a complete breakdown in the system in two or three years.

In spite of that, the Administration has recommended that Congress increase the funds to support the training of doctors by only 5 million dollars a year—from 9 million in the last fiscal year to 14 million this year.

Dr. Cooper on rising medical bills: *Patients get "more-sophisticated care, more costly service than ever before."*

Q. What are those funds used for?

A. For what is now called the physician-augmentation program, administered by the Bureau of Health Manpower of the National Institutes of Health. The money is passed on to medical schools on a project basis for operating expenses, minor construction, renovation and similar costs associated with their educational programs.

Q. How much do you want the Government to provide?

A. We are asking for the full amount authorized by the Health Manpower Act of 1968—20.4 million dollars. We were extremely disappointed when the House Appropriations Committee did not recommend any increase in the 14-million figure. We are hopeful that the Senate Appropriations Committee will recognize the seriousness of this matter and recommend an increase in funds.

Q. Are medical schools hard pressed for money?

A. Private medical schools, I am sorry to say, are in severe financial difficulty. There are questions in several of them about whether they can remain open.

Q. Can't they get the money they need by increasing tuition and fees?

A. There is a limit to the tuition you can ask if you hope to have students from a broad economic background in medical school.

Q. Are there loans that needy students can get?

A. Students from the lower economic groups usually end up their undergraduate, premedical careers with debts in the thousands of dollars. They then face a period of further high-cost education that dissuades many from going into medicine. They just don't feel they can make it.

What's more, the amount of money in the Federal Student Loan Fund for medical students is only a fraction of what our schools estimated the students would need—about 8 million dollars instead of 23 million.

Q. Does the Federal Government provide money for major construction projects at medical schools?

A. Yes. There is an authorization for 170 million dollars a year for buildings. The program is now being held down to about 150 million. We are asking for the full amount.

Another thing that concerns us about the Administration approach is a proposal to cut back on support for research training and similar programs in the medical schools.

Medical centers are very complicated operations with highly interrelated activities, and the research training really is a part of faculty training. When you train people to do research, they also receive training for all the other functions performed by faculty members.

If you reduce that type of program, you affect undergraduate medical education.

What I'm saying is that the Administration is prescribing a Band-Aid when we need a blood transfusion. Certainly, the recommendations it made are not in keeping with the statement about the seriousness of the crisis facing us.

Q. Would you favor having the Government build its own medical schools to train more doctors?

A. We are opposed to that. We have consistently maintained that medical schools, as now established, can produce the needed manpower more cheaply than you could do it by creating a Government institution to produce medical officers for the uniformed services. The tradition of this country is that higher education is either a private or a State enterprise, and we feel this is the way it ought to remain.

Q. Are increases in physicians' fees related to the apparent shortage of doctors?

A. Physicians' fees are not set traditionally in the market place.

I think a substantial part of the increase in fees is due to the fact that patients receive more-sophisticated care in the physician's office than ever before. There is more advanced equipment, more costly service rendered to the patient.

But in addition to all of that, it is perfectly obvious that the personal income of the physician has gone up substantially as have incomes in other professions.

Q. Will the changes you are proposing lead to relatively less expensive medical care over the long run?

A. I think so, over all.

[From U.S. News & World Report, Nov. 3, 1969]

Medical Shortages Abroad, Too

REPORTED FROM WORLD CAPITALS

One way or another, virtually every nation in the world seems to be facing the same health crisis: rising demand for better health care, coupled with a shortage of doctors, nurses, technicans and hospital facilities.

This crisis follows, in very many cases, the adoption of some form of Government-backed medical plan aimed at bringing the advances of medical science to all, or a large part, of each nation's people.

Lack of medical personnel is most severe in poor and rural areas around the world. But little headway is being made in solving the problem in either modern or backward countries.

Reports by "U.S. News & World Report" staff members based in capitals abroad tell the story.

BRITAIN: OVERWORKED DOCTORS, OVERCROWDED HOSPITALS

London.—There are 65,000 doctors in Britain now, not nearly enough to satisfy 54 million potential patients whose bills are paid by this country's National Health Service.

Hospitals are crowded and understaffed. Case loads for doctors are heavy everywhere. Nurses, paid about $2,400 a year, are in short supply.

Unhappy with these conditions, from 400 to 500 doctors leave Britain every year. The gap is being filled—inadequately, in the opinion of many—by foreign-trained physicians who are entering the country at a rate of 2,000 a year. Britain faces an unmet need for 10,000 doctors by 1976, a royal commission warns. As a result, a Government plan is under way to increase the number of qualifying doctors by 37 per cent, to a rate of 3,700 annually, by that time.

WEST GERMANY: 30,000 NURSES NEEDED RIGHT AWAY

Bonn.—Big shortage in this country, which pioneered Government health insurance, is in the nursing field.

Just as Britain has been forced to import doctors, Germany has to rely on nurses from elsewhere, as far away as Korea, Taiwan and India.

Some 2,000 to 3,000 of these foreign nurses are working in West Germany, and the total nurse shortage is still estimated at more than 30,000.

Hospital aides, technicians and clerical staff are also in short supply. The number of doctors, however, appears to be adequate for present needs. At this time, there is one doctor for every 714 people in West Germany.

Current attendance at German medical schools is counted on to maintain that ratio.

FRANCE: PLENTY OF DOCTORS, BUT—

PARIS.—French hospitals are Government-run, with plenty of doctors on hand to staff them. Many more are on the way—too many, health officials say. French medical schools are turning them out at a much higher rate than needed to keep up the present ratio of 1 doctor for each 800 Frenchmen.

But the real squeeze in health care is developing here because of the shortage of other medical personnel. As one French physician describes it—

"In most full-time hospital services, the doctor cannot work in the afternoon because of the lack of nurses and orderlies. Operating theaters are shut down for lack of 'dressers.' Laboratory tests are delayed. Sometimes one radiologist must serve a hospital of 1,000 beds. Costly equipment lies idle for two thirds of the day, for lack of people to operate it."

SWEDEN: 1 OUT OF 2 POSTS VACANT IN SOME AREAS

STOCKHOLM.—Since 1955, Sweden's Labor Government has offered free hospitalization and low-cost medical care for everyone.

In addition, a patient's loss of income while under medical care is largely offset by generous cash benefits.

The result has been a booming demand for health services—and a persistent shortage of doctors. In the public-health service, over all, 1 physician's post out of 5 remains unfilled. And in some remote areas, vacancies are running as high as 50 per cent.

At least 10 percent of all nurses' jobs are unfilled, as well.

To cope with the problem, the Swedish Government is increasing pay rates for both doctors and nurses in the public-health service. Medical schools have increased their facilities and begun to take more students. In addition, more nurses are being trained.

Nevertheless, one official warns that Sweden's "health crisis" is likely to persist in the 1970s, "as more and more people seek medical services for less and less serious ailments."

ITALY: A SERIOUS LACK OF WELL-TRAINED NURSES

ROME.—In Italy, the supply of doctors is adequate for those who can afford them in the big cities, but scarce in the poor, rural areas.

In the mountainous regions and in the South, where the level of incomes is low, one public-health doctor often serves 4,000 to 5,000 patients.

But the worst shortage in the medical field is the lack of well-trained nurses. Throughout Italy, there is a 40,000 gap between the number of trained nurses needed and those available.

[From the Washington Evening Star, Nov. 6, 1969]

MEDICARE PRICE RISE UNKINDEST CUT

(By Judith Randal)

The administration's decision to raise Medicare premiums may seem to be justified by the speed with which health-service costs have been rising, but a close examination of what is likely to ensue is enough to give anyone the chills. No matter how you slice it, the elderly, most of whom live on fixed retirement incomes and therefore can least afford it, will be paying more and getting less.

Nor is there anything in the government's announcement to suggest that jacking up health insurance prices for the old folks will not continue.

If government were making more than half-hearted efforts to insure that its health-care dollars were being wisely spent; if any but the most token attempts were under way to match the health system to the nation's needs, the increases might be in the public interest.

But Department of Health, Education and Welfare officials—while they talk a good game—seem unable to find a handle to grasp problems so complex. It is far simpler just to raise the prices and leave the elderly to cope as best they can.

Next January, for example, anyone entering a hospital expecting the bill to be met by Medicare will have to pay $52 instead of $44 before the coverage takes effect—$12 more than the $40 he would have had to pay in July 1966, when Medicare began.

And if he is so unfortunate as to have to stay more than two months, it will cost him $13 a day instead of the present $11 to do so—this at the very time when both his health and his finances are at their lowest ebb.

The 10 percent boost in Social Security benefits proposed by the Nixon administration would, some may argue, offset these increases. But with the cost of living rising as it has been for so long and many elderly people at or below the poverty level, this hardly makes sense.

The purpose of Social Security is to give people the decent standard of living they have earned from a lifetime of work and contributions to the program. The monthly stipends are by no means charity. Besides, experience shows that when the federal government increases the payments, welfare payments in many states fall by a like amount, leaving the aged no better off financially than they were before.

Furthermore the outlook for Part B of Medicare—the insurance portion for doctors' bills, as opposed to hospitalization—is even gloomier. Starting next July, the monthly premium is to be increased "substantially," probably to more than $5. (It is now $4.)

Considering that Part B covers only 80 percent of a physician's bill anyway and that the costs of medical care keep going up—they rose 7.7 percent between September 1968 and September 1969—it is hard to escape the conclusion that doctors could become a luxury which even many "protected" by Medicare would be unable to afford.

The situation is complicated by the fact that the Blue Cross and other policies which millions have bought to supplement their government insurance are also bound to increase in price, thus exerting an extra strain on the already limited reserve of the retired citizen's pocketbook.

When the Medicare law was written, it was wisely decided to provide coverage not only for doctors' bills and hospitalization, but also for recuperation in nursing homes and so-called extended care facilities. Many people cannot be restored to health if released to their homes directly from the hospital, but thus can be spared invalidism at less cost than long-term care in a general hospital would impose.

Now a patient who stays more than 20 days in such an institution will have to pay $6.50 a day for care instead of $5.50. When you are old and living at the poverty level, these dollars add up.

What are the alternatives in the face of very real inflation? Certainly, there are no easy answers. But meeting rising costs by penalizing beneficiaries can hardly be what the architects of Medicare had in mind. The coverage was none too generous in the first place, and to further limit it is downright cruel. One wonders why, when for years the Post Office Department has been heavily subsidized, the elderly have been singled out as the group which must pay its own way.

Why, instead of cutting benefits, could the administration not suggest that Congress dip into the Treasury funds to whatever extent necessary in order to maintain health benefits at no additional cost to the people whose very lives depend on them? And why should not the people and institutions providing health care set for themselves the goal of giving Medicare beneficiaries what Congress has said is their due?

Admittedly, it would take a massive effort to revamp the present health care system to meet community needs. But with more emphasis on action and less on lip service and intraprofessional rivalries, it surely could come to pass.

In ancient times, people too old and too ill to be productive were taken to the tops of mountains and left there with three days' food to die. Willy-nilly, the United States seems headed in the same direction.

[From the Washington Post, Nov. 7, 1969]

HEW Aide Blasts Medical Industry Over Health Costs

(By Stuart Auerbach)

A top federal health official warned yesterday that the government will be forced to step in if the nation's health industry fails to provide better medical care at a lower price for all Americans.

In strong tones, James H. Cavanaugh, deputy assistant secretary of Health, Education and Welfare, told a symposium on health costs attended by health industry leaders that:

"Groups like those represented here today are facing a wholly new task . . . the most critical task that you have ever faced. You are being asked to keep a pluralistic, public-private health care system from dying . . . from being swept away by its own failure to serve the health demands of the American people."

The federal government, he said, wants to be part of the system—"one among equals." But, he declared in no uncertain terms, the private sector must do its part.

The $53-billion-a-year health industry needs "substantive change" in the way it supplies medical care to Americans in the way that care is financed and in the training and use of its manpower, Cavanaugh said.

The HEW official's warning was apparently understood by participants in the symposium, sponsored by the National Pharmaceutical Council.

Dr. Gerald D. Dorman, president of the American Medical Association, said he opposes a single health care system for the nation—whether it is run by the government in Washington or the AMA from its Chicago headquarters.

Ray E. Brown of Harvard, a former president of the American Hospital Association, challenged doctors to cut costs by setting norms for the lengths of hospital stays—the most expensive element in health care.

He cited as a "ridiculous situation," the fact that children in Washingtn spend twice as much time in the hospital as Baltimore patients when they have their tonsils removed. He also said maternity cases stay in the hospital in California twice as long as women in New England.

In a luncheon address, Rep. Paul G. Rogers (D-Fla.) asked the AMA to use its prestige to support programs to train paramedical personnel to ease the shortage of doctors and nurses.

Rogers attacked the health care industry as "poorly administered and rather poorly managed." He also attacked the Nixon adiminstration for failing to set high enough priorities for health care in the nation.

"It is unfortunate," he said, "if we set other priorities at the expense of stemming sickness and disease."

[From the New York Times, Nov. 10, 1969]

Public Health Group Chides A.M.A. on Nation's Medical Care

(By Richard D. Lyons)

Philadelphia, Nov. 9.—The first step toward what may be a challenge to the American Medical Association for the leadership of the nation's health care was made today by the American Public Health Association.

Leaders of the Public Health Association, whose membership of 24,000 could hardly rival the A.M.A.'s 220,000 on power, finances and number, said that they were not seeking a power struggle with the nation's doctors.

But the association's two top officials, physicians in an organization that has relatively few doctors of medicine as members, said in effect that the A.M.A. was not living up to the challenge of bringing modern medical and health care to all Americans.

"The A.M.A. is not doing the sort of thing it should have been," said Dr. Paul B. Cornely, the association's president-elect. "A start has to be made [on fully meeting the nation's health needs] and has to be made now."

97TH ANNUAL MEETING

Dr. Cornely, a professor of preventive medicine at the Howard University College of Medicine in Washington, spoke at a news conference opening the association's 97th annual meeting at the Civic Center here.

Dr. Lester Breslow, the association's president and a professor of health services administration at the University of California's School of Public Health in Los Angeles, also spoke at the conference.

They stressed that they were not trying to act as a rival organization to the A.M.A., and would join with the medical association if their interests coincided.

"But the A.M.A. in the past has come on with approaches not to our liking," Dr. Cornely said. He noted that the A.M.A. appointed a "committee on health care for the poor only a year ago."

"We would like to be the spokesmen for health, not necessarily medical care," he said.

The two doctors said they wanted to expand the association into "an informal alliance" that would include not only doctors but also nurses, hospital administrators, air and water pollution experts and other health professionals, as well as representatives of consumer groups.

Dr. Breslow also said that the association "would like to bring in as many doctors as possible who are concerned with public health." The association has about 5,000 members who are physicians.

They said most groups interested in health, including the public health association, are fragmented and urged not only an alliance but also a tightening of their own organization. Dues have been raised and the association in proposing a broader-based membership that would be at least double its present number.

For 18 months the association has been studying the direction in which it was heading and what it believed to be the areas in which it should concentrate. Today's announcement was a distillation of what changes were believed needed.

CHANGING EMPHASIS

"We see the need for a linking up of the health professions," Dr. Cornely said. "Professionels are not moving in our group."

"We would like to shift the emphasis from 'medical care' to 'health care,'" he added.

Dr. Breslow said that the association would "provide a home for consumers who want to advance health."

The association has invited 80 consumers and students to attend the five-day meeting as guests and participants in discussions of current health problems.

"Our society is a lobby-pressure society," Dr. Cornely said, adding that "we need a lobby."

Dr. Cornely, who with Dr. Breslow, recently made a nationwide tour of communities and health facilities, said that health conditions in this country "really are in bad shape."

He said they were concerned not only with the quality of health care, but also with the lack of health manpower, housing and air and water pollution problems.

Neither Dr. Cornely nor Dr. Breslow are members of the A.M.A. Dr. Breslow said he was a member until two years ago, when he allowed his membership to lapse.

[From the New York Times, Nov. 7, 1969]

GOVERNOR SETS UP HOSPITAL AID PLAN—2-MONTH PROGRAM IS AIMED CHIEFLY AT SLUM AREAS

(By Douglas Robinson)

Governor Rockefeller announced yesterday a two-step program designed to provide immediate financial aid for hospitals throughout the state and particularly in slum areas.

The Governor's program provides for a $6-million increase in funds for the State Ghetto Medicine Program and increased operating advances to voluntary hospitals for care furnished Medicaid patients.

The Ghetto Medicine Program, which has been in operation for about a year, authorizes municipalities to contract with voluntary hospitals for the operation of out-patient clinics in slums.

In its year of operation, the program has been limping along on an initial authorization of $425,000.

A statement issued by the Governor's office said many of the out-patient clinics "are now operated at a deficit." The Governor's plan, the statement went on, would allow municipalities to assume the deficit and be reimbursed by the state under existing state-aid formulas.

The statement quoted Mr. Rockefeller as saying that "special attention will be given to New York City, where the need is particularly great."

The other part of the two-point program called for speeding advances on unprocessed Medicaid bills of voluntary hospitals and will have the effect of mak-

ing more operating funds immediately available. The cost of this program comes out of funds already allocated for Medicaid.

At present, local social service districts may advance up to 75 per cent of Medicaid bills submitted by a hospital. To cover these costs, the state makes advances to local districts during the last week of each month of 100 per cent of the estimated Federal Medicaid share and 80 per cent of the estimated state share.

REPAYMENTS OF 100 PERCENT

Under the Governor's plan, the state this month and next will immediately repay a locality for 100 per cent of both state and Federal shares of any advance payment made to voluntary hospitals for unprocessed bills.

The Governor, in the statement, estimated that if all voluntary hospitals requested such advances, it could mean as much as $38-million in operating capital being made available.

The two-point program will be in effect only during November and December. The impact of both parts will be measured in January, and the funds will be reduced over a three-month period to their present levels, the statement said.

In a speech yesterday to the Queens Chamber of Commerce, the Governor, while rejecting Mayor Lindsay's request for a special session of the Legislature to restore cuts in welfare and Medicaid programs, said there was an "over-run" in the state budget this year of $35-million to $40-million.

Mr. Rockefeller said that "through executive action we will be able to use some of this money to help in needed areas."

A spokesman for the Governor said that the $6-million for the Ghetto Medicine Program came from the excess funds in the budget.

In a news conference preceding his speech, the Governor, asked about criticism in Harlem over construction of a state office building, said the project "has the support of the major groups in Harlem."

He went on to say, however, that it might be possible that about half the excavated block at 125th Street and Seventh Avenue could be developed for housing, small shops and other uses, "which will reflect the total best interests of the community."

[From the New York Times, Nov. 9, 1969]

SHORTAGE OF PHYSICIANS—NEED FOR MORE DOCTORS IS HEIGHTENED BY PROSPECT OF WIDER MEDICAL PLANS

(By Howard A. Rusk, M.D.)

Over the past two decades there has been growing evidence that our nation's supply of physicians has not been sufficient to meet the health needs and demands of our people.

This has resulted from an increasing population, growing recognition of the desirability of medical services by individuals, increased ability of individuals to pay for medical services, wider voluntary health insurance coverage, and a number of Federally aided medical care programs such as Medicare and Medicaid.

Recently (Oct. 19) this column was devoted to a discussion of the numerous proposals for national compulsory health insurance.

Even more recently it has been disclosed that President Nixon would himself recommend some such form of insurance on a massive scale following the pattern of his proposals last summer to solve the nation's welfare crisis.

The President has already asked the Secretary of Health, Education, and Welfare, Robert H. Finch, to have an advisory group now studying Medicaid also tackle the complex problem of long-term finances of medical care services.

PROBLEMS HIGHLIGHT

The problems of the existing Medicare program was highlighted in New York this week when Mayor Lindsay, following his re-election, asked Governor Rockefeller to call a special session of the New York State Legislature to consider restoring cuts in Medicaid and welfare.

In a hearing in Albany, New York City's Commissioner of Hospitals, Joseph V. Terenzio, termed the present program a "nightmare" of administration.

Commissioner Terenzio asserted that under the present regulation of Medicaid it was more difficult to give the needy medical services than prior to Medicaid,

when the full cost of medical services to the city's indigent patients was borne by the city.

Mr. Terenzio also suggested that the present medical program should be replaced with the Universal Health Insurance Program.

Irrespective of the final course of action, whether it be returning to more liberal standards of Medicaid or adoption of Universal Compulsory Health Insurance, there is going to be another sharp increase in the demand for physician services.

All of this, ironically, comes when cutbacks, both directly and indirectly, of Federal aid to medical education have further compounded the financial crisis of our nation's medical schools.

Early last week, Senator Jacob K. Javits, Republican of New York, met with the deans and representatives of all the medical schools in New York State to discuss their financial plight.

Senator Javits has proposed a Compulsory Health Insurance Plan patterned after Medicare. He has also proposed emergency legislation establishing a fund of $100-million a year for the next four years to be used to "save medical schools that are on the point of closing because of lack of funds."

The Senator told the conference candidly that his proposals would not solve the long-range problems of the medical schools but were primarily emergency measures.

While the Federal Government is engaged in studies on the future of Medicaid and the possibilities of voluntary compulsory health insurance, it is at the same time actually cutting the funds essential to maintaining our present number of medical school graduates.

Under the Health Professional Assistance Act, the Federal Government allocated $14,240,726 for loans to medical students in the fiscal year that ended June 30, 1969. The budget for the current fiscal year, ending June 30, 1970, is but $8,560,565. This is a decrease of $5,680,161.

The $8,560,565 allocated for the current fiscal year is $13,553,310 less than the $22,113,875 requested. The allocation is but 39 percent of the amount requested as compared to 74.8 percent last year.

All of this means that the number of students assisted in 1969, 12,375, is being dropped by 5,395 to a total of but 6,980 during the current fiscal year.

Last year 35 percent of our nation's medical students received loans. During the current academic year the number will be but 19 percent.

In attempting to justify this sharp decrease in funds for student loans, the Administration has taken the view that this year increased funds will be available to medical students through Federally subsidized guaranteed loans administered by the Office of Education.

In addition to the loans for medical students, the Federal Government also allocated funds for scholarships under which a student of exceptional financial need may receive a maximum award of $2,500 a year.

This year the Administration has requested 7.2-million for the current fiscal year, which is an increase of nearly $2-million over the last fiscal year.

FUND MOVE IN HOUSE

The House of Representatives, however, has directed that this proposed increase in funds for scholarships be transferred to funds available for loans. If this is done, this shift of funds from scholarships to loans would mean that commitments already made to schools and subsequently to students by the schools would have to be withdrawn.

For example, for the past three years there has been a concerted effort among medical schools throughout the country to increase their enrollment of students from minority groups.

One medical school in the New York area had been able to recruit a number of splendid students from minority populations. They found that the students were completely unable to sustain themselves and pay tuition without help.

With the cut in scholarship funds it was impossible for this medical school to admit the students, and they frantically called their colleagues in other schools to see if they could be admitted there, without avail. This instance points out graphically this incongruous situation.

There is no data currently available on the percentage of disadvantaged students now in medical schools who require scholarships and loans to enable them to pay their tuition fees and living expenses for the current year.

The Administration and the Congress should realize that it is futile to think about extending services for the medically indigent under Medicaid or to

contemplate a nationwide Compulsory Health Insurance Program unless at the same time sufficient funds are available through scholarships or loans to produce the medical and health manpower essential to its programs.

[From the Washington Post, Nov. 11, 1969]

HOSPITALS GET "KICKBACKS," HILL UNIT TOLD

Hospitals and nursing homes are demanding and receiving "kickbacks" from drugstores for providing prescriptions under federal health programs, the American Pharmaceutical Association testified yesterday.

In testimony before the House Ways and Means Committee, spokesmen said cash is passed "under the table" from drugstore owners to institutions to win lucrative contracts under Medicare and Medicaid programs.

Jacob W. Miller, a Topeka, Kan., druggist who heads the professional association's public affairs committee, said after his testimony that the "kickback" demands are being made in "every state." Carl Roberts, who heads the APA's legal division, also added in an interview that "it's big money."

Miller said the practice is running up the high costs of drugs, since in some cases, the druggist is pushing up his prices to meet the kickback demand.

All druggists and all hospitals and nursing homes aren't involved, Miller said. "However, the most bitter complaints we have received are from pharmacists who have, in fact, been subjected to 'kickback' demands," he explained.

Nearly $50 million in prescriptions is dispensed annually to nursing homes and other extended care facilities under the Medicare program. In turn, the hospitals get reimbursed for the "in-patient" drug costs. A Medicare patient who is not hospitalized cannot be reimbursed for his drug costs.

Miller said nursing homes and hospitals without their own pharmacies must go to community drug stores for their medicines. "Many pharmcists have been unable to obtain these contracts without being solicited for 'under the table' payments," Miller revealed.

[From the Washington Post, Nov. 14, 1969]

MEANY BLAMES SPIRALING HEALTH COSTS ON "PROFITEERING," NOT WAGE RISES

(By Eve Edstrom)

AFL–CIO President George Meany yesterday blamed "profiteering by providers of medical care" and not the rising wages of hospital employees for spiraling health costs.

"There is something indecent about a small group of people making a lot of money out of the misery of other people," Meany said. ". . . This indefensible escalation of medical costs is depriving millions of Americans of the health care they need."

Both Meany and I. W. Abel, president of the AFL–CIO's Industrial Union Department, declared the time is overdue for a national health insurance plan. They spoke at the opening session of the IUD's two-day conference on the "Crisis in Health Care" at the Shoreham Hotel.

Another speaker, Dr. Jerome Pollack of Harvard Medical School, said the nation has been "so conspicuously slow" in adopting a national health plan that current discussions center on schemes that "would almost have been passe in the late 1930's."

Dr. Pollack warned that the country will be in "serious trouble," if it only sponsors a plan to pay for health care. The financing mechanism, he said, "must include ways to deliver care, such as wider use of group practice plans. If it does not," he said, "the National health bill will continue to spiral with no relative improvement in services."

Meany said it is becoming popular to blame increased hospital costs on the rise in wages of hospital employees. But hospital wages have gone up only about half as fast as total hospital costs, Meany said.

"Hospitals workers were—and all too often still are among the lowest paid and most exploited workers in America," he emphasized.

Meany blamed the doctors' fee-for-service system and cost-plus hospital reimbursement plans for sending health prices skyward.

Meany and Abel called for a comprehensive health care plan for all Americans, financed under Social Security but with general Treasury support to pay for the care of the poor.

[From the Washington Post, Nov. 17, 1969]

HEW Urged To Improve Health Care

(By Eve Edstrom)

Use of Medicaid and possibly Medicare dollars to provide health services instead of just footing rising hospital and doctor bills was recommended yesterday by an advisory task force to Health, Education, and Welfare Secretary Robert H. Finch.

The money would be spent initially in areas with large numbers of poor persons and would support services of proven capability, such as medical group trust plans and home health-care programs.

In calling for a major departure from present policy, the task force said federal programs that create a demand for health services should assume some of the responsibility for supplying them.

The task force, headed by Blue Cross Association president Walter J. McNerney, emphasized that federal programs currently reinforce costly health-care systems, do not discourage waste and put roadblocks in the way of payments or less expensive but efficient methods for health care.

"Medicaid and related programs such as Medicare should not be merely conduits for funds which reinforce the inadequacies of the existing health care system, but should be used as instruments to improve the system," the task force said.

As a beginning, the task force recommends legislation to make available 5 per cent of the federal Medicaid appropriation each year to develop health services.

Based on the present fiscal year expenditure of $2.6 billion, this would have freed $130 million to help supply alternatives to costly in-patient hospital care.

Eventually, the task force said, all private and public programs that influence the demands for health services should set aside a proportion of expenditures to improve services.

In the wake of numerous revelations concerning Medicaid abuses, the task force was named last summer to make both short-term and long-term recommendations on improving and controlling the cost of Medicaid, the federal-state program providing health care for the medically needy.

Later, as administration concern mounted over the nation's health care crisis, the task force was given a broader mandate, including an examination of the feasibility of a national health insurance plan.

Its recommendations on universal health insurance are expected to be made early next year. But implicit in the interim recommendations released yesterday was the suggestion that the nation must not pour more dollars into another program to finance care without making significant changes in ways to provide care.

The interim recommendations focus primarily on Medicaid, with the task force finding that surveillance over the quantity and quality of services "is often inefficient, fragmented, and exacerbated by incomplete federal policy and guidance."

Besides making several recommendations to strengthen federal policy, the task force said HEW should be more aggressive in encouraging states to take advantage of Medicaid's provisions that reward economical operations.

In particular, the task force said there sould be new experiments in payment methods for doctors. In addition to paying doctors their traditional fee for service, the task force said states should experiment with fee-for-time payments and group-plan payments.

The task force also urged that states be prodded to shelve outdated standards of care which now force patients into costly hospital facilities. These patients, for example, might be adequately cared for through neighborhood health centers supported by the Office of Economic Opportunity. But many states bar Medicaid payments for services provided by the centers.

Medicaid, the task force said, "must be more concerned than it has been with the quality of care which is purchased under the program." Among its many recommendations in this area is one that would deny federal Medicaid payments to chiropractors and naturopaths.

The task force found that many of Medicaid's difficulties relate to its being operated as a "passive" payment program under welfare departments instead of being tied to other health programs.

Therefore, the task force recommended establishment of a new unit in the office of the assistant HEW secretary for health and scientific affairs to set policy for all federal health programs, including Medicaid.

The task force also expressed concern over the "undignified, callous and indifferent treatment" received by many Medicaid patients, and it suggested ways to simplify eligibility procedures to preserve the self-respect of applicants. It also said more low-income persons and other consumers of health services should sit on health advisory committees.

[From the Wall Street Journal, Nov. 19, 1969]

Medicine in Crisis

Nearly everyone now agrees there is a crisis in medical care: Shortages of facilities and personnel, rapidly soaring costs. No such unanimity exists, however, as to just what should be done.

The trouble is by no means new. For more than a decade medical-care costs have been climbing more swiftly than other components of the cost of living; the general price inflation in recent years has given medical and hospital outlays a strong upward shove.

The roots of the problem are complex and intertwined. For one thing, the $53 billion-a-year health industry has been slow to adjust to fast-growing demand. This demand has been augmented, suddenly and immensely, by Medicare and Medicaid, but those programs were not the only factors.

The industry's scientific advances, for example, have outpaced its management capability. Doctors and hospitals can do so much more for so many people now than they once could—if only they could provide the space, equipment and personnel to handle them. Rising incomes and the spread of private health insurance, moreover, greatly increased the public's ability to pay for health care long before the development of Medicare and Medicaid.

Hospitals and medical schools already draw a large part of their financing from the Federal Government. In a recent interview with U.S. News & World Report, Dr. John A. D. Cooper, president of the Association of American Medical Colleges, strongly urged that this Federal support be increased, and perhaps it will have to be.

At the moment, though, the overriding reason for restraint in Government spending is the need to check inflation, which is now doing so much to worsen the medical crisis. Both for now and for the future, hospitals and the medical profession must take steps to improve their efficiency.

Dr. Cooper touched on some steps that are being tried. Stanford University is experimenting with an MD program, taking into account the knowledge the student already has and what his interests are, that may enable many students to complete medical school in less than the usual four years.

In a number of areas nurses are taking over some of the tasks usually performed by fully qualified doctors. Health-care "teams," composed of doctors, nurses and technicians, allow a more economic use of available personnel.

Modern management methods are finding their way into more hospitals. Private clinics, some small and some large, allow doctors to share sophisticated and costly new equipment. Except in a few nonurban areas, the exigencies of the situation probably are forcing the elimination of the old personal relationship with a single family doctor.

The health industry long has made poor use of its personnel. At the levels of nurses and technicians, salaries have been low in relation to the skills required; this deficiency is gradually being corrected, which is still another factor contributing to the rise in medical costs.

If the higher costs lead to a larger more effective work force, the money will be well spent. Dr. Cooper thinks the chances for such a result could be enhanced if more opportunities were provided for nurse's aides to become nurses and for nurses to become doctors.

No one suggests that the effort will be easy, but there is ample reason to regard it as essential. James H. Cavanaugh, Deputy Assistant Secretary of Health, Education and Welfare, recently put it bluntly to a group of health industry leaders: "You are being asked to keep a pluralistic, public-private health care

system from dying . . . from being swept away by its own failure to serve the health demands of the American people."

In other words, if the industry doesn't do the job the Government, able or not, will try to do it. Fortunately, at least some Federal officials realize that the Government, in the meantime, should not add to the industry's trouble with something like universal health insurance. As Dr. Roger O. Egeberg, Assistant HEW Secretary, says, "If we can't handle Medicaid and Medicare, how are we going to handle a national health financing system?"

The Government already has complicated the crisis quite a bit. Everyone's obligation now is to try to effect a cure.

[From the Washington Post, Nov. 23, 1969]

Malpractice Suits Affect Medical Care

(By Morton Mintz)

A sharp increase in medical malpractice suits is having major impacts on traditional physician-patient relationship and on the cost and quality of health care.

This is a key finding in a 1,047-page report issued by the Senate Subcommittee on Executive Reorganization.

The report, entitled "Medical Malpractice: The Patient Versus the Physician," offers evidence that fear of lawsuits is stimulating the practice of "defensive medicine."

HEADING OFF LITIGATION

The Department of Health, Education, and Welfare, for example, told the subcommittee that some doctors try to head off possible litigation by ordering unnecessary and expensive X-rays, laboratory tests, and hospital and nursing care.

At the same time, other doctors are said to turn away patients with a high potential for litigation and to avoid diagnostic procedure that they believe to be necessary but that cannot be performed without a degree of serious risk to the patient.

Several subcommittee sources identified as a root of the growing malpractice problem a change in the image of the physician from healer to businessman.

Crawford Morris, a Cleveland lawyer who has spent years defending doctors and hospitals against malpractice litigation, told the subcommittee:

"It is common knowledge today that almost all doctors are making enormous amounts of money, refuse to make house calls, play golf on Wednesdays, drive expensive cars, own yachts, hunting lodges and apartment houses.

"IMAGE SADLY TARNISHED

"The doctor's image is sadly tarnished.

"Once thought of as 'the old country doctor driving through the rain all night to sit beside a sick patient,' they are now thought of as 'supersuccessful businessmen.'

"This, perhaps subconscious, attitude make patients more willing to sue their doctors and make juries more willing to return a verdict, and one of considerable size, against doctors."

In an introduction to the report, the subcommittee chairman Abraham A. Ribicoff (D-Conn.) said that the increase in malpractice suits "threatens to become a national crisis" and may lead to federal involvement, possibly in the form of a government-aided mechanism to reinsure private carriers.

It was at Ribicoff's direction that the subcommittee staff made a nine-month study of the problem. The report draws on statements from lawyers on both sides of malpractice cases, insurance firms, the American Medical Association, the American Hospital Association and HEW.

RISING NUMBER OF CLAIMS

Eli P. Brenzweig, HEW's specialist on malpractice, told the subcommittee that "it is becoming increasingly clear that the rising number of malpractice claims is significantly affecting the entire health care delivery system.

"In one way or another," he said, the claims "are affecting the costs of health care, the quality of health care, the attitudes of the public toward physicians and

nurses, the prescribing practices of physicians, the costs and availability of malpractice insurance, utilization rates of hospitals, trial techniques in malpractice cases, approaches to medico-legal education, and numerous other consequences."

Some of the major findings in the report:

Although precise national figures are unavailable, the degree of proliferation of malpractice suits is indicated by reports from insurance companies. The Nettleship Co., a Los Angeles firm that insures 11,000 M.D.s in southern California had one claim for every 20 doctors insured in 1957. This year, it will have one claim for every 10 physicians. Aetna Life & Casualty reported a 43 per cent increase in claim frequency since 1964.

The size of judgments and settlements is skyrocketing. In 1964 the Nettleship firm incurred an average closing cost per claim of $2,991; in 1968 it was $5,333. Aetna reported that its average cost of settling a claim has increased 200 per cent in five years. Employers Insurance of Wausau, a Wisconsin firm that insures more than half of the licensed physicians in New York State, said that the average claim it paid (excluding no-cost settlements) in 1964 was $6,051, compared with $12,768 in 1968.

The larger number of claims and the higher price of settling them are resulting in higher charges for insurance coverage. In Utah, premiums for general surgeons this year are $3,910—13 times the $294 charged last year. Nettleship's premiums for the same category went up 110 per cent last month, from $1,900 to $3,900. This figures out to 85 cents per patient per year compared with 43 cents previously. Surgeons rated as "substandard risks" pay premiums averaging between $8,000 and $10,000 a year.

Nettleship's average premium was $367 in 1964, $748 in 1968 and $1,200 in 1969. Employers Insurance of Wausau's average premium was $253 (for coverage limits of $8,000 to $240,000) in 1964, compared with $436 (for coverage limits of $450,000 to $1,350,000) in 1968.

Sen. Ribicoff said the evidence convinced him that most malpractice suits "are the direct result of injuries suffered by patients during medical treatment or surgery," that the majority "have proved justifiable," and that the indirect cause of such suits is "a deterioration of the traditional physician-patient relationship."

CATALOG OF DISASTERS

The report contains a catalog of medical disasters that left patients dead, permanently disabled or seriously hurt.

David M. Harney, a Los Angeles lawyer who has represented patients for 17 years, provided the subcommittee with 40 examples, including these:

"Case No. 12.—Man goes into hospital for elective simple surgery and 'ghost' surgeon operates . . . trainee anesthesiologist runs out of oxygen . . . patient suffers cardiac arrest, goes into a vegetative state, and dies one week later."

"Case No. 18.—Young woman rising in her career as a professional singer undergoes tonsillectomy . . . by a surgeon who is a chronic alcoholic (unknown to patient) and tissue unrelated to tonsils is removed, ruining patient's voice and her career."

"NEGLIGENT PRACTITIONERS

Harney said that the increase in malpractice actions "will continue so long as the medical profession permits negligent practitioners to continue in business." At the same time, he said, "The No. 1 reason" for the increase is probably "public awareness that medical negligence does exist."

Harney said that he has never heard of a single physician in California who was disciplined by a professional organization after being sued—even successfully sued—for malpractice.

Ribicoff said that "physicians, lawyers, and insurance companies alike would not speak for the record as to how well the medical profession has regulated itself." But, he said, "Privately, they feel that the physician and hospital staff regulatory mechanisms are wholly inadequate."

Last year, state boards of medical examiners revoked the licenses of 64 of the nation's 300,000 physicians. An additional 59 license revocations were ordered but were stayed, allowing the disciplined doctors to continue to practice medicine.

SPECIALISTS VULNERABLE

Because of their specialities, certain physicians have a greater potential exposure to malpractice suits than others. Such specialists include orthopedic surgeons, general surgeons, neurosurgeons, anesthesiologists, obstetricians and gynecologists.

The American Medical Association emphasized changes brought by the times. "In former days, the family doctor was more likely to be a family friend," the AMA said. "Most patients wouldn't think of suing a family friend. Today the doctor is too busy to have many family friends," and the patient "may have a string of specialists" whom he is apt to regard as "impersonal businessmen."

[From the New York Times, Nov. 23, 1969]

HEW PERPLEXED AS MEDICAID "EATS UP FUNDS FOR OTHER AREAS"—RISING COSTS RAISE MANY QUESTIONS BUT SUGGESTS FEW ANSWERS—CUTBACKS IN RESEARCH AND TRAINING NECESSITATED

(By Richard D. Lyons)

WASHINGTON, Nov. 22.—When the Nixon Administration dismissed the head of the beleaguered Medicaid program last summer it bowed to rising criticism by Congressmen and state legislators over the health payment plan for the needy.

Medicaid, which was created by Congress almost as an afterthought to Medicare, was running out of control fiscally, and still is.

In its first fiscal year of operation, 1966, Medicaid cost $1.2-billion. The total is expected to be five times as high by next year and 10 times as much by 1975.

When Robert H. Finch, the Secretary of Health, Education and Welfare, first saw the Medicaid cost projections he reportedly threw up his hands in amazement. A committee he appointed to study the program issued its first report a week ago but recommended few changes that would immediately hold costs in line.

The ever-increasing cost of Medicaid, whose funds come from the HEW budget, is responsible for slashes in medical research funds, reductions in money to help train more doctors and other health professionals, and cutbacks in cash for programs that would attempt to remedy the nation's patchwork system of health care.

DEFICIT OF $350-MILLION

"The deficit in Medicaid this year is $350-million, which HEW has had to find elsewhere in its budget," Arthur E. Hess, deputy Social Security administrator, said recently.

This $350-million about matches the financial trims in research, training and services. Compared with the department's total budget, $17.4-billion, the amount seems small, but a majority of the total budget is an irreducible amount of money used to supplement Medicare and programs of direct financial assistance to persons on various forms of welfare, as well as Medicaid.

As the costs of Medicaid and Medicare rise beyond original predictions, funds for other programs of the department must be trimmed to fuel the medical payment plans.

Lewis Butler, who directs the department's planning, complained in an interview that "Medicaid eats up all our money—our budget is dominated by Title 19," as the program is called in federalese. The number refers to Medicaid's section of the Social Security Act.

Interviews with a dozen persons in and out of the Administration about the Medicaid program have elicited a general hand wringing about means of correcting the runaway costs of the system but few concrete suggestions as to how immediately to correct a program that has been without a leader for four months.

A JOB NOT IN DEMAND

An indication of the desperation caused by Medicaid is the dismissal of the director before a successor could be found. Since the formal resignation of Dr. Francis L. Land was demanded and received in July the Administration has yet to find a replacement, although many persons have been considered.

According to one perhaps whimsical account, when a Federal recruiter approached one prospect here with an offer he replied "not me" and fled in the opposite direction. To some persons, the idea of accepting the Medicaid directorship smacks of professional suicide. In addition, the salary for overseeing one of the world's largest medical payment programs is only $33,500 a year.

Dr. Land was held accountable, however illogically, for the skyrocketing costs of medical services over which he had no control, plus charges of mismanagement and administrative laxity that have led to fraud in some states.

"When I was in Washington there was exactly 87 persons in the Medicaid administration, and half of them were clerks," Dr. Land said in a telephone interview. "Even the states don't have an adequate number of administrators."

Even some Medicaid critics have conceded that the program's administrative difficulties stem from the lack of funds, which could be voted by Congress and the state legislatures, to hire an adequate professional staff to run the program. Mr. Hess has described Medicaid as being "underorganized and starved for manpower."

Dr. Land, now a professor of family practice at the University of Nebraska College of Medicine, in Omaha, forecast troubles for his successor, whoever he might be. "The way the program is set up the Federal share has to rise," he said.

Medicaid uses a mixture of Federal, state and local money to pay the medical and other health care expenses of those persons deemed by the states as unable to afford the services.

The Federal share of the cost varies from as little as half for the richer states to as much as 83 per cent for the poorer. As a rule of thumb, the Federal Government pays almost half the cost since Medicaid is most fully implemented in the richer states that, ironically, have larger numbers of poor residents.

This year Wisconsin will spend about $80-million of state funds on its Medicaid program, 20 times as much as Virginia, which has about the same number of residents.

About eight million Americans are now receiving some benefit from the Medicaid programs, which vary in comprehensiveness from state to state. Judgments on need are usually keyed to a person's or family's income. In some areas all dental care is covered; in some states only routine care is paid for, while in others no dental care is provided.

When a service is provided, the doctors, dentists or hospitals send a bill to the state or local agency responsible for repayment. Sometimes reimbursements require almost a year's wait. In some states lack of administrative staff prevents professional auditing of the bills and leads to fraud.

Dr. Land was quick to defend the philosophy of Medicaid, pointing out that "the program has provided a very much needed service in spite of the criticisms of mismanagement and alarming costs."

Even John G. Veneman, the Under Secretary of Health, Education and Welfare, said "it's drawing off our department's resources, but we all agree with the idea of Title 19."

According to one medical administrator, costs have risen rapidly not only because of the rising expenses of medical services but also because of the lack of comprehension when the program was enacted of "how badly in need of care the poor actually were."

CRITICISM OVER RED TAPE

Aside from cost criticisms, the major complaints about the program center on complicated eligibility requirements in the state programs, red tape, gouging by the dispensers of services, and strains placed on existing health services leading to complaints by patients of poor care and long waiting periods.

When the Medicaid program went into effect in New York persons were theoretically eligible for enrollment. But the legislature, stunned by the increasing costs, has tightened eligibility requirements three times so that now only 4.3 million persons can receive benefits.

The changes in eligibility require a huge reshuffling of paper work.

Many of those who are eligible but not enrolled in Medicaid have balked at filling out the forms certifying their levels of income and need. A small percentage of these forms usually are investigated for accuracy, a practice that could be personally embarrassing for the applicant even if he has replied honestly.

To reduce red tape, Mr. Finch's Medicaid study committee recommended that a potential recipient of Medicaid merely fill out a simple statement of need and that it be taken at face value. This would reduce the number of investigators needed.

The committee also complained that many institutions and medical professionals have been giving "callous and indifferent treatment" to the poor.

One survey of optometric care given Medicaid patients in New York City found about one out of six receiving unsatisfactory care. Dr. Lovell E. Bellin and Dr. Florence Kavaler of the City Health Department, who made the survey, estimated that 5 per cent of health professionals have abused the Medicaid system. Dr. Bellin said it was almost unavoidable that some small amount of money, 2 or 3 per cent, be wasted in such a huge program.

California's Attorney General, Thomas Lynch, made headlines by charging that between $6-million and $8-million was being lost yearly through fraud and abuse in the Medicaid program there. Yet this is only about 1 per cent of the program's annual cost.

CARE FOR FIRST TIME

Dr. Bellin pointed out that Medicaid in New York had many shortcomings, mainly increased costs, red tape and reimbursement problems. But he insisted that many of the poor were receiving some medical care perhaps not the best for the first time in their lives.

It is this demand for services that further escalates their expense. The demand for services has strained the source of supply, driving their cost up.

John W. Gardner, former secretary of Health, Education and Welfare, said the payment mechanism of Medicaid pits the patient's need against an almost inelastic source of medical services so that costs "skyrocket." Mr. Gardner believes that a revamping of the manner in which medical care is delivered may be the only way quality care will be given the needy.

Yet according to Dr. Bellin many of the needy are receiving decent care despite the cost. And as to cost, Dr. Bellin added that "you can't get quality medical care on the cheap." His point was that costs will continue to rise if Americans are determined to extend health care to all those who need it.

[From the New York Times, Nov. 25, 1969]

HUMPHREY URGES NATIONAL HEALTH SYSTEM OVERHAUL

(By Irving Spiegel)

Hubert H. Humphrey called yesterday for the establishment of a "health coalition," of experts in medicine and health to overhaul the nation's medical system.

The former Vice President proposed that the Government use the coalition to effect a long-range overhaul of medical programs that would enable every citizen to have "full access to humane and comprehensive health care."

The "health coalition," Mr. Humphrey said, would be composed of doctors, hospital administrators, pharmacists and patients "who can do for the health of the nation what the Urban Coalition hopes to do for our cities."

The former Democratic Presidential candidate spoke at groundbreaking ceremonies for a new wing at St. Barnabas Hospital for Chronic Diseases, Third Avenue and 183rd Street, the Bronx. The six-story structure for 188 patients will cost $10-million.

Mr. Humphrey held a new conference before the ceremony and invited Mayor Lindsay to join the Democratic party.

"I have a red carpet for him—and be sure to print that," Mr. Humphrey remarked, saying, "Lindsay has always been a Democrat but he never knew it."

At City Hall, a spokesman said that the Mayor has always been an enrolled Republican "and that on numerous occasions he has said he has no plans to change that enrollment."

Mr. Humphrey also reiterated his criticism of Vice President Agnew's attack on newspapers and television commentators.

"Vice President Agnew's attack smacks not so much of principle as it does of partisanship, not so much of fundamental philosophy as it does of a political attitude," Mr. Humphrey said.

Mr. Humphrey noted that President Nixon, in his Inaugural Address, asked for a "lowering of voices." Mr. Humphrey then suggested that President Nixon "call in some of the official family and tell them to hush up."

In his address at the ground-breaking ceremonies, Mr. Humphrey asserted that health care "should not be a matter of privilege," adding that "it is a right as basic as those itemized in the Bill of Rights."

Mr. Humphrey said that intensive health care "requires prompt action to relieve the most immediate injustices—those affecting the poor and the aged on fixed incomes."

"But," he said, "we cannot let those immediate needs blind us to the urgent long-range need to restructure our entire health-care system."

Mr. Humphrey said it was imperative for "medical statesmen to invade the jumble of unplanned, incoordinated, unsophisticated, unresponsive health-care system and come up with significant changes that enable us to utilize our health resources efficiently and economically."

Mr. Humphrey added that nearly all medical insurance programs—including Government-financed Medicaid and Medicare—provided "only a half-pound of care and never an ounce of prevention."

Later in the evening, Mr. Humphrey, appearing at a Brandeis University dinner at the Pierre Hotel, warned that education, "which once served as a means of ascendance for the poor, is in danger of becoming a bar to the new poor."

He said that as employers require more degrees for "more and more jobs, more and more of our less fortunate citizens are locked into menial jobs."

As a result, he added, educational institutions are increasingly unable to serve as "purveyors of equal opportunity."

The dinner honored Arthur G. Cohen, a New York industrialist who has established a fellowship at Brandeis.

Before his address at the groundbreaking, Mr. Humphrey was the guest of honor at a luncheon given by St. Barnabas at the Union Club, 101 East 69th Street.

[From the Afro-American, Dec. 2, 1969]

HEALTH IN ACTION—COMMUNITY PARTICIPATION HELD ESSENTIAL TO HEALTH PROGRAMS

About five years ago the Office of Economic Opportunity came out with what was considered a revolutionary approach in solving community problems. It was labeled community participation or citizen involvement.

There is nothing new about this concept, however, except that for the first time the black and the poor were to take part in policy-making. This was revolutionary.

The black community and the poor welcomed this concept. For years they had begged to be included on boards and committees that influenced their lives. However, there were problems.

Dr. James G. Haughton, Deputy administrator of the New York City Health Services Administration, in a recent speech at the annual meeting of the National Urban League in Washington pinpointed a few of these problems.

He said, "In the field of health care there was an initial attempt to defend nonparticipation on the grounds that the decisions to be made were technical decisions and only those with the necessary expertise could make them.

"This argument was, of course, not supportable when it was common knowledge that the boards of directors of hospitals were composed almost completely of laymen and furthermore that not all the decisions were technical ones."

But in addition to the expected resistance from those already in power, there were other problems and these problems were in the community itself. Dr. Haughton said he found that citizen participation in OEO Neighborhood Health Centers was marred by "incredible turbulence."

"I have had the opportunity of observing at close hand the development of a number of OEO health centers. In every instance community participation in the planning of the center has resulted in a delay in the beginning of services," Dr. Haughton said.

He described the "turbulence" as mostly in-fighting between factions of the community. In other cases projects were held up over trival matters.

According to Dr. Haughton, citizen participation should not be included in the planning stage of neighborhood projects because of these delays. "After the project is well on its way," he said, "is the proper time to involve the community."

While I agree with most of what Dr. Haughton has said, I cannot go along

with him on this point. It is in the planning stage that I believe the citizen to be served renders a most valuable service despite the delays.

For example, Dr. Dan Goodrich, coordinator of medical services at the West Oakland (California) Health Center, candidly admitted to me that without resident participation in the planning of the Center, it would have completely neglected two vital health services.

"A foot doctor, or podiatrist. And, now that I think about it I ask myself how could we (the medical experts) have overlooked such a basic need in a poverty community.

"Poor people spend more time on their feet than anybody in cheap shoes. They're bound to have feet problems," said Dr. Goodrich.

The other service which would have been left out of the Center was a physical therapy treatment setup. "Poor people are generally laborers with a lot of aching muscles," asserted Dr. Goodrich.

In a variety of projects around the country, community participation is being recognized as an essential element of community planning. And, as for delays, I cannot see it any worse than delays caused by establishment politicians and bureaucrats.

Community involvement at the poverty level is here to stay, and those who feel otherwise ought to catch up with the times.

[From the Washington Post, Dec. 3, 1969]

AMA Delegates Spurn Call for New Health Care Attitude

(By Eve Edstrom)

Denver, Dec. 2.—The American Medical Association today slapped down a panel of its most distinguished members who had spent 17 months drafting 57 recommendations aimed at changing the AMA's approach to the nation's health needs.

One of the key recommendations called for the AMA to stop merely justifying existing health care systems and to avoid dwelling on such time-honored terms as private practice, fee-for-service payments and free choice of doctors.

The 60-page report, which came before the AMA's House of Delegates today, contained so many statements offensive to the delegates that they sidestepped any discussion of its contents and, through a series of parliamentary maneuvers, delayed action on its recommendations until at least next June.

The unusually blunt report emphasized that:

"Until and unless the association addresses itself publicly, actively and objectively to the resolution of the very concrete problems that exist in health care, its attempts to justify present delivery systems and payment mechanisms will be incomprehensible both to the public and government, and will be interpreted as self-seeking on the part of the profession."

PRIVATE PRACTICE

But the AMA paid no attention to that warning. In fact, in an earlier action today, it agreed to begin an all-out effort to extol the virtues of private practice.

Implicit in that AMA action is its desire to preserve fee-for-service practice, which critics say is a major cause of escalating medical costs.

Along with this criticism has been an increased demand for prepaid group plans and salaried doctors to provide more efficient and economical care.

However, the AMA insisted that private practice "is still believed to be the best method of serving mankind's medical needs." And it established a Special Committee on Private Practice to get its message across.

COMMITTEE FUNCTIONS

The functions of the new committee include publicizing to patients the merits of private practice and developing new methods to promote private practice throughout medical schools.

The AMA's action on private practice underscored one of the basic criticisms of its policymaking House of Delegates, which was contained in the panel's report.

"The majority (of delegates)," the report said, "tend to be conservative in their political and social philosophies, and, almost without exception, are deeply concerned with preserving the traditions of their profession and their time-honored relationships with their patients."

"BILL OF RIGHTS"

The report, which was concerned with long range planning for the AMA, was prepared under the chairmanship of a Manhattan surgeon, Dr. George Himler, who previously has taken conservative positions but now states that the AMA "must shape up or face obscurity." Among members of its committee, was Dr. John H. Knowles of Boston, who was Health, Education and Welfare Secretary Robert H. Finch's first choice for assistant HEW Secretary for Health and Scientific Affairs.

Many of the committee's recommendations focused on the need for the AMA to assume leadership in finding new ways to deliver health care to all Americans regardless of their ability to pay. The AMA also was urged to establish a "health bill of rights," to identify services that should be included in any program of comprehensive care.

And the committee warned that if the public is not offered voluntary health insurance coverage at reasonable rates, it will sacrifice the person-to-person relationships with doctors and turn increasingly to government programs.

[From the Washington Post, Dec. 4, 1969]

U.S. CUT IN FUNDS PERIL FACULTIES, DOCTORS SAY

(By Victor Cohn)

In the face of a shortage of 50,000 doctors in the United States, federal funds to train medical school faculty and advanced medical specialists will be down a painful "20 to 30 per cent this year at a minimum."

This gloomy estimate came yesterday from Dr. John A. D. Cooper, president of the Association of American Medical Colleges, in one of the most serious indictments so far of Nixon administration's health policy.

The result, Cooper said, will be "an even more severe faculty shortage," when medical faculties are already short more than 2,000 doctors.

Dr. Michael DeBakey eminent heart surgeon of Baylor Medical College, Houston, said the cuts mean "2,000 men sorely needed as junior faculty for our presently expanding and new medical schools, will not be trained."

Cooper and DeBakey were among witnesses who told a Senate appropriations subcommittee headed by Sen. Warren G. Magnuson (D-Wash.) that federal health cuts will sorely affect medical manpower and care.

Dr. Mary Coleman of Children's Hospital here said she expects to have to turn away children with mongolism and dystonia, a crippling muscle disorder now being treated with research drugs. Her plea was backed by some 30 mothers accompanied by their mongoloid children and babies.

Dr. Sidney Farber, immediate past president of the American Cancer Society and Dr. Solomon Garb, scientific director of the American Medical Center at Denver, said the government is "choking off cancer research" and "letting down" cancer patients.

The national doctor and nurse shortage is already critical, testified Dr. Abraham Bergman of Seattle, and "the men with the green eye shades at the Bureau of the Budget are telling you we should fight medical care costs by further aggravating the manpower supply."

By cutting health funds, he charged the administration is "playing Russian roulette with the health of the American people."

Cooper reported that there are now 101 U.S. medical schools, but some are new and have only part-faculties. Five more are "in development or planned, and in the next 10 years there will be 10 or 15 more."

[From the Washington Post, Dec. 4, 1969]

AMA Backs Health Care for Poor But Stands Pat on Other Issues

(By Eve Edstrom)

Denver, Dec. 3.—The American Medical Association today took a substantial step forward in supporting an action program to provide health care for the poor, but stood pat on numerous other issues.

In the field of smoking and health, it rejected a resolution calling for an end to radio and television advertising of cigarettes and the discontinuance of federal subsidies to tobacco growers.

It also agreed to maintain its ties with the tobacco industry on research projects, although there had been earlier arguments at a work session that the AMA is "being tainted" by its $18 million contract with the cigarette manufacturers.

On abortion law reforms, the policymaking House of Delegates, which ended a four-day meeting here today, took no stand in support of efforts to liberalize state laws.

Instead, the delegates retained a 1967 policy that approves abortions if the physical or mental health of the mother is in danger. The 1967 policy had replaced one that had been on the books since 1871 and that stated the AMA denounces the conduct of abortionists and "holds no intercourse with them professionally."

While much of the discussion here centered on the AMA's need to change its image, the AMA agreed that one of its attempts at image-changing had been so costly it should be scrapped.

That attempt was the AMA's establishment of the Institute for Biomedical Research in Chicago in 1963. At that time, the AMA was concerned that the public looked upon it as a trade union of doctors.

Therefore, the institute was set up to enhance the AMA's image as a proponent of scientific knowledge. But delegates agreed today that the institute, headed by Nobel laureate Dr. George W. Beadle, was a "financial burden" costing more than $1 million a year, and should be discontinued as soon as possible.

As is usual at most AMA sessions, delegates spent much of their time debating their own pocketbook issues.

They were particularly incensed at the Senate Finance Committee, which probed Medicare and Medicaid costs earlier this year. Large payments made to doctors under both programs were revealed, and eventually the names of some of the doctors became public.

In committing itself to an action program for the health care of the poor, AMA adopted several new policies.

These include programs to attract and retain doctors in slum areas, to develop educational materials related to the cultural backgrounds of the poor, to support adequate nutrition services and to increase the participation of minority group doctors in AMA activities.

[From the Washington Post, Dec. 13, 1969]

Health Care Costs Inflated by Dollars Without Doctors

(By Joshua Lederberg)

The health budget of the United States is now about $60 billion a year. At the one-third mark in the transition from private to public responsibility for citizens' health, it is obvious, however, that the benefits of health services are very unequally distributed among rich and poor.

We do not have adequate indicators of health status, for health depends on the quality of the environment, the style of life, preventive measures and the genetic endowment more than it does on medical care. Nor may we dismiss the truism that poor health reinforces poverty by draining earnings. However, if we need statistics to buttress our commonsense observations, we have the shameful range in infant mortality, from about 19 per 1000 among Midwestern whites to 55 per 1000 among Mississippi rural blacks.

If money were all that was needed, we might seek about $40 billion more to give the entire population the same standard of care under the present system. Our experience with Medicare, however, has shown that pushing dollars into the consumer side of the system will inevitably inflate the power is the bottleneck item.

Medicare and Medicaid were not enacted as parts of a carefully designed improvement in health care, for they made negligible provisions for increasing medical services and manpower. The have had some desirable side effects—for example, in modernizing the wage structure of nursing and other hospital employment. They have made some progress toward their original objective of lessening the burden of private health care for over-65s and some indigent people. But they have also pushed hopsital costs sky-high, and the massive center of the citizenry is probably in worse shape than ever in finding and paying for good care.

The medical schools have been caught at the center of the grievances about health. As a constituency, they are weak and divided, not to be confused with organized medicine either in ideological orientation or in political power. Far from being benefited by the increased consumer buying power of Medicare/Medicaid, educational costs are systematically disallowed and the teaching hospitals are in a worsening crunch, as shown by John Walsh in Science magazine.

The medical research budget is around $1.5 billion, almost all of it coming from Federal agencies like the National Institutes of Health. For some time, this investment has been at a standstill—actually being eroded by inflation, and providing shrinking opportunities for new graduates to attack new problems.

I was dismayed recently at a meeting of the Mayo Clinic Alumni to hear HEW Secretary Robert H. Finch address this problem with little of the customary regret about competing needs in a budget limited by military commitments on one side and rival social investments on the other. He implied instead that federal support of biomedical research was a drain on manpower resources that should be diverted back to patient care.

Finch undoubtedly shares this misconception with many legislators and citizens who have been taking misdirected potshots at research. In fact, the most avidly research-oriented schools have rarely succeeded in keeping as many as 15 per cent of their medical graduates in academic medicine, and these are not only the researchers but also the teachers of further generations.

The medical schools are more than eager to answer the need for manpower. They are obstructed above all by the fact that direct federal support of medical education is mostly rhetorical. The institutions which train medical graduates have been developed in the name of research in compliance with the congressional mandate.

They should be training many more M.D.'s; they should be developing new levels of health professions; they should be working to fill the near-vacuum of education for environmental health. Attacking the support of research may spear a convenient scapegoat, but it serves us ill to dismantle these institutions when we have not developed the national commitment, the policy or the budget to fulfill their wider role in serving human needs.

[From the New York Times, Dec. 15, 1969]

OEO To Expand Medical Program—Neighborhood Care Centers To Have Broader Role

(By Harold M. Schmeck Jr.)

Washington, Dec. 14.—The health sector of the Office of Economic Opportunity is working on plans for a larger role in solving the nation's urgent medical care problems.

The plans took concrete form this summer when the agency made grants in four communities to start an experiment in reorganizing health care. The grants, averaging about $200,000 each, were for reorganizing the out-patient departments of municipal hospitals, using lessons learned in the OEO. Neighborhood Health Center program.

These out-patient departments are where most of the urban poor get most of their medical care. Dr. Thomas Bryant, associate director of the agency, said in a recent interview.

Many observers have said this care is often minimal and poor.

The four cities in which the efforts are being made are Boston, Cincinnati, Minneapolis and Newark. The agency also plans to make a similar grant in San Diego.

LOCAL ORIENTATION

The plan is, in effect, an extension of the Neighborhood Health Center Program that has been credited with many successes during the past few years. The Neighborhood Health Centers are local clinics offering a wide range of family out-patient medical services and preventive care for populations of about 15,000 to 30,000. The intent is to offer comprehensive care in the neighborhood and to give the citizens there an important voice in the center's affairs. There are 49 such centers in operation now in 23 states to help the poor get better medical care.

Dr. Bryant, who heads the agency's Office of Health Affairs, said the new program would focus on much larger population groups than are covered by the neighborhood health centers. The plan is to deal with the health care problems of groups totalling 100,000 to 200,000 in the economically depressed areas of major cities.

The idea would be to use the out-patient departments of existing municipal hospitals as a nucleus for care programs in the communities, but in a manner far different from the way these same hospitals do it today. Just how it might be done is under study in the projects being funded by the agency now.

Dr. Bryant said he sees the possibility of group practice teams of doctors based in the hospitals; related groups practicing in the neighborhoods served by the hospitals and other hospital-based health workers going out into the community to provide such services as guidance in nutrition, family planning, child care, narcotics problems and other specialties.

Like the Neighborhood Health Centers Program, the new one would try to involve local people and be responsive to their desires concerning the arrangement and the types of services needed.

EXPANSION PLANNED

If Dr. Bryant's new program proceeds as planned it will probably expand to include major community health projects in five to 10 cities throughout the country. The agency's involvement would reach a peak in fiscal 1971 and would then begin to fade out after having proved that the concept works.

The agency estimates that such a program for a population group of roughly 100,000 to 200,000 would cost from $5-million to $10-million a year. Substantial reimbursement from Medicaid would be expected.

Dr. Bryant sees the program as a way of helping medical schools get involved in the health centers of their communities and as a way of interesting young medical graduates in entering practice in slum areas where more physicians are urgently needed. He noted, for example, that Boston City Hospital, focus of one of the first five grants, is affiliated with three major medical school—of Harvard, Tufts and Boston University. Some young doctors training at those three schools would be drawn into the community health project, Dr. Bryant hopes.

He said he thinks the O.E.O. might have an excellent chance of getting something done. Its focus would be on better health care for the poor. Its objective would be demonstration of a principle.

[From the Washington Post, Dec. 16, 1969]

VA HOSPITAL FUNDS CALLED INADEQUATE

(By Stuart Auerbach)

The nation's chief health officer during the Johnson administration charged yesterday that wounded Vietnam veterans are being deprived of needed medical care because of President Nixon's anti-inflation policies.

Dr. Philip Lee told a Senate subcommittee that the government should be spending $240 million more a year to treat the returning wounded who are flooding Veterans' Administration hospitals.

The government tried to cut the VA medical care budget by $70 million—but the Congress restored half of it.

"The tragic fact is we are asking the veteran to pay in his health for the anti-inflationary policies that are followed by the administration. I think we are asking him to pay too high a price," said Lee, who is now chancellor of the University of California Medical Center at San Francisco.

Later, a psychiatrist said shortages of doctors at VA hospitals means that "thousands and thousands" of shell-shocked veterans walk around in "a chemical cocoon" because they are given high doses of drugs rather than psychiatric treatment.

This happens, Dr. Louis Jolyon West said, when there are more than 250 patients for each psychiatrist.

Sen. Alan Cranston (D-Calif.), chairman of the subcommmittee investigating the medical care of veterans, said VA hospitals across the country have one psychiatrist for every 535 patients.

West, chairman of the department of psychiatry at the University of California at Los Angeles and consultant at VA hospitals across the country, said their psychiatric services have deteriorated greatly since the Korean War and now do not match California state hospitals.

Brentwood Hospital at the Los Angeles VA Center, he said is 20 to 25 years behind current psychiatric trends.

Lee, who testified with his father, Dr. Russel V. Lee of the Palo Alto (Calif.) Medical Clinic, urged that Congress give the VA hospitals more money and remove personnel ceilings that have been placed on Federal agencies.

"It is tragic at a time when the veteran population is increasing rapidly, when medical advances promise better quality of care and when the veterans of Vietnam have special and urgent medical, dental and psychiatric needs, that Congress would impose crippling budgetary and personnel ceilings on the Veterans' Administration," said Dr. Philip Lee.

He said the VA hospitals need $100 million more for personnel, $100 million for new facilities and $30 million to $40 million for research and teaching facilities that will both improve patient care and help ease the Nation's health manpower shortage.

Lee was assistant secretary for health and scientific affairs of the Department of Health, Education and Welfare in the Johnson administration.

[From the Washington Post, Dec. 19, 1969]

TIGHT BUDGET INDICATED FOR HEALTH CARE IN '71

(By Victor Cohn)

Health and the cleanup of the environment will be kept on slim pickings for at least another year, an advance draft of President Nixon's fiscal 1971 health, education and welfare budget indicates.

The draft shows small increases in most areas. They amount to $88 million more for all health research and training agencies—to give them $3.090 billion compared with the $3.002 billion they will probably wind up with this fiscal year.

The increases would give individual agencies boosts of a few tens of millions or less in most cases, with no sizable ones to speed production of doctors, or other health workers, or increase medical research.

Fiscal 1971 does not start until next July 1. But administration budget proposals are now at the printer's, and the final figure, it is understood, may be even less than those in the draft obtained yesterday.

The National Institutes of Health, main sponsor of medical research and training, would get just an $83 million increase, the draft shows, 6 percent more in obligational authority than its expected fiscal '70 sum. Its actual outlays, the draft shows, may add even less: a $65 million or 4.5 percent increase.

The draft shows the allowance for pollution controls going up only $19.8 million, despite word that the President plans a major push to improve the environment, starting next year.

He is expected to deliver a special message on the subject early in the year. A special budget request would have to follow it, if environmental spending is to be significantly increased.

AIR POLLUTION CONTROL

The draft sets out $106 million for air pollution control, compared with $86.4 million this year. It shows $50.6 million for other environmental controls (including solid wastes and water), compared with $50.3 million this year.

The draft also bears out predictions that the Budget Bureau—after Congress acts on health appropriations—will hold spending down further to flight inflation in keeping with a presidential order.

Spurred by an Appropriations subcommittee headed by Sen. Warren G. Magnuson (D. Wash.), the Senate on Wednesday voted key health agencies some $300 million more than the House allowed.

Health sources say Magnuson and others will make a strong fight in conference committee to retain all or part of this. But the Budget Bureau—the new budget draft indicates—already plans to cut many sums to levels below those the House voted.

CALLED "EMACIATED"

A Washington health publication—Drug Research Reports (the "Blue Sheet")—yesterday called the fiscal '71 sums another "emaciated" budget on top of the "austerity" fiscal '70 figures. "The figures," it said, "fail to reflect the 'health crisis' President Nixon described in a White House message in July."

Most increases, it added, are "far less than the 8 to 15 percent cost of living increase experts say" is needed to keep research "on a spending plateau."

Among specific proposals:

• Medical research would get $1.064 billion, compared with $1.020 billion this year.

• Health manpower support—to train doctors, nurses and technicians would add up to $256 million, compared with $218 million this year.

• Mental health research would stay even, at $118 million.

• Mental health manpower training would get $122.6 million, less than the $122.9 expected this year.

• State and community mental health programs would get $66.3 million well below this year's expected $66.9 million.

• The Food and Drug Administration would get $81.1 million, up only $3.3 million over this year's $78.8 despite strong pressure of increased scrutiny of food and drugs.

[From the New York Times, Dec. 20, 1969]

TOPICS: HEALTH CARE SYSTEM—A SICK BUT CURABLE PATIENT

(By Leona Baumgartner[1])

There is much talk of the health crisis—rapidly rising costs, personnel shortages, long waits to get into hospitals, nursing homes, doctors' offices, Medicare, and Medicaid. There is less talk of the disorganized, inefficient, fragmented no-system through which the Americans, rich and poor, get their medical care. It accounts, in part, for the health crisis.

Hospitals are often built where they are not needed. Patients stay in them longer than their medical status demands, sometimes because space in nursing homes is not available. Clinics operate at the convenience of staff, not customers. Some physicians spend all day in or near one hospital; others are "on the road" much of the day from one hospital to another between home calls (if any) and time in the office; some are not on a hospital staff; patients are sent to stay in hospitals for tests that could be done on an ambulatory basis; and doctors do tasks those less well trained can do as well.

Every hospital feels it must provide all the latest, most sophisticated treatments, despite cost or need. Take a New England city of 175,000 with four hospitals. One already has the radiation therapy equipment and staff necessary to treat all the patients with cancer in the city and surrounding area.

There is no evidence that there are any patients who go without treatment when needed. But the other three hospitals are struggling to find personnel, space, and equipment so they, too, will have similar services. One hospital in the same town has an excellent cardiac service and is able to do all the simple heart operations the area needs—but another is searching for a cardiac surgeon. The city is less than two hours by car away from one of the nation's great medical centers where cardiac surgery, seldom an emergency, is superbly done.

POOR DISTRIBUTION

In the United States four-fifths of all such operations in 1961 were done in 99 hospitals; whereas some 800 are staffed and equipped to do them. Certainly all are not necessary, especially since 270 hospitals of these 800 reported no cases

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[1] Dr. Baumgartner, former Health Commissioner of New York City, is executive director of Medical Care and Education Foundation, Inc., and a visiting professor at Harvard Medical School.

at all that year. The skills of a team are not kept up without about 100 or 200 cases a year. Across the nation Government hospitals (Veterans) stand half empty when other hospitals in the same town are jammed.

The Federal strategy of dealing with the health crisis has been to increase purchasing power on the apparent assumption that the capacity to deliver would be available to meet the greater demand. The large increases in Federal expenditures for health have come recently, rising from some $3 billion in 1963 to $12.7 billion in 1968 in response to the country's concern for the aged and the poor. The money has largely been poured into purchasing power and with little or none going into increasing the capacity to deliver care.

REMODELING PROGRAM

What is needed? A deliberate, well-financed program of remodeling the health system—aggressive planning for better use of scarce resources, merging of small inefficient hospitals, firm links of smaller community hospitals to larger regional medical centers, wider use of telecommunications to bring expertise to larger numbers, more ambulatory care, more group practice, more emphasis on early and preventive care, more "allied" health workers—all these and more.

Manpower shortages are known to all who try to get a doctor or nurse for an emergency. The President's Health Manpower Commission made it clear that it would be impossible to train sufficient workers if they were to be used as they are now used.

FUNDING PROGRAMS

The Congress recently passed two bills specifically designed to promote the better use of manpower and other health resources; Regional Medical Programs and Comprehensive Health Planning. Both are now just getting started. Neither is adequately funded, nor is legislation supporting manpower training. Without public support, they too will not be. Cuts in appropriations designed to improve the capacity to deliver health care can only make the crisis worse.

The voice and power of the health care consumer has begun to be heard and felt. How the country's health resources and personnel are allocated should be high on the consumer's agenda, and on the Administration's which has admitted to a national health crisis.

[From the New York Times, Dec. 28, 1969]

STUDY SHOWS ONE OF FIVE HERE CHRONICALLY ILL, WITH THE POOR HIT HARDEST

(By Peter Kihss)

One of every five New York City residents suffers from a chronic ailment, and the rate is linked to income rather than to ethnic origin, according to a study by the Center for Social Research. Most difficulties were found to be suffered by the poorest.

A study of health conditions as a basis for planning services has been developed and made public by the center, a component of the City University's Graduate Center.

Based on a sample of 5,500 households, the study reported that 20.3 per cent of the city's civilian noninstitutional population during 1966 had one or more of eight most frequently reported chronic ailments:

Heart conditions, high blood pressure, diabetes, peptic ulcer, arthritis and rheumatism, asthma, hay fever and chronic bronchitis.

Each of these conditions—either a condition listed as "chronic" by the United States National Health Survey or reported by the individual himself as first noticed more than three months before an interview—was reported by at least 1.5 per cent of the population.

For every 1,000 persons with family incomes under $4,000, 414.6 such conditions were reported. (A person may have more than one chronic ailment.) For every 1,000 persons with family incomes between $4,000 and $7,499, the rate was 221.1. For every 1,000 with family incomes of $7,500 and more, the rate was 218.6.

The over-all rate of 266.1 such conditions for every 1,000 persons in New York City during 1966 was 23 per cent higher than the rate of 216.4 for the entire New York-Northeastern New Jersey metropolitan area for the two-year period from July, 1957, through June, 1959.

The findings were set forth in a 27-page report by Dr. Donald G. Hay and Prof. Morey J. Wantman.

They said 22.5 per cent of women reported one or more of the chronic conditions, compared with 17.7 per cent of men. There were 299.5 conditions for every 1,000 women, and 227.4 for every 1,000 men.

Such women cited 101.6 cases of arthritis and rheumatism, as against 37.6 for men, and 61.5 instances of high blood pressure, as against 28 for men. On the other hand, the men reported 33.6 cases of heart trouble, to 22.4 for women, and 18.9 instances of peptic ulcer, to 13.6 for women.

The report cited studies suggesting that women may be more aware of or better remember illnesses, while pressure may be greater on men as breadwinners to ignore all but the most serious or disabling symptoms.

Among whites, excluding Puerto Ricans, 22.1 per cent reported one or more chronic conditions. This compared with 16.2 per cent for Puerto Ricans and 15.8 per cent for nonwhites. There were 289.7 conditions for every 1,000 such whites, compared with 195.6 for Puerto Ricans and 216.5 for nonwhites.

The reported higher prevalence rates for such whites may be largely attributable to age, the study said. Of the whites, 41.7 per cent were 45 years old and older, compared with 14.8 per cent of Puerto Ricans and 20.9 per cent of nonwhites.

Prevalence rates increased with age. There were 133.9 conditions reported for every 1,000 persons under 45, compared with 396.1 for those aged 45 to 64 and 756.2 for those 65 and older.

The City University authors noted that Federal studies suggest that the progressive nature of many types of chronic illness reaches a stage for persons after the age of 45 "where it interferes with usual activities and thus becomes a limiting factor in the amount of family income."

But they also noted that poorer diet, environment or health habits may be associated with lower income. Environmental factors, Professor Wantman and Dr. Hay commented, may account for chronic bronchitis reported much more frequently for low-income residents, and hay fever among those of higher incomes.

Whites with family incomes under $4,000 had 574.6 chronic conditions for every 1,000 persons, or double the 236.2 for those with higher incomes. For nonwhites and Puerto Ricans combined, the rates were 273.7 for those with under $4,000 incomes and 159.9 for those with higher incomes.

Three-fourths—76.4 per cent—of the reported conditions had been discussed with physicians during the preceding 12 months. The authors said "it would appear that New York City is providing physician services for the poor."

This involved a difference, however, between higher- and lower-income nonwhites. The better-off nonwhites' rate of physician service was 75.2 per cent, compared with 69.2 per cent for those with under-$4,000 incomes.

"This," the authors commented, "may suggest either that nonwhites have less health services available, or they have to be made more aware of facilities they could make use of and don't."

[From the Progressive, December 1969]

THE COMING STRUGGLE FOR NATIONAL HEALTH INSURANCE

(By Erwin Knoll[1])

"If there is one thing that binds together the poor people of this country with the well-to-do people, it is the complaints that they have about medical care," Dr. Robert Coles of the Harvard University Health Services told a Senate subcommittee last year.

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[1] Erwin Knoll is the Washington editor of The Progressive. He was formerly a reporter, and editor for The Washington Post and the Newhouse National News Service. He and William McGaffin are coauthors of two books: "Nothing But the Truth" and "The Scandal in the Pentagon: A Challenge of Democracy," a paperback just published by Fawcett.

In the volatile climate of current American politics, one prediction is safe: The scandalous state of the nation's health services is ready to surface as a major campaign issue. By 1972, it may well be the dominant domestic theme. Battle lines are being drawn for another fight to establish in the United States a right that every other advanced nation has guaranteed its citizens for decades—the right to medical care.

The early warnings are already going out to the organized medical profession, which stands ready as ever to throw its formidable resources into an all-out effort to preserve the status quo.

"Slowly but forcefully, a movement to change the way most physicians practice in the United States is gaining momentum," Senior Editor John Carlova wrote last summer in *Medical Economics*. "All the experts I consulted agree that if the cost of medical care continues to outsoar the Consumer Price Index, if doctors remain a target for criticism, if Medicaid's maladies grow worse, if the public intensifies its protests against the high costs of health care and Congress reacts with more and deeper probes into their causes, then the chances of national health insurance will increase."

The preconditions cited by Carlova seem well on the way toward being met, and *Medical World News* reported recently that "the message out of Washington is getting louder and clearer: Compulsory national health insurance is on the way."

How soon? What kind? These questions will soon be the topics of lively political debate, but the record offers little encouragement to those who believe that the time is long past due for instituting a rational and equitable system of medical care in the United States.

National health insurance had been in force in Germany for three decades and Britain's national plan was three years old when the American Association for Labor Legislation drafted a bill in 1914 for submission to state legislatures; not a single state acted. By 1935, when the American Medical Association lobbied successfully to keep health insurance out of the New Deal's Social Security Act, Austria, Hungary, Norway, and several other European nations had adopted insurance plans. In 1948, when the Wagner-Murray-Dingell bill was bottled up in Congressional committee, Britain was establishing its National Health Service and virtually every other developed nation had instituted a universal health insurance system.

Medicare and Medicaid, the two major health care programs established in recent years after strenuous political exertions, have proved to be calamitous disappointments to their supporters and supposed beneficiaries. In the process of enactment, both were modified and compromised to the point where their prime impact has been an enormous contribution to the cost of medical care and to the enrichment of the medical profession.

Medicare, which was intended to meet the health needs of the elderly, now covers less than forty-five per cent of their basic medical costs. The monthly Medicare premium paid by almost twenty million elderly Americans—many of them barely able to make ends meet—which began at $3 and is now $4, will be increased in 1970 to "somewhat over $5" to keep up with rising doctors' fees, the Nixon Administration recently announced. At the same time, Senate investigators disclosed that some thirty officials of the AMA were among physicians who received $25,000 or more in Medicare fees last year.

Medicaid, under which Federal and state funds are allocated to pay the health costs of the poor, is in an even more acute state of distress. A Government task force was announced last summer to "deal immediately with the crisis in that program."

In the absence of effective Federal action, the private health insurance industry has enjoyed massive growth. Private insurers collected $11.1 billion in health premiums in 1967 (and spent $1.6 billion of it—more than fourteen per cent—on operating expenses). Nonetheless, private coverage falls far short of meeting the needs of the insured, and often provides no protection at all for the neediest. Of 178 million Americans who were below the age of sixty-five last year, twenty-four million had no hospitalization insurance; thirty million had no surgical insurance; sixty-one million had no coverage for in-hospital medical expenses; eighty-nine million had no coverage for out-of-hospital X-rays and laboratory tests; 102 million had no insurance for physicians' office visits or home calls; 108 million had no coverage for prescription drugs, and 173 million were not insured for dental care.

Americans will spend some $60 billion for health services in 1969—a fivefold increase since 1950. The medical industry ranks second only to the military machine in the gross national product, accounting for about 6.5 percent of the GNP—a larger percentage than is spent by any other nation. Yet U.S. and the international public health statistics point to a sorry return on this huge investment.

According to the latest available figures, the United States ranks eighteenth among the nations of the world in life expectancy for males, and eleventh in life expectancy for females. The death rate for middle-aged males is higher in the United States than in any nation of Western Europe. The infant mortality rate is lower in at least thirteen other industrial nations (including Japan), and at least eleven have a lower percentage of mothers dying in childbirth. Dr. Frank Falkner, associate director of the National Institute of Child Health and Human Development, recently summed up the U.S. health situation as "a disgrace and totally unacceptable."

More shocking still are the statistics pointing to the health care gap within the United States. Dr. Martin Cherkasky, the director of Montefiore Hospital and Medical Center in New York City, testified before Congress last year that the infant mortality rate in the southern Bronx, with a largely black and Puerto Rican population of 650,000 was 37.3 per 1,000 live births, while in the principally white middleclass northern Bronx it was 18.8.

"A gap of twenty-five blocks and a social and economical gap of astronomical proportions dooms twice as many babies to death in the greatest city in the greatest country in the world," Dr. Cherkasky said. "It is very disconcerting to see on television a heart being transplanted from one human being to another and at the same time find on checking 200 consecutive children who go to a city hospital clinic that half of them have no evidence of being vaccinated against smallpox and polio. Hard to believe."

The situation, he noted, is the same in "every urban area in the United States." But even in the most favorable circumstances—even in Utah, for example, which has a virtually all-white population—the infant mortality rate "is equal to the highest infant mortality rate in the most deprived province of Sweden," Dr. Cherkasky said. "In other words, even where you have middle-class whites, with few Negroes who tend to be deprived and poverty-stricken and therefore have higher infant mortality, even where we do not have these negative factors, our infant mortality rate is very poor."

That a crisis in health care exists seems, finally, to be a matter of universal agreement. Even Dr. Gerald D. Dorman, the president of the AMA, acknowledged recently that "one major illness or accident can be a financial as well as a physical tragedy." President Nixon declared last July that the "problem is much greater than I had realized. We face a massive crisis in this area and unless action is taken both administratively and legislatively . . . we will have a breakdown in our medical care system affecting millions." Dr. Roger O. Egeberg, the Assistant Secretary of HEW for Health, diagnoses the state of the health system as "grave tending to be critical." Dr. John H. Knowles (whose appointment to the post held by Dr. Egeberg was blocked by AMA pressure) predicts that "there will be a comprehensive medical care program for all Americans, whether it takes two years or twenty . . . Sooner or later, health will be perceived as a right."

"If we are to act realistically and adequately in order to deal with this health care crisis," says Walter Reuther, the president of the United Auto Workers, "we must first free ourselves of the illusion that we really have a health care system in America. What we have, in fact, is a disorganized, disjointed, antiquated, obsolete non-system of health care. The American people—the consumers of health care—are being required to subsidize a non-system that fails to deal with their basic health care needs—and the cost of that system is continuing to skyrocket at a rate that is two-and-one-half times faster than the increase in the general price level."

Reuther is an important figure in the developing fight for a national insurance plan. He is the prime force behind the Committee for National Health Insurance, a blue-ribbon group of prominent liberals organized about a year ago to promote the cause. Serving with Reuther as officers of CNHI are Dr. Michael E. DeBakey, the famous heart surgeon; Mr. Albert D. Lasker, the medico-philanthropist, and Whitney M. Young Jr., executive director of the National Urban League. The committee's roster of eighty or so members includes the Reverend Ralph D. Abernathy and Mrs. Martin Luther King Jr. of the Southern Christian Leadership Conference; Senators Edward M. Kennedy, Ralph M. Yarborough, and John

Sherman Cooper; Harvard economist John Kenneth Galbraith; Mayor Carl B. Stokes of Cleveland, and a platoon of labor leaders.

Details of the program to be pushed by CNHI—it is already being called "the Reuther plan"—are still being worked out, though the hope is to have legislation ready for introduction early in 1970.

At a two-day conference sponsored by the committee in mid-October, a series of "tentative specifications" was unveiled for representatives of about fifty national organizations, including the AMA, the American Dental Association, the American Hospital Association, the American Nurses' Association—the full panoply of organized medicine. With varying degrees of distress, they listened to the outline of a compulsory insurance plan that would pay for the personal medical care of every American replacing such programs as Medicare and Medicaid and supplanting private insurance plans and such groups as Blue Cross and Blue Shield, except to the extent that these might cover expenses not provided for in the Federal program.

The financing of national health insurance would be based on "the mechanisms which are now well-developed and time-tested in the financing of the national social insurance system of Social Security, utilizing the Treasury Department and the Trust Fund procedures." The plan calls "tentatively" for meeting two-thirds of the costs from payroll taxes and one-third from Federal general tax revenues. Cost estimates are sketchy, but CNHI estimates that the plan would attempt to cover services amounting to about $40 billion of the $60 billion now being spent on health care.

Doctors and hospitals would be paid directly by the insurance system. "The methods of payment have to start with the status quo," according to the tentative specifications, "but NHI should include incentives for the development of a more desirable system." Eventually, the system should move away from "fractionated fee-for-service payments" and toward "hospital-affiliated or hospital-based medical groups, in order to stimulate better organization within and between institutions."

In the opening address to the October conference, Reuther was careful to stress that CNHI "does not propose a system of socialized medicine. . . . What we need to do is to develop a uniquely American system which will preserve the best features of the current delivery system while dealing with its basic organizational and financial deficiencies in order to make possible the provision of comprehensive, equitably and soundly financed high quality care on a universal basis." Max W. Fine, the executive director of CNHI, adds that "in this country the style is such that we might produce a better health-care product by not going the route of socialized medicine. We can use the existing mechanism to finance something better."

Despite such disclaimers, the old cry of "socialized medicine" is likely to be resounding in the halls of Congress by next spring. The AMA has already prepared its ounce of prevention—a bill introduced in the House by Democrat Richard Fulton of Tennessee and in the Senate by Republican Paul Fannin of Arizona that would help defray the costs of private health insurance by a system of graduated income-tax credits. If the idea sounds familiar, it is. It was the AMA's answer to the first Medicare proposals a decade ago.

Another plan, sponsored by Senator Jacob K. Javits, New York Republican, would establish a nationwide, compulsory health insurance system patterned on Medicare and administered by the private insurance carriers. Aside from its obvious appeal to the insurance industry, the plan seems to have little to recommend it. "The insurers," says Fine of CNHI, "are part of the problem, not part of the solution."

Just where the Nixon Administration is likely to take its stand remains to be determined. So far, despite the President's prediction of a "massive crisis," he has confined himself to appointing study committees—and to intensifying the crisis by ordering severe cutbacks in Federal expenditures for health research. But it is conceivable—likely, in fact—that by next year a cut-rate alternative to national health insurance will have the Administration's support. "At the moment," says Fine, "nobody at the White House seems to know anything about health."

The "Reuther plan," in whatever form it finally emerges, seems virtually certain to be supported as the prescription most acceptable to Congressional liberals as they address themselves to the crisis in health care within the next few years. Whether the plan is sufficient to effect a cure is far less certain—especially when one considers the dilution that is certain to take place on the way to enactment.

Dr. Isidore S. Falk, who helped draft the original Wagner-Murray-Dingell bill in the 1940s and whom *Medical Economics* calls "probably America's top authority on national health insurance," delivered a penetrating analysis a year ago of what went wrong with Medicare.

"The legislation was framed to make only a manageable beginning and to stay within boundaries of cost, mainly because of political considerations," Dr. Falk told the American Public Health Association.

"Its *insurance* design was dictated largely by its *insurance opponents*, not by its proponents; and the apparent objective was to conform as far as possible—especially for the noninstitutional services—to insurance through cash indemnity rather than through service benefits. Its *medical service* design was dictated largely by its *professional opponents;* and the apparent objective was to conform as far as possible to solo medical service supported by fee-for-service. These may have been unavoidable compromises, the prices that had to be paid to achieve enactment of the legislation in 1965. I suggest that these compromises should not have further longevity in Medicare for the aged, and that they should be avoided in the design of any extension to other population groups."

Dr. Falk was the principal draftsman of the "tentative specifications" submitted at the CNHI conference in mid-October. Surprisingly, he seemed to be laying the groundwork for new "unavoidable compromises." The specifications declare, for example, that national health insurance "should extend to the entire range of services required or useful for the maintenance of personal health"; three paragraphs later, however, is the warning that "further discussion is needed" on the coverage of costs of medicines, dental care, and treatment in mental hospitals—three of the costliest and least adequate components of the present medical system.

Loophole language occurs throughout the specifications draft: "NHI should undertake—*as far as it can*—to make total and fully adequate payments to the providers of the services without requiring any such payments from those who receive the services." "*As far as may be feasible* there should be no direct financial barriers to the receipt of needed services that are available under NHI. . . . *If there are to be exceptions*, they should apply only to those limited areas in which charges to the patients are demonstrably related to effect utilization and/or to necessary fiscal controls—as with respect to some aspects of dental care, eye glasses, or medicines." (Emphasis added.)

Entirely missing from the draft specifications—and apparently from CNHI's active concerns—are such important issues as the use of generic name drugs in place of costly brandname products; the development of new, neighborhood based health programs, relying on institutions and services now outside the medical structure—such institutions as public schools, for example, which are specifically excluded in the draft program; the need to cope with environmental pathology, a principal factor in today's health crisis.

With the exception of its laudable emphasis on group medical practice, the CNHI program seems wedded to the health care system that is crumbling around us. "What CNHI has done is add another refinement to the conventional wisdom in health," says a disappointed participant in the October meeting, President Theodore O. Cron of the recently organized American Patients Association. "Under the guise of innovation it is really enforcing our archaic ways of taking care of sick people. The members of the committee seem to be unable to address themselves to today's and tomorrow's ways of living, which produce far more complex disease conditions than they seem able to contemplate within their framework."

Max Fine, CNHI's executive director, is not indifferent to such criticism. The draft specifications are now being "liberalized," he says. "If we don't profit from the experience of Medicare, we're morons. Many people gave too much away to the opposition in that fight." At the same time, he adds, "it isn't going to be possible to do some of the things we want to do, because we have to avoid polarization of opinion. It isn't necessary to throw out the baby with the dirty water. We can preserve a good many things."

But isn't that baby the same creature that Reuther calls "a disorganized, disjointed, antiquated, obsolete non-system of health care"? The "Reuther plan," it seems clear, is the system of national health insurance that the United States should have adopted twenty or forty or sixty years ago. Is it enough today? No one is answering that question. Hardly anyone is even asking.

[From the Washington Post, Jan. 4, 1970]

Crisis in Health Care Grows Despite Medicare Successes—Hill Hoping to Cure Runaway Costs of Health Care

First of a Series

(By Eve Edstrom)

The nation's "fastest-growing, failing business"—that's what America's $60-billion, health-care industry has been called.

The 1960s ended with a litany against its Nieman-Marcus prices, its gyp providers and its grab-like quality of merchandise.

The 1970s will begin with at least three major congressional committees scrutinizing the industry's sickness.

The end result, most observers believe, will be some form of a health insurance plan to cover all Americans by the end of this decade.

But the same observers insist that the enormous public discontent with the inflationary burdens of both Medicare for the aged and Medicaid for the poor mean that any universal plan must be more than just an extension of the existing uncontrolled, money-shuffling system.

It became a cliche of 1969 to call that system a "non-system," to call the health industry—soon to be the nation's largest employer—a "cottage industry."

Practically every national leader, from President Nixon on down, declared that a "massive crisis" exists in the health-care field; that it can be solved only if there are equally massive changes in the way health care is delivered to all Americans.

But despite this seeming agreement, a young doctor in the Bronx, charged with the impossible task of bringing quality health care to 45,000 of the poor, asks:

"Where is the national commitment? Give me some evidence that I can see, not hear."

And on the West Coast, a doctor involved in this country's largest and most successful prepaid group health plan for middle-class workers, simply says:

"The nation is chasing its tail at the moment."

His comment will be underscored when the House Ways and Means Committee, the Senate Finance Committee and a Senate antitrust subcommittee explore why daily hospital charges have gone up almost five times as fast as the consumer price index in the last three years and why doctors' fees have climbed twice as fast.

Out of these explorations will come a rash of headline-grabbing statistics—the six-figure incomes collected by some doctors from public programs and hospital markups ranging from 40-to-125 per cent for the same commodity in the same community.

"But you know in all this mess," said one Senate investigator, "I still can't separate the guys who wear the black hats from the guys who wear the white hats."

The reason is understandable. Doctors and hospitals are doing exactly what Congress ordered.

In fact, Medicare is living up to all of its promises.

Its chief promise was to provide a financial underpinning for Americans 65 and over who lived in fear of being pauperized by illness.

PAYS 45 PER CENT

It introduced, for the United States, a revolutionary concept in the financing of hospital care—a compulsory system that requires workers to make payments during their productive, healthy years so they will be entitled to hospital benefits when they are old and ill.

Medicare pays only 45 per cent of the total health-care costs of the aged. But its advocates believe it represents a good beginning toward providing the mechanism that eventually will finance broader benefits.

This hasn't happened as quickly as expected, simply because Medicare's birth and growth were beset by complications. Some of them, as health-care observers predicted when Medicare became law in 1966, were these:

- Health-care costs would skyrocket by the end of Medicare's first year.
- Needless and costly medical equipment would proliferate; obsolete hospitals would get a new lease on life.

• Private enterprise aspects of health care would become so entrenched that no meaningful changes in providing health care would be made.

• Incentives to bring costs down would not exist because the fox had been put in charge of the henhouse.

ARGUMENT ATTACKED

On this latter point, doctors, hospitals and health insurers argue that health care has not become unmanageable because Congress let them call the shots under both Medicare and Medicaid.

Hospitals repeatedly cite wage increases as a predominant factor in runaway costs. Wages of ill-paid hospital employees have gone up substantially, but studies show that wages, as a proportion of total hospital costs, have remained almost constant since the mid-1950's.

Another factor often cited is that America's outstanding medical advances have required the purchase of phenomenally costly equipment and the hiring of trained technicians to maintain and operate it.

This argument was attacked by a parade of witnesses in 1968 when they appeared before Sen. Abraham A. Ribicoff's executive reorganization subcommittee.

CASE OF "ME-TOOISM"

They not only suggested that American hospitals were suffering from a gigantic case of "me-tooism," buying capital equipment whether needed or not, but that this buying spree was resulting in poorer, not better, care.

On this point, Dr. Martin Cherkasky, director of Montefiore Hospital and Medical Center in New York, said:

"Let me interject a point which can be duplicated all too often.

"We have 15 open-heart programs in the city of New York, and I pointed out how expensive open-heart surgery is.

"Seven of those open-heart programs do 83 per cent of all the heart surgery; eight of them do 17 per cent. Those eight who do 17 per cent do about one case a month. Do you know what it costs to maintain the specialized equipment and the specialized personnel when you do one case a month?

"That cost is astronomical, and . . . when you do one case a month it not only costs a lot but you do it badly.

"The city of New York does not need 15 programs. It only needs seven. No effort on the part of those who pay has been directed to making sure that these unnecessary draining programs of money and space and personnel are avoided."

"Medical care," Cherkasky says, "is too serious to entrust to administrators and doctors."

FEE-FOR-SERVICE

But the political price for passing Medicare over organized medicine's opposition was to permit no changes in the traditional way that hospital administrators and doctors do business.

And the traditional way is the most costly and fragmented approach to health care. It is based on the piecemeal fee-for-service method, which permits a separate billing for an injection, and another for a test and a third for a surgical procedure.

"Where dollars lead, doctors will go," said one practical observer. "Don't expect them to have virtues that the rest of us don't have."

Another factor that has compounded the high cost of health care is that the health insurers, the traditional bedfellows of hospitals and doctors who have been allowed to act as the government's middle-men under Medicare. This means that they process—but hardly any question—the financial claims of doctors and hospitals.

"It might all have been different if just one word in the Medicare law had been changed," a legislative technician said a few days ago. "Just suppose that word had been changed to 'everything'."

GOVERNMENT CONTROL

The word he was talking about is "nothing" and this is how it is used in the Medicare law:

"Nothing in this title shall be construed to authorize any federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure or

compensation of any officer or employee of any institution, agency or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency or person."

In translation, this means the government has no say over the spending of billions that it pours into hospital coffers and doctors' pockets.

This lack of government control will be at the crux of the national debate over health care in the 1970s.

AMA METHOD

There are increasing soundings from Capitol Hill that hospitals should be regulated like public utilities if they want to share in federal funds and that controls should be placed on the doctors' fee-for-service charges.

Unlike the 1960s, the national dialogue over health care no longer is centered on the need for a financing mechanism to pay for care. Even the American Medical Association has come up with its version of such a mechanism, called "Medicredit," for the payment of bills.

The issue in the 1970s is not how to provide a payment method for care, but how to deliver care at controllable costs.

This means radical surgery for present delivery methods, and this is what the AMA feared when it initially attacked Medicare as government's "foot in the door" of private practitioners.

Once again, the AMA is fighting to keep fee-for-service medicine intact. In an effort to stem moves against prepaid group health plans and salaried doctors, the AMA established a special committee in December to champion private practice and health plans that give patients a "freedom of choice."

"What does that mean—that I can go look up a doctor in the yellow pages?," asked a Portland, Ore., housewife recently.

She, her husband and six children are covered by a prepaid group health plan that has been examined and re-examined by individual experts and bodies of experts—and the results are always the same. It provides quality care at substantial savings.

In the view of many of these experts, this is the real scandal of America's health-care "crisis"—that the nation does have systems of proven capability to deliver health care economically yet it opted for Medicare.

Next: The Kaiser Plan

[From the Washington Post, Jan. 5, 1970]

KAISER'S HEALTH PROGRAM STRESSES PREVENTIVE CARE

Second of a Series

(By Eve Edstrom)

The nation's largest and most sophisticated prepaid group health plan began in California during the Depression at a cost of five cents a day for each employee.

It was the late Henry J. Kaiser's response to the health needs of his workers, starting first on construction projects in isolated areas, then moving to West Coast shipyards.

Offered to the public for the first time in 1945, the Kaiser Health Foundation Plan now has almost 2 million subscribers, with only 3 per cent on Kaiser payrolls.

Labor still considers the plan the "best buy" for its health dollars, and is trying to spur Kaiser to expand to the East.

Unlike Kaiser and other group practice plans, most prepaid insurance coverage is weighted in favor of reimbursing costs that incur in the hospital.

Although all but about 15 per cent of Americans have some sort of health insurance, only about 50 per cent are covered for visits to doctors' offices, for X-rays, laboratory tests and other preventive services.

It is only recently, for example, that California Blue Shield has begun to circulate pop-arty folders for "the 'keep well' plan you've been waiting for." The folder says:

"Now, for the first time . . . based upon a new and fresh concept!"

Yet the "keep well" philosophy is at the heart of the 25-year-old Kaiser plan, akin to that of the Chinese centuries ago—pay the doctor to keep you well and he'll take care of you when you are sick.

Variations of that philosophy are tied to today's critical appraisal of the nation's health care.

Why, the critics ask, are American wage earners being priced out of the health-care market when this country spends more of its Gross National Product for health care than any other nation?

OUNCE OF PREVENTION

The answer generally is that America funnels her billions into "sick care"—into costly hospital care instead of supporting a comprehensive system that prevents people from going to hospitals.

Kaiser has documented the fact that when preventive care is available and there is no financial barrier to its use, hospital admissions to do so are no barrier to its use, hospital admissions go down dramatically.

This is the key to Kaiser's economies, numerous studies have shown. Outside experts, including a Johnson administration advisory health panel, agree that the limitation on hospital use keeps costs down while providing Kaiser members with "equivalent, if not superior," care.

Kaiser is operated quite differently than the most prevalent types of prepaid health insurance plans.

In the words of one Kaiser doctor, Blue Cross and other indemnity plans are "just hunting licenses for the patient to find his own care, while our bag is delivering it."

THEIR OWN CLINICS

What he means is that Kaiser assumes the responsibility for building, buying, or leasing medical offices, laboratories, clinics and hospitals. It staffs them with its own partnerships of doctors.

An example of the differences between the two types of plans, as outlined recently by a Kaiser West Coast manager, is this:

If Blue Cross enrolled 900,000 members, it would add the necessary billing staff and equipment to process claims.

But if Kaiser enrolled 900,000 new members, it would organize 915 doctors, 6,300 auxiliary employees, 1,621 hospital beds, and $83,000 in capital investment for each 1,000 members for doctor's offices, hospitals, land, equipment and administrative facilities.

Like any other health care system, Kaiser is hit by inflationary wage scales. It recently had to increase monthly rates in California.

But those rates still buy about one-third more services—all types of outpatient care, physical examinations, laboratory tests, doctors' home and office visits, as well as surgery and hospitalizations—than most insurance plans.

EARLY TREATMENT

Because patients have paid for their care in advance, with the exception of some nominal fees, many tend to seek medical help earlier and avoid hospitalizations.

Kaiser doctors have no reason to place patients in hospitals to obtain reimbursement, as most insurance plans require. Nor do doctors have an incentive to order unnecessary tests as a way of jacking up bills.

This is because Kaiser doctors are not paid a fee for each service performed, like most of the doctors practicing in this country. Kaiser doctors don't worry about bills because they receive set annual incomes plus bonuses if operating expenses are less than have been forecast.

One charge leveled at the Kaiser plan is that it provides impersonal service, "stand-in-line" medicine.

Kaiser facilities viewed in Portland, Ore., and San Francisco do not bear this out.

An unscheduled visit with Dr. Henry R. Shinefield, a pediatrician in the San Francisco clinic, tells a lot about the Kaiser system.

He had just identified an infant's skin condition, and was eager to have the diagnosis confirmed by a dermatologist. One telephone call located a skin specialist in the adjoining Kaiser hospital, and the infant, along with his medical records, was on his way to be seen.

With that settled, Shinefield began returning patients' calls.

"A runny nose, eh?" he said. "Well now, there are a lot of runny noses these days, but let's see what we can do . . . if that doesn't work, bring him by."

In Portland, Ore., a mother of two sets of twins said:

"I like my obstetrician. I like my pediatrician. My husband likes his internist. If we didn't, we would just choose others here at Kaiser.

"Most of all I like the fact that I can make appointments for all the family at once, instead of trotting back and forth to doctors' offices."

Kaiser is not without its critics, and they aren't all within the ranks of organized medicine, which believes fee-for-service private practice is sacroscant.

LABOR COMPETES

In California, for example, major labor unions have banded together to form the California Council for Health Plan Alternatives (CCPHA) in an attempt to get nonprofit California hospitals to establish prepaid group practice plans in competition with Kaiser.

CCPHA director Thomas G. Moore Jr., in an interview with Medical World News, had this to say about Kaiser:

"They're just so damn big. They build capital by overloading in favor of reserves, so people can't get into the hospitals or see the doctors. Kaiser is going to meet their target if they walk over every member they've got.

"They haven't had to accommodate the consumer in years. All they have to do is declare open enrollment and they're swamped. No one should get so big that he has no rival."

But Moore said then and he later told The Washington Post that "Kaiser is still the best buy for the dollar" that labor spends on health. And national labor leaders, such as the United Auto Workers' Walter P. Reuther, agree with him.

Moore's basic complaint isn't so much against Kaiser, as it is against the lack of similar competitive systems. He want to use labor's dollar clout to stimulate the formation of such systems so that "we won't continue to bargain like hell and still stand still" when it comes to broadening health benefits.

Edgar F. Kaiser, chairman of Kaiser's board, is in complete agreement that "more plans like ours should be in operation."

FREEDOM OF CHOICE

And ever since the Kaiser plan's inception, it has been offered only if employee groups have a choice of at least one essentially different plan, like Blue Cross.

Until recently when it began programs in Cleveland and Denver, Kaiser only operated in California, Portland, and Hawaii.

But in those localities, consumer acceptance has been unusually high. For example, only about 6 per cent of federal employees belong to group practice plans nationally, compared to 58 per cent for Blue Cross; yet, in Kaiser's home base of California, 27 per cent belong to group plans (principally Kaiser), compared to Blue Cross' 36 per cent.

Furthermore, when there were enrollment periods for federal employees in California in 1965 and 1966, Kaiser gained more than 7,500 members, while Blue Cross lost more than 400. A recent enrollment period closed in November and its results are not known yet.

Prepaid group plans like Kaiser have been spreading, but many of them, like Washington's Group Health Association, are hampered by not owning their own facilities, and, thereby, not being able to control how they are used.

Yale, Harvard and Johns Hopkins (with the latter operating in a new city of Columbia, Md.) are now deeply involved in the development of new plans, as are some insurance companies.

GOVERNMENT CAUTIOUS

The federal government also is cautiously exploring the prepaid group health field and, through Medicare and Public Health Service grants, is supporting projects to prove its potential.

Yet, as far as the Government's effort is concerned, some observers wonder why the obvious must be proven. It was in 1968 that an incredulous Sen. Abraham A. Ribicoff (D-Conn.) interrupted testimony to ask:

"Give me that figure, again. In other words, your hospital utilization for Medicare patients, people over 65, is just half of the national average of Medicare?

Dr. Ernest Saward, medical director for Kaiser in Portland, said Ribicoff's interpretation was correct—Medicare patients enrolled with Kaiser in Oregon were being admitted to the hospital about 50 per cent less frequently than the national rate of Medicare hospital admissions.

Ribicoff, cognizant that hospital admissions are the most expensive of Medicare's costs, said:

"It would seem to me this ought to make Medicare's administrative agencies' hair stand on end."

"We hope at least, that they are interested," Saward said.

Next: Reform, but slowly.

[From the Washington Post, Jan. 6, 1970]

HEALTH-CARE REFORM COMES SLOWLY

Third of a Series

(By Eve Edstrom)

When "Cheap Charlie's" five-and-dime became the Bathgate Avenue health center, it was to have been the beginning of the end to "hard bench" emergency room medicine in the Southeast Bronx.

Whole areas of that New York neighborhood look like a war-abandoned city, with burned-out tenements, boarded-up stores, and brick rubble covering vacant lots.

Yet 45,000 of the nation's 25 million urban poor live there—and many more than need be die.

Violence has so shattered the area that Sister Virginia, a public health nurse, says it is rightly known as Fort Apache. But murders, muggings and knifings do not produce its most chilling statistics.

That is reserved for the number of babies who needlessly die. On some blocks the infant mortality rate is as high as 41 per thousand or double the national rate.

The brutality of that statistic lies in the fact that 37 of the 41 babies could have lived—if Bathgate's quality of medical care had been readily available.

There are many measurements that experts use to show how well or how poorly a nation delivers its health care. And on the most commonly used scales—length of life, infant and maternal mortality—America's ratings are shockingly poor.

STILL IN 10TH PLACE

Even if the nation's most-deprived citizens, like the Negroes and Spanish-speaking residents of the South Bronx, were excluded from the statistics, the United States would still rank 10th among Western nations on the infant mortality scale. If all citizens were included, this nation falls to 15th place.

"Now, that is a scandalous comment on the availability of health services in the United States, because we have the knowledge, we have the ability to deal with the problem of infant mortality," former Health, Education and Welfare Secretary Wilbur J. Cohen once said. "There is no mystery about what needs to be done."

It is young doctors, like Canadian-born Dr. Harold B. Wise in the South Bronx, who are showing what can be done. Among mothers who have received prenatal care at the clinic he heads, the infant mortality rate has dropped to four per thousand or one-fifth the national average.

As Dr. Wise has noted, the ghettoes don't need any more scientific breakthroughs, not when a leading cause of infant death is still easily treatable diarrhea.

And there doesn't need to be additional evidence that America's system of delivering existing medical knowledge is drastically deficient when Dr. Wise finds that a 19th century discovery, such as smallpox vaccine, has not been applied to many childen being seen in his clinic today.

There are those who suggest that the poor don't receive health care in this nation simply because they are too lazy to get it.

PROVE OTHERWISE

Dr. Wise's three-year-old operation and 48 similar ones being supported throughout the country by the Office of Economic Opportunity prove otherwise.

The South Bronx project began in the Bathgate Avenue storefront, but now its main facility is a renovated five-story former warehouse, which opened in August, 1968, and is known as the Dr. Martin Luther King Jr. Health Center.

Community acceptance has been overwhelming, with 28,000 of the 45,000 residents registered for care. In fact, enrollment has been closed until additional facilities to meet the demand can be made available.

CHOSEN FOR WEDDING

So warmly do some of the residents feel toward the project that one young Puerto Rican couple recently asked and was allowed to be married at the Bathgate satellite center, which was festooned with pink streamers for the occasion.

Before the health project began, South Bronx residents presumably had a couple of ways to get medical care.

They could go to a private physician, which the American Medical Association says is the best way to get care. But private physicians have fled the ghetto. The South Bronx had five of them left, and two were in semi-retirement.

Morrisania City Hospital was another place to get care. But for many South Bronx residents, it was two bus rides away, and then there was the lengthy wait to see a doctor. It was not unusual to spend six hours to make the trip, receive care, and return home.

And so the normal pattern of care in this section of the skyscraper city was to go to Morrisania for emergencies only; otherwise, get medication from a druggist or a "herb doctor."

To change these habits, it took much more than establishing an accessible facility, and making available the services of Dr. Wise, his assistant Dr. W. B. Lloyd, and teams of internists, pediatricians, obstetricians and other specialists.

ESSENTIAL PERSONNEL

Essential to the functioning of the doctors have been public health nurses, and family health workers—persons trained at the health center and trusted by the neighborhood because they have grown up there.

These workers, by visiting families and knowing their life style, constantly are educating the doctors. For example, it doesn't do much good to prescribe medicine three times daily with meals, when the neighborhood worker reports the family eats only one meal a day.

And a family worker can uncover the cause of a child's bedwetting, a case which defied some specialists. The youngster was afraid to get up at night for fear of stepping on rats. In the absence of rat control measures, a long cord attached to a night light solved the problem.

Currently, the public health nurses and the family workers are detectors of the possible cause of mental retardation, brain damage and other neurological disorders found among many slum children.

NOT IN PRACTICE

This does not mean they are practicing medicine. They are simply making home visits to get samples of paint and to perform tests that determine whether the paint contains more than one percent lead.

It is the eating of paint and plaster chips that results in many poor children becoming the victims of lead poisoning with its eventual permanent damage. The Bronx center now has a mass screening project under way to detect it.

"We can find it, we can treat, it, but there's nothing in the medical books to show how to prevent children from eating the paint chips once they return home," said Dr. Lloyd the other day.

INCENTIVE CENTER

For this reason along with the numerous other health hazards that exist in the ghetto, a community health advocacy center has been established to work with the health center.

Once lead poisoning is diagnosed, community health advocacy attorneys are notified so that they can explore legal remedies to get the paint removed. They

also are working on a raft of other measures, ranging from the enforcement of sanitation standards to obtaining day care centers so mothers will have a place to leave children when they have medical appointments. In fact, the magnitude and the severity of the problems uncovered have so taxed the health center's staff that it has been impossible to concentrate on preventive health care in an uncroweded, unhurried setting as was planned.

"Patient registration and visits have increased by 200 percent during the past year," the center's third annual report to OEO states.

". . . We are finding ourselves frantically doing more and achieving less. The physician under pressure will tend to think less and refer more, leading to the fragmentation we had hoped to avoid.

"Systems which function adequately with small knowledgeable staff break down under the onslaught of 300 visits a day."

And so Dr. Wise fears that once again "care for the poor" will become "poor care."

If there is one myth that is slow to die in this country, as the Urban Coalition's John W. Gardner has emphasized, it is the commonly held belief that the very poor, along with the very rich, get good medical care.

HIT-AND-MISS CARE

The poor get hit-and-miss care at best, and often they don't get any care, even when they live in the shadow of the nation's major medical centers.

Not so many years ago, Dr. John H. Knowles once observed, the highest concentration of tuberculosis in this country was one block from Massachusetts General Hospital.

"It was only if those people could somehow enter the system, find a way around the block to our hospital, would we see them and help them, and our function was totally passive," Dr. Knowles said.

"We didn't go across the street to uncover disease and prevent it. There was no extension of our interests outside of the walls of that hospital. That has changed . . . (but) it has not changed in most of the urban hospitals of this country.

It has been the fledgling OEO—and not the age-old Public Health Service—that has been in the forefront of attempting to bring about change.

OEO has done this through establishing new delivery systems of care as it has in the Bronx, and through the new use of existing systems. In Portland, Ore., for example, 1,200 poor families have been folded into an existing Kaiser prepaid group health plan.

OEO pays for the poor families' health care, and, contrary to predictions, Kaiser facilities have not been swamped with poor people seeking unnecessary services. Neither has there been the predicted disruption of services to Kaiser's regular middle-class subscribers.

This has led to the conclusion that it would be "most useful and appropriate to motivate existing medical care systems, such as prepaid group practice plans, to accept a greater burden of responsibility in organizing medical care for indigent populations."

HASN'T WHEREWITHAL

While OEO is doing a creditable job, it does not have the wherewithal, let alone the authority, to bring about massive reforms in the nation's $60 billion health care industry.

Any wholesale reforms will depend on whether middle-class Americans insist upon them. Increasingly, there is evidence that taxpayers are fed up with paying skyrocketing prices for what has been described as the "general sloppy nature of our entire health effort."

Labor unions, in particular, are upset over studies showing that they are paying superior prices for inferior care, as well as unnecessary hospitalizations and medical procedures.

This is leading to the formation of broadly-based consumer interest lobbying groups which have a single purpose: Wielding their dollar power to force America's health care industry to deliver its medical potential.

Next: Administration Slow To Reform Health Care

[From the Washington Post, Jan. 7, 1970]

Administration Slow To Reform Health Care

Last of a Series

(By Eve Edstrom)

President Nixon flatly opposed a national compulsory health insurance program during his 1968 campaign.

He said any new health programs "should be geared only to persons in need."

But by July of his first year in office, President Nixon said the nation's health-care problems were "much greater than I had realized," that a "massive" health-care crisis "affecting millions of people" was in the making.

And by the fall of 1969, Health, Education, and Welfare Secretary Robert H. Finch broadened the mandate of a federal panel so it specifically could look into the feasibility of a national health plan.

GOVERNORS' SUPPORT

This action was taken just a few days after the nation's governors—three-fifths of whom are Republicans—voiced their support for a national health insurance program.

During this same period, the administration's top health official, Dr. Roger O. Egeberg, was not-so-subtly changing his stance on national health insurance.

During his first meeting with the Washington press last July, Dr. Egeberg rejected national health insurance outright, declaring, "I don't think that we are ready for anything of that kind in this country."

In the months that have followed, however, he has emphasized that health services are in short supply, that they are being overtaxed by Medicare and Medicaid, that the administrative problems of existing public programs must be straightened out and health services must be expanded before the nation embarks on a national health insurance plan.

In effect, Dr. Egeberg has been saying: Don't push us too fast, let us get our house in order before we take on new challenges.

And this is expected to be the administration's position when a wide-ranging variety of national health inusrance proposals are discussed during the next session of Congress.

CALIFORNIA REFUND

To meet the "massive crisis" which Mr. Nixon spoke of last July, the administration has recommended only a handful of legislative proposals, aimed principally at tightening cost controls over Medicare and Medicaid.

These include stimulating additional experiments to give incentives to health providers to cut costs. Such experiments do pay off as the San Joaquin, Calif., Foundation for Medical Care proved last month when it refunded $200,000 to Gov. Ronald Reagan.

The foundation, an organization of 330 doctors in private practice, agreed to provide medical care to 22,000 Medicaid patients at the prepaid cost of $165,000 a month. The doctors carefully reviewed each other's bills for service and, by the end of a year, they found services cost $200,000 less than had been estimated.

California officials said that "millions" could be saved if the plan, which covered four counties, could be adopted statewide.

And many federal observers believe Medicare and Medicaid costs could be cut by billions if prepayments, based on forecasted budgets, were made to hospitals and doctors, instead of simply paying hospital costs and doctors' charges after services are given.

But there is no indication that the administration will initiate any widespread reforms in existing programs, or that it will seek dollars to substantially increase health facilities and manpower.

In fact, some supporters of a national health plan, like Bert Seidman, director of the AFL–CIO Social Security Department, say that the nation already has enough doctors and hospital beds if they are used intelligently. Seidman insists that more comprehensive and higher quality health services could be provided to all Americans "for no more and perhaps less" than is now being spent on health care.

Even those who maintain that health care shortages exist give short shift to the administration's argument that it can't move ahead on a national health plan until existing gaps are closed. As Sen. Edward M. Kennedy (D.-Mass.) has said:

"To those who say that national health insurance won't work unless we first have an enormous increase in health manpower and health facilities and a revolution in the delivery of health care, I reply that until we begin moving toward national health insurance, neither Congress nor the medical profession will ever take the basic steps that are essential to reorganize the system.

"Without national health insurance to galvanize us into action, I fear that we will simply continue to patch the present system beyond any reasonable hope of survival."

KENNEDY PLAN

While urging the administration to submit its own proposals, Sen. Kennedy has said that he will introduce a comprehensive plan that would phase in children by 1971 and would be expanded to include all Americans by 1975.

Other senators working on legislative proposals include Sen. Jacob K. Javits (R-N.Y.), who is drafting a bill with the aid of Medicare's architect, former Health, Education, and Welfare Secretary Wilbur J. Cohen.

Among the most influential advocates of a national health plan is the newly formed Committee for National Health Insurance, which includes 100 labor, business, government and medical leaders.

The committee's chairman is Walter P. Reuther, president of the United Automobile Workers. Vice chairmen are Mrs. Albert D. Lasker, Dr. Michael E. DeBakey and Whitney M. Young, Jr.

In a statement issued last month, the committee warned the administration against adopting a "tunnel-vision approach to the nation's health-care needs."

The committee insists that a national health insurance plan must go hand-in-hand with improvements for delivering health care.

Under its proposals, the committee would earmark funds to develop new health-care systems and to expand support for prepaid group practice plans, which keep costs down by emphasizing preventive services and out of hospital care.

"These are not pie-in-the-sky proposals," the committee said.

". . . Operating on the philosophy that keeping people well is cheaper than making them well, comprehensive group practice plans offer many advantages in quality and cost, both for doctors and consumers."

PREPAID PLANS

For example, the committee noted that federal employees who belong to prepaid group practice plans are hospitalized only one-half as often as employees who belong to other plans.

This is because other plans, such as Blue Cross, have only recently begun to offer insurance that covers preventive services. Therefore, to obtain care, a beneficiary has had to use the most expensive element of the health industry, the hospital.

"What sense does it make," Anne R. Somers, who with her husband, Herman, is a frequent writer on health-care matters, once wrote, "to guarantee a federal employee a whole year of completely free coverage as a hospital inpatient at an average cost of about $60 a day and a potential cost of about $22,000, and deny him a pair of needed glasses that would cost about $25, or a hearing aid that would cost $200 to $300?"

Such costly and inefficient reimbursement policies were reinforced by Medicare, which established a financing mechanism to pay for the health care of the aged but did nothing to change the way health care was delivered.

AMA'S MEDICREDIT

And this would be continued under the American Medical Association's national insurance proposal. Known as "Medicredit," the AMA would provide tax credits for those who purchase health insurance. The federal government would buy the insurance for those who cannot afford monthly premiums, but there are no provisions for restructuring the health-care system.

The Reuther committee, on the other hand, asserts that a basic aim of national health insurance must be to "assure the availability of health-care services for all Americans, not just pay for them."

On this point, Great Britain's 1944 White Paper on Health Policy stated:

"If people are to have a right to look to a public service for all their medical needs, it must be somebody's duty to see that they do not look in vain."

The United States may never have a nationalized health service. But the next session of Congress will begin the debate over how the right of all Americans to health care will be fulfilled.

[From the Washington Evening Star, Jan. 9, 1970]

Why Economize on the Health of Americans?

(By Carl T. Rowan)

President Nixon has threatened to veto the Health, Education and Welfare Department appropriation bill because Congress has allocated more money than he requested. Before the President acts he surely ought to read part of a recent speech by a fellow Republican, Sen. Charles McC. Mathias of Maryland.

In pleading for more money for medical research, Mathias recently told the Senate about Danny Rose, a patient at Children's Hospital here.

"Danny . . . came to Children's two months ago with his undersized body twisting into grotesque positions. He could not control his movements and was unable to speak. Recently, he sat up unaided and for the first time in three years, he spoke. Danny, who is 11, suffered from dystonia, a brain disease. He is being treated with L-Dopa, a new drug that provided exciting results in the treatment of Parkinson's disease.

"Dr. (Mary) Coleman expects and hopes to have Danny walk out of Children's Hospital one day soon. But he may not. Dr. Coleman's work may be curtailed by cutbacks in research funds."

As Mathias points out, Danny represents the human side of a dollars and cents debate that has wracked Congress and the administration.

Budget cuts proposed by the administration in the fields of health, together with the eroding effects of inflation, have caused alarm and bitterness among scientists and medical authorities. These proposed cuts ought to also cause concern in every American family for all are affected in some way.

The cutbacks mean reductions in chronic disease control, rehabilitation, medical research and training, and health profession scholarship and loan funds. They directly affect desperately needed research in our two greatest killers, cancer and heart disease, work with the mentally retarded, hospital construction, the education of new doctors and nurses, and research on stroke, diabetes, arthritis, respiratory, neurological and other diseases.

For example, the budget proposed for the National Institutes of Health would force the NIH to phase out five major programs to attack chronic and crippling diseases and 19 clinical research centers (including seven devoted to childhood disease), cancel a major heart research project and dismantle some of its unique medical research teams.

A cancer researcher has complained that the budget for the National Cancer Institute is "grossly inadequate" and "cannot fail to jeopardize our fight against cancer," a disease which cost this country about 325,000 lives in 1969, more than eight times the toll of American dead in Vietnam since the start of the war there.

Dr. Michael de Bakey, the prominent heart surgeon, testified that federal health cuts would mean that 2,000 men sorely needed as junior faculty for medical schools will not be trained.

Other medical authorities have noted that it will be difficult to recruit young people for careers in these fields if they must periodically face economic dangers due to federal budget changes.

Dr. Coleman of Children's Hospital told senators she expects to have to turn away children with mongolism and dystonia who are now being treated with research drugs.

One physician, Dr. Abraham Bergman of Seattle, charged in Senate testimony that the administration is "playing Russian roulette with the health of the American people."

The impact of cutbacks becomes more evident and frightening when you realize that the federal government provides about 65 percent of all funds for health research and that 43 percent of all medical school faculty members have some of their salaries paid by government funds.

Nixon's argument is that he cannot approve so heavy an increase in federal spending "at this critical point in the battle against inflation"—despite his support of the objectives of these programs.

Few people would argue that we need not curb inflation. But millions of Americans will ask why inflation was overlooked when Nixon requested $96 million this year for the supersonic transport, but it has become a paramount issue when the health of little Danny Rose and millions of other Americans is at stake.

[From the New York Times, Jan. 12, 1970]

IN HEALTH, THE ACCENT SWITCHES TO PREVENTION

(By Harold M. Schmeck Jr.)

WASHINGTON.—If the hopes and expectations of medical scientists come true, the 1970's will be most notable for the things that don't happen, not for the things that do.

That will mean fewer stores of "miraculous" revival at death's door; many more cases in which the patient was not even sick enough to go to the hospital. And it will mean a healthier generation of Americans who simply won't realize what they have missed.

As the decade opens it is already possible to list some of the age-old menaces that are almost certain to be erased from the American health scene.

Mumps, measles, polio, rubella, rheumatic fever and some forms of pneumonia can become rare diseases within a few years if the proper public health steps are taken. In fact, it has already happened with polio.

Erythroblastosis Fetalis, more commonly known as Rh disease, should also disappear.

To the child and young adult of the mid-seventies these afflictions will only be half-remembered names from the past. There will be occasional outbreaks, but nothing more.

Freedom from all these diseases will be taken as a matter of course. No one will count the number of babies who did not die, the number of children who did not get heart disease or crippled limbs or suffer damaged vision or hearing or the ultimate tragedy of mental retardation. But the numbers saved because of vaccines and other countermeasures will be great.

In the normal course of things, a nationwide rubella epidemic would be expected sometime in the early 1970's. Judging from experience, it would almost certainly cause more than 50,000 babies to be born dead or deformed. At least 20,000 survivors would need special care all their lives.

Rubella vaccines already licensed can prevent such an epidemic from ever occurring again in the United States.

An even larger number of healthy lives can be salvaged by preventive treatment for Rh disease—a life-threatening hazard to the unborn baby that arises when the mother's blood is Rh negative and the father's is Rh positive.

The danger arises when the baby's blood has the Rh blood factor and the mother makes destructive antibodies against it. This problems kills about 5,000 infants a year and harms or endangers many more. Treatment that has only recently become widely available can prevent it.

The toll of mental retardation should be diminished not only because doctors are discovering some specific causes, but also because of new attacks on the indirect causes.

The Nixon Administration has already decided to give high priority to problems of maternal health, infant care and family planning. Scientists in this area of study expect to make important progress.

During the seventies at least one major epidemic of influenza is to be expected comparable to the deluge of Hong Kong flu of 1968. Studies sponsored by the National Institute of Allergy and Infectious Diseases are already working toward means of snuffing out such outbreaks as they hit our shores. Included are better ways of giving flu vaccine and ways of making more effective vaccines and tailoring them more quickly to match sudden shifts in the notoriously changeable flu virus.

Heart disease and kidney disease are sure to be among the nation's most important public health problems in the next 10 years. Improvements in the art and science of transplantation will be adding more years of youthful life to more of these patients. New artificial aids such as heart booster pumps and improved,

inexpensive and miniaturized artificial kidney machines are also on the horizon.

The National Heart and Lung Institute is already sponsoring major programs to find better ways of saving the victims of heart attacks and to learn the warning signs that say a heart attack is imminent.

Today more than half the persons who die of heart attack don't survive long enough to reach a hospital. Better prediction and some home-treatment measures available to high-risk patients might save tens of thousands of men in their most productive years.

In a recent interview, for example Dr. Gerald D. LaVeck, director of the National Institute of Child Health and Human Development, predicted far safer and more effective means of contraception would be developed in the next decade. Specialists believe that this will mean that the babies who are born will be healthier and have a better chance in life. There are many reasons for this. One example illustrates the point.

From the viewpoint of good maternal and child health, the best age for a mother to have her baby is probably in her early 20's and intelligent family planning can help arrange this. When the mother is between 20 and 25, the risk that her baby will be born mentally defective is one in 2,000, Dr. LaVeck said. If she is over 45, the risk is one in 40.

Better understanding of the link between nutrition, early environment and a child's mental developement should also make the generation born in the late 1970's brighter as well as physically healthier. Major studies are in progress now to discover the ties that link malnutrition and poverty with depressed mental capability—and the best ways to erase, or prevent, that depression.

The advances of the next decade will not all be in child health, even though this is the field where the payoffs are potentially greatest.

As the old decade closed, scientists seemed to be on the brink of proving that some cancers of man are caused by viruses and, in a somewhat related area of research, that immunology—the science of man's own internal defenses against disease—can be useful in fighting against cancers that have already developed. Some preventive vaccines and powerful immunological weapons against cancer are at least conceivable in the next 10 years.

All of the items on this roster of hopes for a new decade can be listed because of research that was done in the last two decades or before. The advances will have a profound impact on the delivery of medical care, partly because prevention is usually more economical than cure.

The timing of each advance cannot be foretold in detail. However, it has been the common experience of medical scientists and administrators that they overestimate what can be done in the immediate future, but underestimate the achievments that will come in the somewhat longer range.

[From the New York Times, Jan. 12, 1970]

ADMINISTRATION SEEKS SHORT-RUN GAINS IN NATION'S MEDICAL SYSTEM

(By Richard D. Lyons)

WASHINGTON, Jan. 11.—Six months ago yesterday the Nixon Administration branded the nation's medical system a "cottage industry" and warned of a "breakdown in the delivery of health care unless immediate concerted action is taken."

Half a year later, the Administration is not pursuing crisis methods but instead is focusing efforts of what it terms the "pressure points" in the system that might yield short run gains.

The reason for this is that as serious as it views the problems of medical care, the Administration is more concerned with the need to hold down Government spending as a counter against inflation.

President Nixon and his Secretary of Health, Education and Welfare, Robert H. Finch, have become, after a year in office, only too well aware of the dimensions of trying to overhaul the nation's laissez-faire health care system, an industry that continues to be a patchwork with few if any nationwide, much less state or local, controls.

John G. Veneman, Mr. Finch's Under Secretary, was asked the other day to equate the Administration's statements with its performance since last summer.

"Well, I don't see the point of issuing a lot of rhetoric," Mr. Veneman said, shaking his head. The statements were made merely to call attention to the problem. They were not meant to solve them."

Government officials at all levels, as well as many persons within the health industry, have repeatedly made the following points:

There is a shortage of medical manpower.

The administration of many medical programs is weak.

There are few incentives to hold down ever-increasing health costs.

Services are fragmented and lack coordination.

The Nixon Administration has found that pumping more money into the system will not in itself solve the problems.

"We're on the horns of a dilemma," Mr. Veneman said. "Putting more money in has the negative inflationary effect of driving costs up so that the money pays for less. Thus more money is needed just to stand still."

PRICES ARE RISING

Medical prices are rising at twice the rate of increase in the cost of living, and in the coming fiscal year the Medicaid program alone will cost about $1.5-billion more that it does now. This not only increases H.E.W.'s budget but also offsets savings in other Federal departments, such as the space agency.

The Administration is concentrating its short-term efforts on the administrative tightening of the Medicaid program to try to control its ever-increasing costs, to improve methods of delivering health care services, to train more doctors and nurses and to make birth control services more readily available to anyone who seeks them.

Yet according to statements and predictions by Administration officials, the health budget for the fiscal year 1971, which is now being prepared, will not be radically different from even that of last year.

Loans, scholarships and traineeships for medical and dental students, for example, probably will be the same as last year, although nursing scholarships may rise somewhat and support for schools that train medical and dental personnel may go up as much as 25 percent.

Mr. Veneman asserted that even if massive new support was devoted to training more doctors and nurses, its effect would not be felt for at least five years.

The nation's shortage of doctors is estimated by Health, Education and Welfare officials at more than 50,000, and even though medical schools are grudgingly increasing enrollments, the demand for physicians' services keeps increasing faster than domestic abilities to meet them.

Mr. Finch said in a recent interview that "an astronomical number" of newly licensed doctors, "some 30 to 40 percent," had been trained abroad. The quality and performance of these foreign medical graduates has been coming under increasing scrutiny. They are in great demand in the nation's understaffed hospitals.

Mr. Finch mentioned that the Administration was considering a plan to place young doctors in ghetto areas to man health centers and hospitals "for a given period of service if the Federal Government pays the costs of their medical education."

But leaders of the United States Public Health Service, which would administer the program, have expressed pessimism that such a program is near at hand. They said the health service was prevented by law from doing this and that the Selective Service System had first call on the young physicians to staff the Medical Corps of the armed forces.

Mr. Finch and other department leaders have repeatedly suggested that enlisted medical corpsmen could, on leaving the service, be trained as physicians' assistants, a category of health professional widely employed in the Soviet Union.

These men might, after six months or so of additional training, go into areas that are short of doctors to take temperatures, dispense drugs for common ailments, set simple fractures and insure that rarer and more difficult cases are promptly brought to medical centers for more expert diagnosis.

Early last year, the concept of training and using physicians' assistants received wide support in the department, but reformers ran into two problems that have yet to be resolved: Who is to certify that these workers are competent, and who will insure them against malpractice, such as setting a broken leg improperly?

AGENCIES RELUCTANT

States license doctors to practice medicine, and certification agencies have shown a reluctance to adopt the new concept. A few states in the South and Far West are making limited progress, but most have resisted innovation. Companies

issuing malpractice insurance also are wary of involving themselves in something new and untested.

Premiums for malpractice insurance for doctors themselves are skyrocketing. One California surgeon pays $40,000 a year in premiums, to the point that there have been discussions within the Department of Health, Education and Welfare of setting up a national malpractice insurance corporation, or something like it, at the state level.

Medical malpractice suits, a little-understood area of increasing concern, are intended to protect a person against poor or even disastrous professional work by a physician. Yet the potential for suing a doctor for poor performance may sometimes work against the benefit of the patient.

As Senator Abraham A. Ribicoff, Democrat of Connecticut, said after conducting a malpractice survey recently, the rising number of malpractice suits is forcing doctors to practice "defensive medicine"—that is, ordering "excessive diagnostic procedures, thus increasing the cost of care," and "declining to perform other procedures, which in themselves may entail some risk of patient injury."

NO SOLUTIONS SEEN

As a lawyer in California, Mr. Finch represented both plaintiffs and defendants in medical malpractice suits and is aware of their increasingly negative impact on medicine. Yet he concedes that there are no immediate solutions.

One of the 10 reforms mentioned in a White House report on health care needs, issued six months ago, said: "We will move in the direction of reducing the Medicaid burden on general revenues by shifting to various forms of prepayment."

This means using an increasingly popular medical treatment idea that in New York City is named the Health Insurance Plan, or more commonly "HIP," and on the West Coast is called the Kaiser-Permanente Program. This is an attempt to treat a person's total health, not merely to afford him insurance protection when he becomes ill.

NO MAJOR MOVEMENT

Neighborhood clinics are sometimes used near the consumer's home so that he may be given more frequent attention and medical examinations. The objective is to detect disease before hospitalization becomes necessary.

In the long run, these plans have been shown to be more efficient in improving a member's total health and less expensive than the far more common approach of waiting until a disease hits and treating it in a hospital.

While many medical reformers in the Administration concede that prepayment plans have an excellent chance for success, there has been no major movement toward instigating them. They would require money, manpower and imagination, items that have traditionally been in short supply in the health care industry.

On the positive side, the Administration has cracked down hard on medical bookkeeping. It instituted a freeze on fees doctors could charge under Medicaid, which caused a doctor's backlash against the Administration.

It instituted fee reimbursement mechanisms that use a doctor's Social Security number when paying bills to allow computers to compile his income for audit, something that was impossible in the past. Doctors are also unhappy with this feature.

Allowances to hospitals and nursing homes for unidentified costs were eliminated, forcing better accounting methods. More frequent reviews of the necessity for a person's hospitalization have been started. This is an attempt to reduce the number of unnecessary patients to hold down costs.

The administration of Medicaid has also been tightened somewhat with the addition of more administrative personnel and better accounting methods. Yet this massive program has been without a director for almost six months, and a search for a replacement has been unavailing.

Mr. Finch, whom Administration officials credit with fighting long and hard to obtain more money and political backing for his department, may have summed up the Nixon Administration's first year of efforts to amend the health system when he said of Medicaid "Right now the only thing we can do is to mend and patch."

[From the New York Times, Jan. 12, 1970]

Health Care Faces Severest Demands

(By Roger O. Egeberg[1])

Whatever else it may witness, the nineteen-seventies will see the most severe test of America's capacity to deliver decent health care to those who need it.

Health-care delivery, the complex of ways in which health services are provided and paid for in doctors' offices, clinics, hospitals and nursing homes, is in a crippling squeeze between sharply rising demand and an only barely improving supply of essential resources. The result is soaring costs coupled with grim evidence that millions of Americans simply are not getting needed health care.

Several things have brought the health-care crisis to a head. Population growth, for one, is putting increasing pressure on our health care delivery systems. But other factors are even more significant.

The great advances in medical science—new drugs and medicines, new surgical procedures, better methods of diagnosis—have increased rather than lightened the load on manpower and facilities. Because medicine can do more for people than it could 30, 20 or even 10 years ago, more and more people expect to share the fruits of progress.

A BURDEN ON DELIVERY

Equally important, the citizens of the most affluent country in the world believe, rightly, that they are entitled to health care, regardless of the ability to pay for it. The adoption of Medicare and Medicaid, both of which are aimed at making health services available to large numbers of people who have been economically excluded from first-rate care, placed a heavy burden on an already faltering delivery system.

The signs of the health care crisis are obvious and predictable. The cost of health care is rising twice as fast as the over-all cost of living. Doctors, who typically work an average of 60 hours a week, are finding it increasingly hard to expand their productivity. They have little time for preventive care and, instead, are forced to concentrate on caring for sick people who should have been kept well.

A situation made bad by rising demand is made even worse by health-insurance plans that encourage a patient to go to the hospital when he could get equally good care at home or in a clinic or doctor's office, and get it at considerably lower cost.

The way out of this dilemma won't be easy to find. But there is little doubt that effective solutions will have to be worked out in the coming decade if the health-care delivery system in the United States is not to collapse.

Some parts of the remedy are obvious. More doctors are urgently needed. It has been estimated that we need 50,000 doctors to meet present demand, and that by the mid-nineteen-seventies we will still be 40,000 short of the minimum necessary to keep up with population growth. As for dentists and registered nurses, we will fall still further behind in the next five years.

BREAKTHROUGHS

Adding more doctors and other health professionals may never prove fully effective unless substantial changes occur in the way people get health care. While such controlling factors as long periods of training and supply of professional health schools and faculty are relatively inflexible, there are virtually no limits on the demand for health care. It may be that we can never produce enough health workers, which means that we will have to find better, more efficient ways of using them.

Health-care delivery is now a field of research in its own right, one in which breakthroughs are urgently needed. Every aspect of the system is coming under close and questioning scrutiny, from medical school curriculums and admissions practices to the design of hospitals and the staffing of neighborhood health centers.

In addition to increasing efficiency all along the line, it seems certain that we are going to have to develop some new ideas about what constitutes health care and how to get it.

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[1] Dr. Egeberg is Assistant Secretary for Health and Scientific Affairs, United States Department of Health, Education, and Welfare.

New kinds of professional health personnel, such as physicians' assistants, could do much of the routine work that now limits the ability of doctors to use the skills they acquire over years of training.

Medical history-taking, immunizations, and physical examinations could be successfully carried out by persons specially trained to provide these health services, leaving the physician with time available for duties that utilize his sophisticated training and experience.

But perhaps the key to solving the health-care delivery crisis will lie in efforts to keep people healthy and out of the hospital, as opposed to the present emphasis on remedial care and hospitalization.

[From the New Republic, Jan. 17, 1970]

THE GROWING PAINS OF MEDICAL CARE (I)—PAYING MORE, GETTING LESS

(By Fred Anderson [1])

Several months ago President Nixon, Secretary Finch and the Assistant Secretary for Health and Scientific Affairs, Dr. Roger Egeberg, gathered at the White House to tell the nation that it is about to face a complete breakdown in the delivery of health services. Many think the breakdown has already occurred. Long waits for an appointment with a physician, poor service, and astronomical medical bills have gradually become the rule, rather than the exception. The public does not understand how this state of affairs came about, nor why physicians, hospitals and insurers have not done something about it. Particularly irritating is the federal government's failure, though it paid 29.6 percent of the $53.1 billion spent on health in 1968. Long hours in the "waiting room," hurried and impersonal attention, difficulty in obtaining night and weekend care, reduction of services because staff is not available, high drug and treatment costs, loopholes in insurance coverage, and the like, tell only part of the story. The rest is told by statistics which smash any remaining confidence that we lead the world in health care. Fifteen other countries have longer average life expectancies. (Ten-year-old females have a longer life expectancy in twelve other countries, while the American male child of ten years is bested in 31 countries.) Infant mortality is less in 14 other nations. Five countries have better maternal mortality rates. Twelve have better records for ulcers, diabetes, cirrhosis of the liver, hypertension without heart involvement. Twenty have less heart disease.

Whatever life expectancy a white American has, subtract seven years from the life of his nonwhite counterpart. Infant mortality rates are two times as great for nonwhites as for whites. Infant mortality rates for Negro children in Mississippi or a Northern city are comparable to Ecuador's; nationwide, to Costa Rica's Nonwhite maternal mortality is four times as great as the white rate. (The disparity in maternal death rates has grown from twofold to fourfold since the end of World War II.) In the city slums there is three times as much heart disease, five times as much mental disease, four times as much high blood pressure, and four times as many deaths before age thirty-five than there is nationwide.

The National Advisory Commission on Health Manpower (1967) reviewed 15 representative studies of the quality of health care service in the United States. Here are the findings in three of the studies: (1) a survey of medical laboratories sponsored by the National Center for Communicable Diseases (U.S. Public Health Service) found that 25 percent of reported laboratory results on known samples were erroneous; (2) an evaluation of all major female pelvic surgery performed during a six-month period in a community hospital revealed that 70 percent of the operations which resulted in castration or sterilization were unjustified in the opinion of expert consultants; (3) the medical records of a random sample of 430 patients admitted to 98 different hospitals in New York City during May 1962 were reviewed by expert clinicians. In their opinion only 57 percent of all patients, and only 31 percent of the general medical cases, received "optimal" care.

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[1] Fred Anderson, a graduate of Oxford and Harvard in law, recently interrupted advanced work in political science at Berkeley to become a staff associate of the National Academy of Engineering. His "Death and Doctors" appeared in the April 19, 1969, New Republic.

Organized medicine attributes deterioration in health care to our failure to produce enough physicians for the growing demands for services. That's correct, to a point. Over the decade 1955–1965 "physician-directed services" rose 81 percent and hospital services 65 percent, although the increased output of physicians (22 percent) barely exceeded population growth (17 percent). In fact, the increase in physicians who went into patient care (12 percent) was *less* than population growth. Thus the availability of direct, personal treatment by a physician has diminished at a time when demand for medical care is going up rapidly. Demand has been so great that the expected undersupply of physicians should have occurred years ago. What happened? Physicians learned to delegate many tasks to other medical professionals, a practice which should be encouraged. Between 1955 and 1965, professional nurses increased by 44 percent, nonprofessional nurses 63 percent, X-ray technologist 56 percent, and clinical laboratory personnel 70 percent. Nevertheless, in the opinion of the National Advisory Commission on Health Manpower, the existing organization of medical care will soon require more physicians than the medical schools are capable of producing. "If additional personnel are employed in the present manner and within present patterns and 'systems' of care," said the Commission, "they will not avert, or even perhaps alleviate, the crisis." That seems to say that no number of additional physicians will be sufficient unless medical care is reorganized. But the Commission did not say how reorganization should be carried out.

What is so unsatisfactory about the organization of our present medical care system? It consists by and large of physicians in practice alone, or in small groups, on a fee-for-service basis. The model is the independent business entrepreneur, and a strong sense of nineteenth century individualism still guides professional conduct. (About 60 percent of physicians in direct care of patients are solo practitioners, even though less than two percent of current graduates go into general practice. Of physicians in office practice, about 72 percent still work on a fee-for-service basis.) The "nonsystem" of separate practitioners and few hospitals which grew up in the last century has somehow managed to underpin the vast array of interlocking referrals, specialities, clinics, hospital services and financial arrangements which exists today. That foundation is crumbling.

We cannot allow the further duplication of services, equipment and personnel, not only because of the high cost of redundancy, but because fee-for-service medicine is medically one-sided. It is adequate for episodic care for patients with a specific complaint. But such care, though good, is delivered in sporadic bursts. It is not the personalized, lifelong program of prevention, diagnosis, treatment and rehabilitation that it should be. Patients very rarely receive preventive screening or treatment. How could a fee-for-service bill be written for "diagnosing" and publicizing a dangerous playground? Who would be billed? The city? Parents? Fixing up several broken arms is a medical "service," with a going rate per arm. Getting embroiled with nonmedical "playground" issues is not, even though the expense of an ounce of prevention may be less than that for a pound of cure.

It is not quite fair to lay all the ills of the health care system at the feet of the practitioners who favor the fee-for-service system. The American Medical Association, as chief defender of fee-for-service, is almost a caricature of an Establishment, an easy target. But medicine has two Establishments, both of which contribute to our troubles. The second Establishment, hostile to the first, is based in urban hospitals. It is research and technology oriented, often salaried, and provides the world's best surgery and treatment for complex illnesses. The result is that though this is the best country in the world in which to have a serious illness, it is one of the worst countries in the world in which to have a nonserious illness. That part of medicine which most people encounter most often is mediocre. At the same time, we have outstanding open heart surgery, plastic surgery, surgical organ transplantation, and diagnositic skills. It is this paradox which makes it possible for a patient to read in the waiting room literature of America's latest triumph of medical technology, while failing to receive quick, effective and inexpensive treatment for a sore throat.

The strength of the new hospital-based Establishment is in its domination of the medical schools. Dr. Charles E. Lewis of Harvard's Center for Community Medicine and Medical Care believes that the inertia of medical schools and their affiliated teaching hospitals is the health care delivery system's chief problem. The schools and their hospitals turn out excellent clinicians, scientifically imaginataive researchers, who appear more concerned with a patient's interesting electrolytes than with his humdrum good health. A department chairman, selected

perhaps, because he discovered subtle mechanisms of kidney function, makes the school's reputation (and much of its money) by his work and by the grants which he gets for research. No one can tell the collection of department chairmen who run a medical school, or their granting agencies, that the funds which they collect should go to teach students how to care for whole patients in the environment in which patients live.

The fee-for-service system has not adapted well to third-party payments, whether from insurance companies or from government. The public finds this awkward welter of insurance plans and complex federal programs confusing and vexing.

Picking one's way through the medical maze requires, in the words of Dr. Sidney Lee of Harvard Medical School, "the flexibility of a worm, the dexterity of a locksmith, and the hairsplitting ability of a Philadelphia lawyer." For instance, new employees at the Lawrence Radiation Laboratories in California are handed a chart which folds out like a roadmap into a description of eight programs and benefits for 21 selected services. In the 168 separate boxes of fine print are detailed the conditions of coverage and exclusions of each of the eight plans. Making sense of health insurance is a problem for all of us, even if we are not given "helpful" charts. With approximately 1800 separate plans in existence to choose from, what are we to do?

Perhaps it would be worth working through the maze *if* private insurance provided complete coverage. It does not. *All* third-party payments, including federal programs and philanthropy as well as private insurance, accounted for only half of personal health care expenditures by 1966. The private health insurers make quite a fuss over how extensive their coverages are. They point out that about three-fourths of the population has some kind of hospitalization or surgical coverage and that the number is growing. But the important point is not that the number of persons covered is going up; it is that the insured are not getting much for their money. The insured three-fourths of the population has about one-third of its medical bills paid through insurance. Large categories of medical expenses, such as drugs, dental care, and nonhospital "ambulatory" office visits, are excluded from most policies. These exclusions are critical at a time when consumers spend about 20 percent of their health dollars on drugs, about 10 percent on dental care, and, according to a recent MIT study, another 25 percent to 50 percent for ambulatory care.

Government, principally through Medicare and Medicaid, has ventured into paying some of the medical bills of those least able to pay—the elderly and the poor. Medicare includes two related programs for insuring persons over 65 against the costs of hospitalization, physicians' services and related health care. There is no means test. Part A, Hospital Insurance Benefits, covers practically all persons over age 65. It draws its money from a special hospital insurance trust fund, in the case of social security beneficiaries, and general revenues, in the case of those not currently covered by Social Security. Part B, medical insurance for some (but nothing like all) physicians' fees and related costs, is financed by voluntary individual monthly payments, although the federal government also contributes from general revenues. Medicare functions quite smoothly, though hospitals complain of the paperwork and restrictions, and patients complain that in some hospitals they are discriminated against as Medicare patients. Lastly, and contrary to general belief, Medicare covers only about 35 percent of the total health bill of persons over 65.

Medicaid is more complicated. The primary recipients here are, in the bureaucratic phrase, the indigent "categorically needy": the aged, the blind, the disabled, and families with dependent children. Each participating state must submit a plan, and the categorically needy must be included. States are permitted, but not required, to include persons who are self-supporting but have no reserves to meet medical expenses. These are (again, their phrase) the "medically needy." States may also extend Medicaid to those whose only qualification is poverty. But the federal government will pay only the administrative costs of providing them with medical care. State Medicaid plans must offer five basic services: inpatient hospital care, outpatient hospital care, other lab and x-ray services, nursing home services, and physicians' services. States may elect to provide five additional services for a comprehensive program.

We constantly hear that Medicaid was ill-conceived, that it slipped by Congress while its attention was on Medicare. It certainly was not ill-conceived. Medicaid is a ten-year plan designed to gently badger the states into providing comprehensive medical coverage for all medically and economically deprived

persons by 1975. Inflation aside, one reason why Medicaid now gobbles up the dollars is because it is growing, exactly according to the plan set out in the original legislation. After four years of varying degrees of state acceptance, the plan does, however, seem to be a shambles: Medicaid currently serves limited categories of the poor and sick, through benefits of Byzantine complexity, which vary astonishingly from state to state (under Medicaid, New York averages $57 per inhabitant for medical assistance; New Hampshire, $5). The states abuse Medicaid, about a dozen of the states have rejected it altogether, and it is under-administered in Washington.

Skyrocketing costs under Medicaid have led to a well-publicized campaign to economize through administrative reforms. The Administration may actually believe that such tinkering with Medicaid, including November's frantic efforts of yet another Task Force, are the kind of "revolutionary change" which the President said he wanted when he drew attention to the crisis in health care. It would appear so, since the Administration's July report, billed as a major interagency study requiring five months to complete, spent most of its shot on administrative reforms. For instance, the government pins great hopes on the strict limits it recently set on fees of physicians participating in Medicaid. But physicians, angered by this effrontery, are likely to respond either by dropping out of Medicaid entirely, or raising their fees to the new legal maximum, causing costs to escalate further.

This sort of reform is worthless. All large institutional funds such as Medicaid, whether public or private in origin, are uncontrollably inflationary in the present *entrepreneurial fee-for-service system.* There is no effective way to police this vast undertaking. Through their right to determine "reasonable" fees, and behind the screen of the simple physician-patient contract for services, hospitals and practitioners are tempted to take what large third-party funds will allow. Proof is not hard to find. Medical costs were already increasing at twice the rate of increase in the Consumer Price Index when Medicaid and Medicare went into effect. But in that year physicians' fees shot up at almost three times the rate of general prices, while hospital charges, incredibly, increased at five times the rate of general prices! Small wonder that the Senate Finance Committee felt obligated to inquire into possible fraudulent behavior among the 10,000 physicians who in 1968 "earned" $25,000 or more apiece from Medicaid and Medicare.

Federal bureaucratic inefficiency is not particularly to blame, as a recent experience of a private insurer shows. Blue Cross of Kansas, a comparatively simple, modestly financed scheme, recently made $250,000 available to its subscribers for walk-in care at the physician's office. Ten percent of the physicians participating used 50 percent of the fund, and $50,000 was paid out by Blue Cross for simple hypodermic injections alone. Four physicians gave most of the injections, collecting remarkably "reasonable" fees. Patients did not need the injections any more than they did before Blue Cross acted, nor did they request injections. Nevertheless, their physicians prescribed them, and patients, because they were not paying or because they had no idea what an injection should cost, did not object to the artificially high prices charged back to Blue Cross.

It is not going to be easy to change all this, to modernize medical care. With $2.5 million of campaign contributions, the AMA was able in 1968 to control the political forces which shape a health care system costing the public $53.1 billion annually. The AMA pattern is clear: first a survey, a recommendation, a legislative proposal for change, supported by physicians and laymen alike, which speaks up for the public, attempting to head off health care crises like the one we're in. The retaliation of organized medicine is always swift and defensive, reaching an emotional crest on the editorial pages of the *Journal* of the AMA. So it was in 1948 when the recommendations of the President's National Health Assembly provoked a $25 assessment on AMA members for a war chest to fight socialized medicine. So it was in 1951 when the President's Commission on the Health Needs of the Nation was called "another flagrant proposal to play politics with the medical welfare of the American people." So it was, for eight years, with the battle for Medicare which ended in 1965.

This article, the first of three about health care, describes our present health care system and explains why it no longer meets health needs. The second article will propose a reorganizational plan to meet these needs. The final article will discuss how health care should be financed in a reorganized system.

[From the New Republic, Jan. 24, 1970]

THE GROWING PAINS OF MEDICAL CARE (II)—WE CAN DO IT BETTER, CHEAPER

(By Fred Anderson)

When the President told the nation last July that its health services were about to break down, he based his conclusion on a major, five-month interagency study. Considering the gravity of the news and the President's call for "revolutionary change," it's astonishing that the study hardly mentioned the one way that we might avoid a crisis—reorganization of the nation's entire health care system. Nothing else could rescue a system where physicians' fees are increasing at twice the rate of general prices, hospital costs are increasing at three times the rate of general prices, and scarce physicians provide fewer services, limited to episodic illnesses, for patients; patients that is, who are not overlooked entirely because of race or class.

Reorganization, if effective, must include three components: group practice, comprehensive preventive care and prepayment.

Group practice is not a new idea. Physicians learned quite some time ago to cut duplication of office expenses by going into business together. Decreasing overhead increases profits. Comprehensive preventive care, on the other hand, is a new idea. It reduces the present overemphasis on episodic, crisis medicine by requiring that physicians provide for prevention of illness, as well as for its cure, on a family and community basis. Prepayment is also a relatively new idea; it helps pass the savings of group practice on to patients. By paying in advance for total care, patients eliminate the itemized doctor's bill which lists a highly inflatable array of fees for each separate service.

These three concepts, when put together, would foster urban and rural group practices, with a variety of health professionals rendering comprehensive medical services, including family and community-centered preventive care, for a prepaid annual fee per group or person. Hospitals would be integrated with the group practices in a regional plan and would be expected to provide types of specialized or intensive care now unavailable to most people.

Solo practitioners, who may number as many as 175,000, have their own fully equipped offices and pay for them by passing the costs on to their patients. But when it is properly set up, a group practice cuts overhead by finding an optimal size for sharing underused resources, such as receptionists, record maintenance, instruments and buildings. Group practice has other benefits. It relieves the medical graduate of the burden of establishing an office and building up a practice. It facilitates collaborative treatment among physicians who know each other well. It makes possible regular hours, time off for vacation, "sabbaticals" for continuing and updating the physician's medical education, and other benefits of a collegial practice. These advantages probably account for the 26,000 physicians who by 1965 had chosen to go into groups, although very few of the 5450 practices had prepayment plans and almost none passed savings along to consumers.

The second component of reorganization, preventive medicine, poses a philosophical challenge to current medical thought about health care. Today, we must wait until we are ill (preferably *very* ill) before modern medicine can bring its sophisticated techniques into play. Hospitals, medical researchers, and, to a surprising extent, private practitioners prefer it this way: illness is impersonal, isolatable, scientific. People, thought of in terms of what's needed to *prevent* illness, are not nearly as tractable. Experimentation now taking place in the urban ghetto in a special kind of group practice may reverse this unfortunate trend.

Not only are these experimental urban neighborhood practices efficient (Dr. Harold Wise, Director of the Office of Economic Opportunity's South Bronx project, says that in his clinic 25 physicians do what normally would require 60); they are a new approach to health services as well. The urban clinics are staffed with a variety of professionals, including the usual complement of pediatricians, internists, and other specialists. But community health nurses, social workers, nutritionists and psychologists are added, in order to give preventive—as well as episodic—care to families. The neighborhood practitioners are critical of the fragmented care which hospitals provide in outpatient departments or emergency wards at night, or in clinics organized around organ systems and diseases—ear, nose and throat clinics, cancer clinics, burn clinics, chest clinics, medical clinics. The patient is critical, too. He sees this array as frustrating, senseless. Need we

be told that diseased organs are found in people, people in families, and families in communities, and that overemphasizing the pathology of tissues may underemphasize simple good health? Good health may require intervention in the social, as well as medical, aspects of a patient's problem. As small as the clinics' impact is, they seem to be gaining: several medical schools have started pilot projects; OEO has 40 clinics in operation; Senator Percy and 22 colleagues have introduced legislation for a $295 million program similar to OEO's; and young health professionals, many through the Student Health Organization, intend to make the clinics work.

Oddly, the communities have not always accepted community medicine with uncloyed gratitude, from which an important fact can be learned. Community leaders want control of the health programs and a larger say in what services they will deliver. Thus, Harvard University, which claims the first university-sponsored prepaid group practice plan, has had to contend with community suspicion that Harvard will provide services only so long as the community is content to do no more than provide plenty of illnesses. Tufts University, also in Boston, found that the community's Columbia Point Health Association had ideas about community health which went well beyond the "programmed" level. These "people difficulties" show that medicine is not nearly in close enough touch with its consumers, even in the inner city where medicine has tried very hard. It leads one to wonder what middle-class patients might learn and say if they, too, had a voice in health care. Preventive family medicine, through dietetics, early screening, and broader consultation, could have a great effect on middle-class maladies; ulcers, diabetes, obesity, dental caries, cirrhosis of the liver, hypertension, heart disease, cancer, neurosis. It does not take a physician to realize that each of these can be prevented or detected quite early, and that families and communities contribute to cause and cure.

The last component in reorganization, prepayment, shifts attention once again to economy. Having agreed to a set lump sum to cover comprehensive care, physicians increase their income through internal savings below their predetermined annual income, not by gradually raising fees, here and there, for the uncountable number of separate services now available. Physicians in a prepayment plan must also give their time to patients whose health needs are greatest. This is a healthy contrast to the present situation, where all too often money determines what patients get. If Warbucks chooses to pay the prevailing rate, he can buy two hours of a Meninger's time for little Annie's sniffles. A prepayment group practice, in theory, must be more economical and apportion its talent and time on a health-oriented basis if it is to make money.

The Group Health Association of America estimates that almost eight million people are served, in part or in whole, by group health prepayment practices. About 25 of these are community plans, the largest of which are the Kaiser Foundation Health Plan (Western states), the Health Insurance Plan of Greater New York, the Community Health Association of Detroit, the Group Health Association of Washington, D.C., and the Group Health Cooperative of Puget Sound. Together, they care for up to four million people. The Longshoremen, the Hotel Union (New York), the Teamsters, the Mineworkers and other labor groups support a variety of plans with checkered coverages for another 3.5 to 4 million people. The collective experience of these plans has revealed some interesting facts: our outmoded system typically requires four hospital beds for every 1000 of population served; in the plans, half as many beds are enough, because office visits and outpatient care are more intelligently used, and because there is no built-in incentive to overutilize hospitals in order for the patient "to get his money back" from insurance plans (which usually provide generous benefits for hospitalization but almost nothing for outpatient care). The plans also keep drug costs down. For example, drugs for subscribers to the Seattle plan cost 50 percent less than the national average. The plans, then, are making dramatic savings in just those areas of health finance which are the most expensive, and usually they do it with substantial improvment in the quality of care rendered.

The Kaiser Foundation Health Plan, which now serves almost two million subscribers, has been particularly successful. Kaiser has saved its California subscribers 20 to 30 percent of the costs which Californians must meet if they are not in Kaiser's program. Further, under the terms of Medicare, Medicaid, and private insurance plans, many services are not reimbursable unless delivered in hospitals, causing a tremendous overuse of hospitals and consequently lower uninsured expenditures for early detection and preventive care. By reversing the incentives Kaiser has cut hospitalization 30 percent and costs even more, and without higher outpatient costs.

But group practices *alone* will not get us better medicine at lower cost. Especially when organized by physicians themselves, they rarely pass savings on to patients. Community and labor plans like the ones above are exceptional, in spite of their successes in some parts of the country. Nor will adding the prepayment device to group practice cut into medical consumers' huge bills unless a way can be found to keep down the initial lump payments. The purchasers of medical care need to be able to find effective representation for themselves and to challenge abuses when there is an increase in annual prepayments. What is needed in fact is countervailing "patient power."

Although prepayment cannot do the whole job, it does lay a foundation for effective patient representation. National norms for what a medical consumer should pay for comprehensive care are already evolving, since a prepaid group practice is a manageable unit for quality review. (The plans mentioned have begun to develop a figure, leaving age differences aside, of around $130 a person a year.) With the evolution of standard costs for comprehensive services for individuals in various age groups, one is able to inquire why any particular group practice cannot hold its rates down to the norm. And given patients, services and profits, it is possible to develop a set of facts with which a group, an insurer, a consumer's representative or a government agency can criticize the quality of care rendered. For instance, the cost of *my* minor respiratory disorder is almost impossible to estimate. But the cost of 2000 of them can be estimated, and that information used for more rational health pricing, or, if need be, as a weapon in the consumer's battle for better care and reduced costs. Furthermore, united consumers can afford physicians, and economists, who are hired to protect *their* interests.

As matters now stand, no one really knows how to challenge physicians' fee scales. (There is much talk and some effort directed to "quality control and review" under the federal programs, but review depends upon statistical analysis, and the needed data cannot be produced under the present organization of health care.) To make things easier, relevant statutes can be amended or passed to require annual reports to subscribers, where statutes do not already require this disclosure as part of corporation or partnership law. There is no good reason why the financing of health (the second largest of all our private industries, second only to education), should not be openly reported. Participants can negotiate collectively for coverage and for items of preventive care from which the community or group as such can benefit. Prepayment can make available additional kinds of health benefits which are unmanageable in a fee-for-service system. The large institutional funds may even do it for them. For instance, state Medicaid agencies have already bargained with the Clackamas County, Oregon, Physicians' Association and with 290 physicians in California's San Joaquin Valley to pay fixed per capita premiums for total care for Medicaid recipients. A private insurer, if it had to, could do the same.

The success of groups like Kaiser in cutting consumers' costs by 20 to 30 percent is encouraging. Similar savings nationwide could save $7.5 billion in hospital bills by 1975. But without being overly cynical one may ask why physicians, who are in short supply, would want to respond to the pressures of patients, who are in large supply, even if annual set rates are charged. There is no final guarantee that physicians would not keep the annual rates as high as they possibly can. But if they attempt to do so they will meet informed opposition where virtually none had existed before. They will have to push prices up under the scrutiny of consumers' representatives who know facts formerly unavailable—facts showing how much increase is due to real costs, normal inflation, waste, or higher incomes for physicians.

Either physicians will see the wisdom of economies in the financing of health care and in reorganization, or they will risk their prestige to demand even larger incomes and the continuation of wasteful practices which make life easier for the physician and harder for everyone else. Even if blinded sometimes by the preeminence which they enjoy in American society, physicians know that they are wide open to every kind of regulation and control once they lose the prestige that has made them so effective in Congress. Many of them believe that group practice and prepayment, combined as described here, or in another way, are a means of preserving the private practice of medicine.

The medical profession may not go gently into reorganization, however, and for reasons other than its desire to continue to receive large incomes and practice fee-for-service medicine. Early efforts to get group practice accepted showed that the profession can be quite effective in oppositoin. Organized medicine, work-

ing determinedly in the forties, has left 20 states with laws that pose barriers to group practice, voluntary care plans, or consumer control of the business and financial aspects of these activities. Of course they want to increase their earnings, but physicians also say that entrusting more than one physician with a single patient's care destroys the crucial "doctor-patient relationship" of trust and continuity. They believe this even though the experience of large hospitals with team treatment has been excellent, even though neighborhood centers have actually expanded the scope of meaningful doctor-patient relationships, even though continuity of care is mainly important in episodic, not chronic or preventive, care, and even though it has been demonstrated that a succession of new faces and fresh interest is better for some patients.

Accustomed as they are to autonomy, many physicians rankle at the thought of quality review, or peer review of a partner's contribution to the practice. Nor are they comfortable with the social side of preventive, comprehensive care. Prevention is vague, frustrating, not scientific; they prefer detective work on tissues, which is more "satisfying" to them. At the same time, they are unwilling to accept other health professionals as colleagues who can give valuable advice and initiate some care. This is particularly unfortunate since supporting staffs now are doing much of the actual work, with physicians spending more and more time just supervising them. Over the decade 1955–1965 "physician-directed services" rose 81 percent and hospital services 65 percent, although the increased output of physicians (22 percent) barely exceeded population growth (17 percent). Tasks were taken over by nurses and medical auxiliary personnel. Lastly, physicians' frustrations are compounded because their expertise in crisis medicine (surgery, cures for infectious disease, treatment for various trauma) is receding as it becomes more important to provide continuing care for children and the elderly, both of whom make up increasingly larger proportions of the population.

Nevertheless, the medical profession is not by any means closed-minded. The three-part reorganization discussed here is palatable, I believe, because it does not run head-on into the charge of medical socialism which other plans face. When led away from politics, where emotions run high, practicing physicians may actually suggest reorganization to improve cooperation and efficiency. Robert Sigmond reported to the National Conference on Health Costs that in a year-long study, he had asked physicians whether, in the event of war or other national emergency, they could reorganize their areas' health facilities so as to free staff and equipment for the emergency without substantial impairment of preexisting care. They said they could, through an efficient regional group practice plan. Many physicians, especially the younger ones, while not sure about family-centered preventive care, are interested in prepaid group practice because of the collegiality, security, regular vacations and regular hours that group practice makes possible. In a sense they have stopped admiring the nineteenth century independent entrepreneur and have started imitating his successors in modern corporations and partnerships.

This article is the second of three on meeting the nation's health crisis. The final article will discuss how health care should be financed.

[From the New Republic, Feb. 2, 1970]

THE GROWING PAINS OF MEDICAL CARE (III)—PAYING FOR HEALTH

(By Fred Anderson)

If it were not for the financial squeeze on the Middle American, President Nixon, Secretary Finch and Dr. Egeberg probably would never have gathered at the White House last summer to admit that the nation's health care system is in very bad shape. Politicians are pretty shrewd diagnosticians themselves. They see where the public hurts—in the region of the pocketbook. And so they prescribe "reform." Rep. John Dingell has a plan; so do Sen. Jacob Javits, Governor Rockefeller and the AFL–CIO. Even the AMA suggests a tax credit proposal which is being advanced by Rep. Richard Fulton and Sen. Paul Fannin. For the most part, all these "reforms" are after short-run savings and avoid "revolutionary change," which is what the President said we should have.

The AMA recommends that the cost of purchasing health insurance be a credit against income tax. These benefits would be graduated, so that those with higher incomes get correspondingly less benefit; persons whose incomes are so low that

they got little or no benefit from the proposal would have part or all of their insurance premiums paid by federal, state or local government. A tax credit rather than deduction at least tends to give lower income groups as much of a break as the rich. But the AMA plan doesn't reach the cause of the crisis. Wasted resources, inflation, limited episodic care, and exclusion from insurance coverage of high risk patients would continue, except that insurance premiums would quickly surpass physicians' fees as inflationary items. Helping the taxpayer pay for inflation is no substitute for better care at less real cost. Where Medicaid waste occurs in exorbitant hospital bills and physicians' fees, the waste in a tax credit plan would come when private insurers got the breathtaking boon of indirect federal payment of a large share of the nation's insurance premiums. Congress ought to think twice before subsidizing a health insurance industry which imposes ever higher premiums, excludes more and more costs and treatments from coverage, and fails to insure more than about one-third of the poor. I hope my first two articles made clear that reorganizing health care is far more important than merely refinancing it. Yet refinancing is really all that the AMA plans, and most of the various national health insurance plans, would accomplish.

I am for national health insurance. But if enacted today, *with no change in the underlying system*, national health insurance would feed inflation for the same reasons that Medicare, Medicaid and private insurance feed it now. The physician's right to self-determined "reasonable" fees and the present physician-patient contract for services shields hospitals and practitioners from scrutiny and tempts them to take what they can get from large third-party funds, principally the federal programs and the private Blues. We saw this happen in the abrupt tripling of the rate of increase in physicians' fees and the quintupling of the rate of increase in hospital fees in the first year Medicaid and Medicare were in effect.

How then should health care be paid for? Two weeks ago I suggested that in return for a regular, set prepayment, each medical consumer ought to be able to receive comprehensive care, largely from group practices adept at family and community-centered preventive medicine. I also suggested that hospital care, and its financing, be coordinated with the group practices. Suppose for instance, that Congress were to authorize the Social Security Administration to increase payroll taxes on a sliding scale, thus creating a large fund out of which the public's medical expenses could be paid. No one would be exempt from this tax; on the other hand, no citizen could be denied its benefits. Suppose also that in order to pay the public's medical bills, Congress added to this fund from general revenues. This National Health Insurance fund would cover as many medical services as Congress could be convinced to include. Patients would be entitled to receive these services without additional charge, and physicians and health care institutions would receive payment for them from federal National Health Insurance. Gradually, other services would be added, until there is comprehensive health care for all.

The critical step comes when physicians or institutions ask National Health Insurance for reimbursement. They will, of course, be entitled to their fees, whether or not they practice in groups, participate in regional hospitalization plans, economize, accept annual lump-sum payments rather than fees-for-service, or practice preventive medicine. In fact, the only thing that might keep physicians or hospitals from being reimbursed is their refusal to submit information on health care delivery in sufficient detail to permit review by panels of physicians. But if physicians and health care institutions actually did move toward regionalized, prepaid group practice, they would be entitled to extra payments from National Health Insurance. Their less progressive, fee-for-service colleagues would have an incentive to do likewise.

The kind of special financial incentive I have in mind would reward pediatricians, internists and other specialists for forming group practices, with a bias toward preventive medicine. But incentives would do more than that. A key concept in reorganization is the sharing of total health responsibility among a team of health professionals. To foster the development of such teams, National Health Insurance might initially pay the entire salary, or a large fraction of it, for a consulting dietitian, or a community health nurse. Thus group practice, preventive medicine and shared responsibility would be made financially attractive to physicians, reducing their changeover costs substantially.

A variety of diseases can be headed off before they do their damage (e.g., glaucoma, high blood pressure, cancer, tuberculosis). Californians in the Kaiser Plan have been delighted that it offers screening (smears, X-rays, etc.) for as

low as $1 per test. Prevention is cheaper than cure, and Kaiser is a *prepaid plan.* National Health Insurance, by offering to buy the necessary screening equipment and pay part of the operating costs, would be offering a further incentive to physicians to set up Multiphasic Health Screening (MHS) throughout the nation. The federal government has already supported MHS on an experimental basis in New Orleans, Milwaukee, Brooklyn and Providence.

The success of National Health Insurance, then, depends on a comprehensive plan which handles the medical care system with the right sticks and carrots. Such a plan is being drawn up by the Committee for National Health Insurance, which exists largely through the efforts of Walter Reuther and the UAW. Its membership includes Senators Yarborough, Cooper and Kennedy, Dr. Michael DeBakey, Whitney Young, Dean Robert Ebert of Harvard Medical School, Arthur J. Goldberg, Dr. Charles Mayo II, and Mayor Carl Stokes. A capable Technical Committee, headed by Dr. I. S. Falk, who has retired from teaching at Yale Medical School, is working on details which will be made public in mid-March. There are still some difficult questions. Will ceilings be set on physician's fees and insurance premiums charged during the transition period? (There seems to be no other way to curb inflation until the plan has a chance to take hold.) Should fee-for-service medicine be strongly discouraged right from the start? How long should the reorganizational changeover be expected to take?

Almost $20 billion of federal and state funds currently goes to medical education, health facilities construction and medical research. The money is not being wisely spent. Not only have we too few physicians; there is an imbalance in the distribution of physicians among the specialties as well. Take surgery. According to economist Victor Fuchs of New York University, surgeons averaged only 220 operations each in 1966, well below most surgeons' capacity for competent care. National Health Insurance would try to alter the career choices of medical students by supporting medical school training programs in undersupplied specialties (particularly those needed for family-centered health care teams), by funding internships and residencies in those specialties, by supplementing the salaries of young physicians who choose these careers, and by helping in critical regions and neighborhoods to build the facilities needed for group practice.

I mentioned earlier that National Health Insurance would gradually replace out-of-pocket expenditures, private insurance, Medicare and Medicaid. Thus, in its first year, NHI might pay the total costs of basic services (outpatient and inpatient hospital care, physicians' services, etc.), adding new services each year thereafter (laboratory and X-ray, nursing home, etc.), until comprehensive care is reached. I favor this approach. Others, however, think National Health Insurance should pay an escalating percentage of *all* personal medical costs until comprehensive prepaid care is attained. Senator Kennedy disagrees with both these approaches and argues that infants, preschool and school-age children up to age 15 should receive total coverage the first year (1971), since preventive medicine would help them the most, and that the rest of the population should be added in ten-year steps (age 25 in 1972, age 35 in 1973, etc.) until National Health Insurance links up with an expanded Medicare program at age 65.

All these alternatives are reasonable ones; the only unreasonable one calls for immediate assumption of the entire $40–45 billion personal health care bill by National Health Insurance. It's unreasonable because it would perpetuate wasteful practices that might be eliminated through incentive payments and reviews. Also, while it is important that patients be able to make set prepayments to National Health Insurance (so that they can budget ahead for health care), it is more important for physicians to be paid in advance for care. Such a system will take time to build. A rapid takeover of the $40–45 billion health bill now paid for care *after* it is rendered would actually protect the fee-for-service pricing mechanism.

The success of National Health Insurance will depend very much upon how physicians react to it. Many have said they favor it; young physicians are not likely to oppose it as strenuously as their older colleagues. Nevertheless, the recalcitrance of physicians could throw health care into chaos. Nowhere in the world have physicians had the prestige, organizational muscle and resources that they do in the US; and nowhere else has there been a professional group more grimly determined to resist "socialized medicine." It is not just the AMA, which draws on dwindling but fervent support from the 20 percent of physicians in patient care who are general practitioners. Most specialists, salaried hospital doctors and medical school teaching staff are not interested in "national" health plans.

The resistance of some physicians to National Health Insurance is predictable; what is not predictable is how public opinion will form in the coming months. There are good reasons to think that the public is more receptive to National Health Insurance than is generally believed. Over the past few months politicians have flocked to the medical care issue, which gives support to this view. At the same time, organized medicine's image has been tarnished. The public did not think much of the AMA's victory last spring when it kept Dr. John Knowles from becoming Assistant Secretary for Health and Scientific Affairs, even though Dr. Knowles was Secretary Finch's choice (and the President's too, it appeared, for a few hours). The press used the incident as a short seminar on power politics, self-interest, and the shortsightedness of organized medicine. A 1967 Harris poll found that a majority of the American people favored a federal medical care insurance plan modeled on Medicare for the entire population. Indeed, most Americans were receptive to a federal role a decade ago. During the 1960 Presidential elections the Inter-University Consortium for Political Research at the University of Michigan found that 59 percent thought that "government ought to help people get doctors and hospital care at low cost." Early public support for a federal role in medical care also helps explain the 1965 passage of Medicare and Medicaid, despite frantic opposition by the AMA.

The Nixon Administration's opposition to National Health Insurance is based on the argument that it would be uncontrollably inflationary. This puts the Administration in something of a quandary. If inflation is running amok, reform of the kind I have described is necessary. And yet such far-reaching reform will be fought by the AMA with all its political resources, and the multi-billion dollar health insurance industry, threatened with extinction, would not be far behind.

The Administration thinks it has a way out through a proposal the AMA advanced in 1968: more medical services and manpower. True, in classic economic theory an increase in supply slows down inflationary demand. But more MDs and support personnel are wasted in a system which quickly loses marginal gains in its general inefficient operation, in population growth, and in increased demand. The most recent confirmation of this was offered in 1966 by the National Advisory Commission on Health Manpower, which concluded that we should not continue to expend vast sums, simply to get marginally more services of the same kind. We *will* need more physicians and other health professionals, but added numbers will not get the American people the care they need at prices they—all of them—can afford.

The Committee for National Health Insurance will soon publish figures on the money we have lost through inefficiency in our health care system—not from inflation, not from poor financing mechanisms, but from plain waste. Taking insurance alone, medical consumers are being squeezed to death by both private and federal insurers. When costs become too great for insurance companies, they raise premiums, refuse to insure for more and more kinds of illnesses and costs, and turn down high-risk applicants. After a while the federal government begins to pay a share, principally through Medicare and Medicaid. Yet government too can apply the squeeze in our present system. Congress has limited the categories of the medically needy and cut funds; the Administration has cut health budgets and talks of ineffectual administrative reform. Congress could end the squeeze entirely by enacting a compulsory National Health Insurance plan, but one which commits government to add, not subtract, benefits, and which includes carefully worked out incentives for the reorganization of our entire health care system.

[From the Chicago Sun-Times, Jan. 18, 1970]

FREE MEDICAL CENTERS PUSHED IN LOW-INCOME AREAS

(By Ron Powers)

In two sections of Chicago, efforts are under way to provide large-scale, free medical service to low-income communities.

The efforts, like the areas in which they have arisen, are diverse in their makeup, background and point of view. And yet there are many similarities—such as the common belief that medical help must be closer and more accessible to poor people than it is now under a system dominated by large, private institutions.

On Jan. 4, the Illinois Black Panthers and a coalition of doctors opened the Medical Care Center Inc. at 3850 W. 16th.

"If this center flourishes," said Dr. Quentin Young, a key member of the Medical Committee for Human Rights who is working with the Panthers, "it could lead to one of the most energizing salvations of the medical system that I know of."

Thursday, a group calling itself the Uptown Community Health Assn. met with Asst. City Health Comr. Jack Zackler to seek authority to run the Model Cities comprehensive health program in Uptown.

$625,000 IN FEDERAL FUNDS

Dr. Bruce Douglas, a Chicago dentist who is chairman of the Uptown project, said, "We're concerned not only with citizen participation, but with tapping the services of business and professional men."

The group will have available $625,000, set aside by Model Cities in September, 1969, in an agreement with the Chicago Board of Health, for the development of a comprehensive community center in the Uptown area.

The Uptown association, Douglas said, will act as an umbrella group for some existing projects in Uptown that are trying to provide community medical aid.

One of these is a struggling effort by the Young Patriots, an association of predominantly white youth, to operate a medical center similar to the Panthers' facility.

On Jan. 3, the Patriots reopened a clinic at 4408 N. Sheridan. The group said it was forced to close a similar clinic at 1140 W. Sunnyside last Dec. 22 by the owner of the building, Alfons J. Spanitz. Marcelle Warden, 20, a spokesman for the Patriots, asserted at a press conference Dec. 31 that harassment by the Gang Intelligence Unit led to Spanitz' decision.

Spanitz, however, told The Sun-Times that he acted only after neighbors complained of noise and broken windows. He acknowledged, though, that police from the GIU had asked him about the Patriots' activities.

John Mulchrone, deputy police superintendent, said the "harassment" charges were ridiculous.

SMALL ANSWER TO BIG PROBLEM

Bobby Joe McGinnis, a Patriot leader, said the group learned last Tuesday it is being evicted from the Sheridan address.

"The landlord found out we were the Patriots and sent back the rent," McGinnis said. "He told us if we didn't get out we'd be trespassing."

McGinnis said the group now is seeking another neighborhood site to operate their health clinic on Saturday mornings.

Some of the Patriots reportedly were bitter that Douglas, who had worked with their clinic, had formed the UCHA. Douglas told The Sun-Times, however, that the Patriots would have a part in the larger operation.

Both the Patriots and the Panthers have said they will provide free health care, pediatric advice and dental service for poor people. The People's Medical Care Center will be open from 2 to 10 p.m. Saturdays and from 6 to 9 p.m. Monday through Friday.

McGinnis said funds for supplies and equipment, such as X-ray facilities, would be done through "mailings to doctors and anyone else who has money." But he emphasized that the donations would be individual. Approaches to foundations, for example, might well mean that "someone would put strings on the money."

Neither the Patriots nor the Panthers have applied for dispensary permits from the city. Each group maintains that its activities do not meet the definitions of "dispensary" set forth in the municipal code.

The city code requires a license for a facility that provides free "surgical advice or treatment, or drugs and remedies."

Jeffery Haas, a lawyer for the Panthers, said the People's center would not come under the code because it would be an extension of each participating doctor's office, under the authority of the doctor, and not a clinic. The Patriots have made a similar claim.

Planning for the people's center began in April, when members of the Panthers sought the co-operation of the Medical Committee for Human Rights. It was intensified after the Dec. 4 deaths of two Panther leaders in a raid by state's attorney's police on a West Side apartment.

"In April the Medical Committee voted to work with the Panthers to develop professional services for the community," said Young. "We assessed each member $5 and raised $750 that way. We engaged in a number of fund-raising activities that brought us a total of about $3,000, which we have used to purchase equipment for the center. We pledged $500 of this to the Young Patriots."

Young said that X-ray equipment, tables, beds and surgical supplies had been given to the center from donors who wished to remain anonymous. He said there are 150 volunteer workers for the Panther clinic. These include, he said, 40 doctors and 110 nurses, lab technicians, social workers, clinical psychologists and voice therapists.

The volunteers work on their own time and were recruited from Michael Reese, Presbyterian-St. Luke's, Billings, Cook County hospitals and the Illinois State Psychological Institute.

Young emphasized that no medical services will be rendered at the clinic unless a doctor is on duty.

BOARD MEMBERS NAMED

The board of directors includes four Panthers and two doctors.

Panthers on the board are Rufus Walls, Bobby Rush, Ronald Satchel and Jewel Cook. Other directors are Young, Dr. Eric Kast of the Lawndale Assn. for Social Health and Mrs. Jewel Barker, a resident of the community.

Kast said he believes the strength of the center will lie in "the universality of acceptance of patients."

"Wherever they come from, whatever their ability to pay, they will be seen immediately by a physician," he said. "There will be none of the bureaucracy often encountered at the larger institutions. The doctors will be serving the people, not the people the doctors."

Members of the board of directors emphasized that the center is not an organ of the Panther Party, although party members are a majority on the board. They point to its corporation status and the fact that many nonparty members are involved in its operation.

SPECIALTY SERVICES PLANNED

Young said the center would try to set up clinics in the medical specialties. A pediatric clinic to be conducted by Dr. George Noeh, a North Side pediatrician, has been scheduled to begin in February. Also planned are sex education classes, programs in preventive medicine, seminars on health and immunization programs.

Young supported the Patriots' assertions that they had been harassed by the GIU, but said he expected no similar trouble at the People's Medical center.

Douglas acknowledged that he was visited by plainclothes policemen shortly after a North side neighborhood newspaper announced he would work with the Patriots' clinic.

"They paid me a cordial visit," he said, "but they told me something to the effect that the Young Patriots were not the kind of organization a nice young doctor should be working with."

[From the Washington Post, Jan. 28, 1970]

THE WASHINGTON MERRY-GO-ROUND

"HEALTH BRUTALITY" AGAINST POOR FOUND

(By Jack Anderson)

A bombshell report, held back by the American Public Health Association, accuses federal and local authorities alike of practicing "health brutality" against the poor.

This column has obtained a copy of the unreleased report, whose grim findings should be read by every concerned citizen.

"We are shocked and still reeling," begins the report by the association's president and immediate past president, Paul Cornely and Lester Breslow, both famed public health physicians.

In Houston, the space age city with renowned heart transplant facilities, the Cornely-Breslow team found neither space nor heart for Mexican-Americans.

The Houston authorities in anticipation of the team's visit to the worst slum area, attempted a hasty clean-up and even ordered a rare garbage pick-up. But they could not hide the stooped, 59-year-old grandmother who had lost four of 12 children to malnutrition-induced diarrhea. Nor could they drive away the snakes and rats which prey on babies there.

POISONING PEOPLE

In Tulare County, Calif., poor whites and Mexican-Americans, too proud to go on relief, told of staggering in the fields as planes illegally sprayed pesticides on them. Some 200 workers are felled or sickened each year despite laws against spraying DDT and other poisons where people are working.

"I took the number of the plane and told the foreman, Nothing happened," said one worker. Another added wearily: "What's the use They don't stop spraying."

Washington, D.C., with its shaded avenues and curving shorelines, is the nation's pride. But in the serene Potomac River, which gently washes Washington's shores, the doctors found "dead fish, floating sewage, rotting plant life . . . more than 400 million gallons of partially treated or raw sewage a day."

Untreated excrement, deadly salmonella and other disease debris are eaten by fish that swim up and down the Potomac and far beyond. Indeed, Dr. Werner Janssen, a scientist at the Chemical Biological Warfare Center of Ft. Detrick, Md., warned the team that the fish were like secret time bombs spreading "the human disease-producing organisms . . . to areas thought to be safe."

The report blames federal and local governments, along with land developers, for despoiling and poisoning such rivers as the Potomac.

ROT IN CHICAGO

In Chicago, Mayor Richard Daley's health commissioner snubbed the two distinguished physicians. But they went down into the city's ghettos anyway.

There they found, a few minutes from the multimillion-dollar towers of the Windy City, "an unforgettable profile of destitution, deprivation . . . children amid rotting garbage and trash."

A Negro woman could not get her abdominal surgery repaired because she couldn't repay 11 pints of blood to a Cook County hospital. Another watched her baby die an agonized death for three hours while waiting treatment in the emergency room. Of every 1,000 children born, 45 die as babies in one area.

The most embittering chapter in the lengthy report deals with the truly "forgotten man"—the Indian who leaves the reservation to make his way on the outside but who winds up in a redman's ghetto.

In Great Falls, Mont., the doctors discovered "Hill 57"—so named because there are "57 varieties" of tin cans and junk on its side. There, 15 large families have a single water faucet.

Across town, 12 Indian families live on a hill used as a trash pile by local residents. One World War II veteran supports his wife and six children by scavenging for auto parts in the hillside junk. He earns $2 on a good day.

Nine years ago, a major cancer operation opened his bowels. He has no time for the surgery to close them, because of his family's pressing needs. The family's sole "utility" is a privy 50 feet from his shack.

Of all the cities the doctors, visited, Atlanta seemed to be trying the hardest. Even there, they found a four-by-eight cell, without ventilation, for the treatment of alcoholics. Its sole occupant was an alcoholic epileptic picked up as he tried to make it to a hospital.

CRY OF ANGUISH

The two doctors, seasoned men who have seen many horrors in their lives, end their report with almost a shriek of anguish: "Who is to blame in this degradation of life and health?"

They draw their answer from a community doctor, who replied fiercely: "First, the political structure and city hall. Second, organized medicine with its platitudes. And third, the health care system.

"If any should think that we present an exaggerated picture," declare the doctors, "let him spend as we did a few full days actually looking, listening and smelling . . . Health care for the poor has broke down. The crisis is not coming, it is here."

Their recommendations: revamping Medicaid, establishing poverty clinics, letting young physicians work with the poor as an alternative to military duty—and, of course, federal outlays.

Ironically, President Nixon is now seeking to trim down the appropriation for the Health, Education, and Welfare Department. Some of the money would go into just such efforts as the report seeks.

[From the Congressional Record, Jan. 28, 1970]

HEALTH CARE/FORTUNE MAGAZINE

AMERICAN MEDICINE

Mr. YARBOROUGH. Mr. President, our health care delivery system is in disarray.

Despite increasing infusions of Federal funds, it is not improving rapidly enough. It seems tragic to me that the wealthiest country on earth seems incapable of providing basic health care to large segments of the population. It need not be so. We have the best trained doctors and the finest medical facilities to be found anywhere. And we devote approximately $60 billion or about 6.5 percent of our gross national product to medical care.

We are not providing adequate medical care to the urban poor or to our rural population. In addition, only a small segment of our entire population, whether urban or rural, whether affluent or poor, is receiving adequate preventive medical care.

Despite the tremendous technological advances we have seen over the last few decades, the medical delivery system has hardly changed. Many of our medical schools follow essentially the same curriculum they followed half a century ago. Despite the proliferation of visual aids and the improvements in teaching techniques, except for rare exceptions our medical schools are not turning out an adequate number of qualified graduates faster.

The majority of doctors continue to operate as independent agents operating on a fee-for-service basis. As a result, all too often doctors are forced to undertake tasks which could better be done at less cost by medical technologists and other paramedical personnel. Our medical insurance plans are generally too limited in the services they offer. And all too often they cover only care while in a hospital. Thus, medical service which could be provided in the home or in the doctor's office is often provided at higher cost in a hospital. What is worse, only a few of these plans include preventive medical care as a part of their coverage.

Pumping additional Federal funds into the system alone is not the answer. Major reform is needed. And since it seems that the medical profession does not have the resources to do this by itself from within, the pressure and aid must come from without—from Government and the private sector. I certainly hope that such reform is not long in coming. I find it frustrating to think that despite the increasing amount of our national resources going into medical care, we rank well below a number of industrial countries in infant mortality, maternal mortality, and life expectancy.

Because I am very concerned with the current state of American health care and because I feel so strongly that before we can bring about adequate reform to get health care to the people, we need to know the full nature of the problem. I invite the attention of Senators to the January 1970 issue of Fortune, which I believe does an extremely fine job of reporting on the current status of American medicine.

Mr. President, I ask unanimous consent that the Fortune report be printed in the RECORD.

There being no objection, the Fortune report was ordered to be printed in the RECORD, as follows:

[From Fortune magazine, January 1970]

IT'S TIME TO OPERATE—BETTER CARE AT LESS COST WITHOUT MIRACLES

(By Edmund K. Faltermayer)

American medicine, the pride of the nation for many years, stands now on the brink of chaos. To be sure, our medical practitioners have their great moments of drama and triumph. But much of U.S. medical care, particularly the everyday business of preventing and treating routine illnesses, is inferior in quality, waste-

fully dispensed, and inequitably financed. Medical manpower and facilities are so maldistributed that large segments of the population, especially the urban poor and those in rural areas, get virtually no care at all—even though their illnesses are most numerous and, in a medical sense, often easy to cure.

Whether poor or not, most Americans are badly served by the obsolete, overstrained medical system that has grown up around them helter-skelter, without accommodating very well to changing technology, expanding population, rising costs, or rising expectations. Demand for medical service has been racing ahead at ever increasing velocity. Medicare and medicaid—the government-financed programs for paying the medical expenses of the aged and the poor—now account for one dollar out of every five spent on medical services. Other insurance plans have also fueled demand, in special distorting ways that add to already overloaded facilities. In the words of the two federal officials who are the most concerned—Secretary Robert H. Finch of Health, Education, and Welfare, and his Assistant Secretary for Health, Dr. Roger O. Egeberg—"This nation is faced with a breakdown in the delivery of health care unless immediate concerted action is taken by government and the private sector."

To be effective, the concerted action will have to make fundamental changes in the nature of the system. Its main purpose will be to raise the supply of care to levels where it can satisfy the new needs. But in order for that very difficult balancing act to be accomplished, doctors will have to reform their ancient ways, hospitals will have to be more rationally managed and coordinated, and insurance plans will have really to bring their subscribers *insurance*—instead of merely racing the motors of inflation. Just more money will not solve anything. Right now, for all the fresh billions so recently pumped into the system, most Americans could still be financially destroyed by a prolonged and serious illness in the family—a virtual impossibility in countries such as West Germany, Sweden, and Britain, none of which devote as large a percentage of their G.N.P. to medical care as the U.S. does.

Thus, as the articles that follow make clear, the time has come for radical change. The financial distortions, the inequities, and the managerial redundancies in the system are of the kind that no competent executive could fail to see, or would be willing to tolerate for long.

The conversion to modern methods, and the institution of the same degree of efficiency that Americans have reached in other realms, would probably effect enough saving so that good care could be brought to every American—with very little increase in costs. Nobody except other physicians should tell physicians how to practice medicine. But the management of medical care has become too important to leave to doctors, who are, after all, not managers to begin with.

Our present system of medical care is not a system at all. The majority of physicians, operating alone as private entrepreneurs, constitute an army of push-cart vendors in an age of supermarkets. Most patients pay by the cumbersome "fee-for-service" or piecework method, which involves separate billing for visits to doctors, shots, X-rays, laboratory tests, surgery, anesthesia, hospital room and board, etc., etc. The American hospital system, as Herman M. and Anne R. Somers of Princeton University said in their book, *Medicare and the Hospitals*, "is largely a figure of speech," the result of a haphazard growth of isolated, uncoordinated institutions.

For a patient simply to *find* medical care can be maddeningly difficult. In poor city neighborhoods and rural areas, the supply is sometimes fatally sparse. The middle-class citizen, living in a region where doctors are statistically abundant, encounters frustrations when he seeks "access"—a suitable entry point into the medical labyrinth, where a competent person can give an accurate diagnosis of his ailment, or relay him to the proper specialist. With more and more doctors working a five-day week, access has become especially difficult on evenings and weekends. Increasingly at those hours, people are forced to resort to the overcrowded, understaffed emergency rooms of hospitals, where admisisons have shot up by 250 percent in the past twenty years, and where only a third of the people waiting for attention are true emergency cases. When he is finally in what he hopes are good hands, the patient is incapable of evaluating either the quality or the quantity of the service he receives. In his ignorance he may submit to more care than is necessary—adding both to the personal risk and to the strain on an inflation-prone system.

Some of the rise in medical costs has been inevitable, because the new life-extending techniques require more manpower and equipment (see "Costly Machine to Save Lives," page 92, Fortune magazine, January 1970). And some of the

increase in hospital costs is unavoidable, too (see page 96, Fortune magazine, January 1970). But the real propellant forcing up costs is the archaic manner in which most medical care is arranged and paid for in the U.S. Since all the components of medical care are generally paid for on a piecework basis, doctors profit by prescribing more elaborate care than is needed.

Even when doctors have the best of motives, as a majority of them doubtless do, this lax competitive climate discourages the efficiency that comes with cost-consciousness. And even if the doctor has a conscience about wasting the money of patient, government, or insurance company, the growing menace of malpractice suits may induce him to pile on precautionary tests and treatments—which he can do without restraint. "Almost nowhere else in the economy," says Victor R. Fuchs, a leading economist at the National Bureau of Economic Research, "do technologists have as much control over demand." The only parallel, Fuchs says, is the military's control of the defense budget in time of total war.

The growth of "third party" payment of medical bills through Blue Cross, Blue Shield, and group insurance policies has provided another inflationary thrust. Until very recently the Blues and the insurance companies, which now disburse about $13 billion a year, have directed very little hard scrutiny at fees or the quantity of the services that they are buying. They have contented themselves instead with the role of a largely automaic "cost-pass-through" mechanism. In the past, some check on costs came from individual patients complaining about high bills. Doctors and hospitals had to worry about the financial hardship that the larding on of services might create. But the emergence of large, "rich," impersonal insurers has removed even these controls.

Third-party laxity has unquestionably contributed to the steep rise in hospital fees. Cost controls have always been weak in many hospitals, partly because many of the doctors have no stake in promoting hospital efficency. Today, most of a hospital's income is provided by Blue Cross and the insurance companies, which dutifully reimburse on the basis of costs *after* they are incurred, rather than agreeing on a fee in advance. This type of cost-plus reimbursement in Fuchs' words, is "an open invitation to inefficiency."

The bad effects of third-party payment do not stop there. Private health insurance covers some phases of medical care more extensively than others. About 85 percent of Americans under sixty-five have at least some hospitalization insurance, and 78 percent are covered to some degree for surgeon's fees, but only 51 percent have any insurance whatever for X-rays and laboratory tests outside the hospital, and only 40 percent for visits to doctors' offices. As a result of this uneven pattern of coverage, says Walter J. McNerney, president of the Blue Cross Association, "use tends to follow prepayment." The whole pattern of medical care is warped in favor of providing treatment in those expensive hospitals. Summing up all these influences, McNerney declares that U.S. medical care is suffering from "a serious discombobulation of the principles of the free market, with no 'invisible hand' to more resources about efficiently."

HENRY J.'S NEW MODEL

Those patterns, however, are not like the laws of the Medes and the Persians—they need not stand forever. Evidence that they can be changed, with benefits for all the parties involved—doctors, patients, and insurers—is piling up. Some eight million Americans now receive medical care under plans that work well, and that are subject to the constraints of the marketplace. These "prepaid group practice" plans are not the only model for reform. Further, even these plans have not yet been brought to the degree of efficiency that they may someday reach. Nevertheless, they represent an alternative that more Americans should be able to choose. Their expansion would exert a badly needed competitive discipline upon the rest of the medical system.

The Kaiser Foundation program is by far the largest of the prepaid systems. It has two million members and its own network of hospitals and outpatient clinics in California, Oregon, and Hawaii. The program began in the late 1930's when the late Henry J. Kaiser, then building hydroelectric dams in remote locations, felt obliged to provide medical services for construction workers and their families. After a conventional, fee-for-service payment system proved unpopular, Kaiser substituted a single fee covering all needed services, and the plan was enthusiastically accepted. In response to requests from hundreds of former shipyard workers, Kaiser kept the program going on the West Coast after 1945, and opened it to the general public. Today, employees of the various Kaiser companies and their families constitute only about 3 percent of the membership.

Th Kaiser plan has made some notable improvements over the orthodox means of distributing medical care. To begin with, access is easy. Physicians of all major specialties are housed in large clinics in each of the regions covered by the plan. A middle-aged man with an abdominal pain can see his internist and can be referred within minutes to another specialist in the same building, which has its own X-ray and laboratories. If the patient requires hospitalization he is sent to one of the Kaiser Foundation's nineteen hospitals, many of which adjoin the outpatient clinics.

Unlike ordinary private "health insurance," which is really sickness insurance designed to reimburse selected medical expenses under the fee-for-service system, the Kaiser program assumes broad responsibility for keeping its members sound of body. The range of services varies according to the employer group or individual member, but a fairly typical plan offered in the San Francisco-Sacramento area currently costs a total of $35.40 a month for a subscriber with two or more dependents, including the employer's contribution. This covers all professional services in the hospital, in the doctor's office, and in the home, including surgery; all X-ray and laboratory services; all preventive care, including physical examinations; and hospital care for up to 111 days per person in a calendar year. Some nominal charges are made for drugs and for doctors' visits ($1 per office visit, and up to $5 for house calls after 5:00 P.M.), and there is a $60 charge for maternity care. Some items are excluded, notably dental care, psychiatry, and nursing-home care (though some Kaiser plans offer psychiatric and convalescent care, too). For an additional monthly payment of 15 cents, hospitalization can be extended all the way to 365 days.

A REWARD FOR CUTTING COSTS

The more liberal of the Kaiser plans probably cover about three-quarters of a family's insurable medical expenses. The very breadth of the coverage provides two important benefits. On the one hand, no paid-up member need be deterred from seeking medical care for fear of the expense. On the other hand, no built-in bias exists favoring a particular *type* of care, since most types are covered anyway. A patient does not have to be admitted to a hospital for a test or a minor operation, which could be given on an ambulatory basis, solely in order to gain insurance coverage.

The Kaiser plan also provides an incentive for efficiency. The provides of medical care—the doctors and the hospitals—*share* the financial risks of illness with the patient. Members' monthly charges are set for a year, and during that period the program must operate on the revenue generated by these charges. If costs exceed revenues during the period, the Kaiser system must absorb them.

But any reduction in operating costs below management's projections swells a bonus fund that is shared by doctors and hospitals. Doctors are not paid on a fee-for-service basis, but receive a relatively stable annual income. When they render excessive treatment, they waste their own time and risk a reduction in their bonus, which, coming atop generous regular incomes, can be sizable. In 1968 the eligible doctors in Kaiser's northern California region each collected a bonus of $7,900. Since they also received regular incomes that ranged from $20,000 to $53,000, they probably fared better, on the average, than solo practitioners in the area. And because working hours are fairly regular in group practice, with members taking turns working nights and weekends according to schedules set in advance, the doctors probably lead a more pleasant life.

Even though there is no limit to the number of times a member can see a doctor, members of the Kaiser plan make slightly *fewer* visits to doctors than the public in general. But the most dramatic savings are in hospitalization. One 1965 study, comparing Kaiser members in northern California with the population of California as a whole, showed that the average Kaiser member spent only 69 percent as much time in a hospital. Still, the Kaiser plan has been affected by the wage inflation common to the health industry. Its nurses won a 40 percent wage increase in 1966, and its hospital workers came under the federal minimum wage law in 1967. As a result, premiums in northern California have risen about 50 percent since 1960, slightly more than the rise in the nationwide index of medical care during this period. But Kaiser's health services still cost from one-fourth to one-third less than the same package of services would cost outside the system.

The Kaiser plan operates in the black. Counting depreciation and some other items, the program generated a total cash flow of $17,200,000 in 1968 on revenues of $216 million, enough to provide funds for expansion. Except for one recent fed-

eral grant under the Hill-Burton hospital program, the Kaiser Foundation has financed all of its expansion from its own revenues and from borrowings. Unlike most voluntary hospitals, the Kaiser hospitals have never had to fall back on rich trustees or public fund-raising programs to cover deficits or obtain funds for expansion.

PRACTICING "PURE MEDICINE"

Kaiser's experience refutes the widely held belief that if medical services are "free," or virtually free, the public will stampede to them. Neither does the evidence indicate that Kaiser has gone to the opposite extreme, cutting corners and denying needed medical care. This criticism is often voiced by doctors opposed to prepaid group practice, along with the familiar charge that group practice precludes the free choice of "family" physician, and that it renders care in an impersonal, "assembly-line" manner, which lowers the quality of medical services.

In fact, the Kaiser program makes possible an educated choice of a family physician, because the patient in a large clinic is in a position to compare doctors. The atmosphere at one Kaiser clinic, in suburban Walnut Creek, California, is a good deal less suggestive of an assembly line than the typical jammed office of a solo practitioner; the place has more the relaxed ambience of a resort inn. A study team from the Johnson Administration's National Advisory Commission on Health Manpower gave the Kaiser program a thorough going-over in 1967, and found the quality of services to be high. One factor raising quality, according to Dr. Wallace H. Cook, the sun-tanned physician in chief of the Walnut Creek Center, is that doctors devote themselves to "absolutely pure medicine here." They have nothing to do with the billing, and they do not have to worry about the financial impact of the type of care that they prescribe on the patient, since virtually all phases of medical care are prepaid.

"Peer review," that much-evoked but little-practiced procedure for uncovering medical incompetence, is inherent in a group operation. "We constantly look over each other's charts," says Cook. An incompetent doctor can quickly lose the respect of his colleagues. In solo practice, doctors obviously can never lose their jobs no matter how incompetent they are; with only a few exceptions, licensed doctors are in business for life regardless of performance. At Kaiser, however, even doctors who have attained relatively secure "partner" status, which comes after a three-year probationary period, can be discharged. Not long ago a surgeon too inclined to use the knife was let go.

Another advantage that Kaiser physicians enjoy over their counterparts in solo practice is access to good health records. Generally, health records are in a medieval state, with incomplete data on each individual scattered in every doctor's office and hospital that he has ever visited. Most Kaiser members' medical histories are readily retrievable, and in a growing number of cases are stored on computer tapes. The eventual goal is to give each member a lifetime electronic medical file, based in part on the periodic, multiphasic testing with which the Kaiser Foundation is now experimenting on a larger scale.

Probably the greatest spur to maintaining the quality of medical services is the fact that Kaiser does not have a monopoly over health care in the areas it serves. Once a year each group, and each individual within a group, has the chance to drop out of the program if he wishes. If enrollment figures are any guide, the consumers couldn't be happier. Membership has grown threefold in the last ten years, and the Kaiser Foundation is expanding about as fast as its financial resources will permit, currently at a rate of 200,000 persons a year. It has recently moved east of the Rockies to start a health plan in Denver, and to team up with a group plan in Cleveland.

By almost any measure, then, the Kaiser program represents a quantum leap ahead of the prevailing pattern of health care in the U.S. Edgar F. Kaiser, Henry J.'s son, who besides heading the various Kaiser industrial companies also serves as chairman of the health foundation, says the plan demonstrates "that it is possible, within our free enterprise system, to organize medical care on a private, financially self-sustaining basis so that the consumer is satisfied and the physician is professionally gratified by his role."

Savings on hospitalization and other medical costs are not unique to the Kaiser program. In recent years members of the Health Insurance Plan of Greater New York (HIP) the country's second largest prepaid group program with 775,000 members, have spent 20 to 25 percent less time in hospitals, on the average, than the general population in the New York City area. According to studies by the United Auto Workers, members of the U.A.W.-sponsored

Community Health Association, a group-practice plan in the Detroit area, spent 45 percent fewer days in the hospital in 1966 than persons insured by Michigan Blue Cross-Blue Shield.

HOW TO AVOID APPENDECTOMIES

The experience of federal employees also testifies to the efficacy of group-practice plans. In many areas they have a choice of three forms of health insurance—Blue Cross-Blue Shield, "indemnity benefit plans" sold by insurance companies, and group practice. Those enrolled in the principal group-practice plans spend less than half as many days in the hospital as those covered by the other two methods. Because group practice stresses early diagnosis and treatment, and contains no incentives for needless surgery, federal workers also spend less time on the operating table. A study comparing federal employees and their families in group-practice plans with those covered by Blue Shield surgical benefits showed that the latter had 86 percent more appendectomies and more than *two and a half times* as many tonsillectomies and adenoidectomics per 1,000 persons. Under Blue Shield, female operations, e.g., hysterectomies, were 52 percent higher.

While some of the other group plans have matched or even exceeded Kaiser's cost savings, they have not enjoyed the same rapid growth in membership. Detroit's Community Health Association, whose rolls have been static for several years, is hampered in part by its "union" label that deters white-collar and other middle-class workers from joining. New York's HIP has been stalled at approximately its present membership for the past year or so, and some unions have withdrawn from the plan. HIP has been handicapped because until recently it did not own its own hospitals; it simply referred patients to community hospitals and paid the bill. In some cases its doctors handled HIP members along with nonmembers paying on a fee-for-service basis. As a result, HIP members have often been kept waiting, and some of them, says a spokesman for a union that recently pulled out, "felt they were being treated as second-class citizens."

Elsewhere around the country, new group-practice programs are getting under way. The main impetus is coming from teaching hospitals—which until now have remained aloof from the nitty-gritty of community health services—and some of the insurance carriers. The new Harvard Community Health Plan, which hopes to attract members from the entire Boston area, is the outgrowth of years of soul searching by the Harvard Medical School on the mission of the medical school and the hospital. Jerome Pollack, associate dean of Harvard Medical School who designed the new program, has combined some existing institutions—four community hospitals that will accept patients from the new program—with a newly opened outpatient clinic operated by the plan itself and staffed mainly with salaried physicians. With premiums set at $50 a month per family irrespective of size, the coverage will be somewhat broader than Kaiser's: patients will be eligible for fairly extensive psychiatric care, as well as convalescent care in nursing homes.

Pollack expects the plan to break even in about three years, by which time he hopes enrollment will have reached 30,000. Instead of bypassing the insurance companies, as the Kaiser program does, Pollack has enlisted their help in canvassing members from among those already signed up under existing programs. Blue Cross is expected to supply 70 percent of the members and a group of ten commercial insurance companies—including such giants in the health field as Aetna, Metropolitan, Equitable, and Travelers—will supply the rest. Pollack is aiming for a cross section of all income groups and races, in order to gain operating experience meaningful for the whole U.S. population. "We envision," he says, "something that the giant insurance companies and Blue Cross will be able to duplicate on a large scale."

The insurance companies have been initiating some experiments of their own. As President Charles A. Siegfried of Metropolitan Life concedes, the big carriers have until recently been "standoffish" about improving the nation's medical system. For a long time, he says, there was "a fatalistic acceptance of rising costs," and "we felt we shouldn't tell doctors how to run their services." All this is beginning to change. Following a meeting in Boston last October, the Health Insurance Association of America, representing most of the commercial carriers, recommended that the companies "exert their influence to bring about soundly conceived changes" in the U.S. health system.

Metropolitan has already supplied funds for a new ambulatory care center at Washington University Medical School in St. Louis which will include a "demonstration" group-practice program. Equitable is providing most of the mortgage money for the construction of a combined neighborhood health center and nursing home that will house a new group-practice system in a Washington, D.C., Negro neighborhood. Perhaps the most deeply involved insurance company is Connecticut General, which is putting up $3,750,000 of mortgage money for a clinic and hospital at the new town of Columbia, Maryland, which will serve members of a new prepaid group-practice plan. Connecticut General, which is also providing $500,000 of development costs, will have first crack at selling the plan, but its involvement stops short of actually setting it up and running it; Johns Hopkins Medical School in Baltimore will do that.

SELLING HEALTH, FOR A PROFIT

Some insurance companies are beginning to consider actually running health systems of their own. The leading advocate is Dr. Paul M. Ellwood Jr., executive director of the American Rehabilitation Foundation in Minneapolis. The Kaiser experience, Ellwood says, proves that comprehensive health care can be provided efficiently and profitably by corporations competing for the citizens' health dollar. The Nixon Administration is sympathetic to the idea. In their statement last July warning of an impending "breakdown" in health care, Secretary of Health, Education, and Welfare Robert H. Finch and Assistant Secretary Dr. Roger O. Egeberg declared: "We will ask and challenge American business to involve itself in the health-care industry, including the creation of new and competitive forms of organization to deliver comprehensive health services on a large scale."

While the insurance companies are the obvious ones to enter this field because of their large pools of capital, other parts of the health industry, including hospitals, groups of physicians, and drug companies, could also evolve into medical corporations. The Upjohn Co., which already operates a network of medical laboratories in addition to manufacturing drugs, is "exploring the possibilities." Ellwood sees absolutely nothing wrong, in principle, with industrial and merchandising corporations, such as I.B.M. or Sears, Roebuck, entering what is obviously destined to be a growth industry. Two nationally known conglomerates recently asked New York's HIP for information on how to run a medical system.

The one type of business involvement that Ellwood vehemently opposes is the recent spread of proprietary hospitals and nursing homes. These offer only one phase of medical care, which the owners, who in many cases include doctors, have an incentive to promote aggressively whether it is required or not. The recent, fantastic boom in nursinghome stocks, large amounts of which are held by physicians, raise possibilities of conflict of interest that call for governmental scrutiny.

THE POTENT MEDICAL LOBBY

The biggest obstacle in the path of a more rational medical system, whether in the form of a health-care corporation or more modest innovations, is organized medicine. Even if the insurance companies or other organizations should decide that the economics of comprehensive health care are very attractive indeed, they might still hesitate to enter the field for fear of antagonizing the medical profession. The American Medical Association has recently muted its opposition to prepaid group practice, but some state and local medical societies still fight it, sometimes viciously. Some incredibly retrograde laws and regulations in seventeen states still prohibit the ownership and operation of prepaid group-practice systems by consumer-oriented groups—i.e., by those who would have the most interest in establishing them.

The legislative history of medicare and medicaid illustrates the potency of the medical lobby, as well as the danger in simply pumping more money into the existing health system. A misnomer, medicare is not a health-care program at all, but a financing mechanism under which the Social Security Administration passes out money to the insurance carriers—Blues as well as insurance companies—which in turn pay part of the medical bills for persons over sixty-five. To make medical more palatable to the A.M.A., which had long opposed it, Congress wrote into the law a passage making clear that the financing plan would not be employed to bring about changes in the U.S. medical system. Indeed, the rather arbitrary division of medicare into Part A (hospitalization) and Part B (doctor's bills) tended to sanctify the fragmentation in the system. The law also

specified that hospitals were to be reimbursed on the basis of costs rather than fixed fees, and that physicians were to be paid according to the "customary" fees in their communities.

The quantity of medicare services rendered to the aged increased roughly in line with government forecasts. The deluge that some had feared simply didn't materialize. But the inflation in hospital costs, which had already been steep, was accelerated. The same thing happened to doctors' fees. The "customary" provision, which had been intended by Congress as a sort of benign ceiling on doctors fees, actually became a floor under all doctors' fees; before medicare went into operation in July, 1966, most doctors raised their "customary" fees to *everybody*, young and old, to qualify for higher medicare payments. Partly as a result, doctors' fees, which had been rising by about 3 percent a year before medicare, started shooting up by 6 percent a year.

Medicaid, of course, was an even more potent inflator. It represented an open-ended commitment by the federal government, jointly with the states, to finance through general revenues a whole range of medical services for the poor and the so-called "medically indigent," those whose incomes are too high to enable them to receive welfare payments, but who are judged too poor to pay for medical care.

There are many reasons why the cost of medicaid skyrocketed from $2 billion in 1966 to an estimated $5 billion in 1969, and why it could easily reach $24 billion by the mid-1970's. For one thing, its potential universe is far larger than medicare's, including all the people considered poor or near poor according to the federal government's definitions—far more than are currently receiving services. Another reason is an incredible amount of bureaucratic red tape and, until fairly recently, very little cost control by the insurance carriers. Still another is the fact that, as author Herman Somers puts it, "the availability of money doesn't produce resources where they don't exist"—in the ghetto and in rural poverty areas where the supply of doctors and medical facilities is stretched thinnest. The result was an ominous, upward pressure on costs, and outright gouging by an unscrupulous minority of doctors.

Compounding the difficulties, medicaid also missed much of its main target group, which was the young poor and near poor. To a far greater degree than its architects foresaw, it has become a device under which the aged poor have supplemented their benefits under medicare. Almost half the money is currently going to persons over sixty-five, and about two-thirds of that is going for nursing-home care, much of it of the long-term custodial type—i.e., for senile and infirm persons who are not convalescing from a serious illness, but have simply been "put away" until they die.

Having made this initial mistake of simply superimposing medicare and medicaid upon an inflation-prone, fee-for-service medical system and then pouring in money, the federal government is now trying to impose some cost controls. Under both medicare and medicaid, for example, the reimbursements of hospitals has been tightened up somewhat, and when new regulations take full effect, doctors' fees generally will be permitted to rise no faster than the cost of living. Like any form of price control, these measures can have only limited effectiveness. They do nothing, by themselves, to eliminate the fundamental causes of medical inflation. And if price control becomes too strict, doctors and hospitals may turn down medicare and medicaid patients.

SOME TEMPTING HEALTH-INSURANCE PLANS

As the sorry history of medicare and medicaid makes clear, any future national health-insurance system must be coupled with measures for imposing order on the distribution of medical care. Of all the proposals being considered, the most ill conceived and most dangerous is the A.M.A.'s "Medicredit" plan for federal income-tax credits to defray families' health-insurance premiums—with credits covering 100 percent of costs for low-income groups and tapering off to zero in the highest brackets. This is strictly a financing plan. To Herman Somers, it "is a proposal to subsidize the present system on the assumption that everything in it is just jim-dandy."

Rashi Fein, professor of medical economics at the Harvard Medical School, has a tax-credit plan somewhat like the A.M.A.'s that also contains no reforms. Unlike the A.M.A., Fein admits and deplores the great waste in the present system. But he believes that only the crisis atmosphere brought about by pumping in additional money will jolt the American people into creating a more rational medical system. This is a precarious assumption.

In contrast to such views, reform is intimately and ingeniously woven into the health-insurance proposal recently presented by Daniel W. Pettengill of Aetna to the House Ways and Means Committee. Pettengill proposed extending private health insurance to everyone in the population under sixty-five, with the federal government providing a subsidy for the poor and for non-poor individuals rated as bad health risks. Washington would establish guidelines for minimum coverage, including a strong emphasis on ambulatory care that would cut down on hospitalization, and it would use its taxing powers to enforce these requirements. Thus, employers who failed to cover their workers for ambulatory care within, say, five years would lose half their present tax deductibility for health-insurance premiums.

The Committee for National Health Insurance, headed by U.A.W.'s Chairman Walter P. Reuther, has proposed a federally run health-insurance plan that would supplant medicare and medicaid, as well as most private health insurance. Two-thirds of the cost would be shared by employers and employees, in somewhat the same fashion as social security taxes, and the rest would be financed out of general federal revenues. The objective is not merely to provide complete health insurance for all but also, in Reuther's words, to disburse the money in a manner that will bring about a "restructuring" of a medical system that is now providing "unacceptable, unsatisfactory, second-rate health-care services."

The Reuther committee does not propose a governmental take-over, or even direct regulation, of doctors and hospitals, nor does it have a precise blueprint for reorganizing the private medical system. "We don't want to lock step with any existing system" such as Kaiser's, says Max Fine, the committee's executive director. "We want to encourage competition and experimentation." For a time, doctors would have the option of solo practice on a fee-for-service basis, but the plan would contain incentives to encourage the spread of prepaid group practice. While it is easy to find fault with the Reuther committee's somewhat ideological disdain for private health insurance, it is hard to quetsion its insistence upon reshaping the medical system.

AN AGENDA FOR REFORM

A lot must be done, and done soon, to prepare the U.S. medical system for the approaching day of universal health insurance. The most important step is for the federal government, which now pays about a third of the country's medical bill, to encourage the emergence of more efficient forms of care. The Hill-Burton program, under which Washington has made available nearly $3.5 billion in grants since 1947 to build new hospitals, has largely accomplished its mission. The task now is to modify Hill-Burton, as the Nixon Administration and some Congressmen have proposed, to make grants available for the construction of ambulatory care centers, including those operated by group-practice plans. Also, it would cost nothing for the federal government to realign the various laws of the 1950's and 1960's that encourage regional planning of medical programs and facilities—laws that now overlap in scope, and carry little more than moral force—and to make effective planning a condition for all future grants and loans. The U.S. Public Health Service, which has abandoned its long-standing neutrality on the matter, has allocated $1,100,000 during the past two years to acquaint community organizations, including labor unions, with the prepaid group system. But a bigger educational effort is needed.

The private insurers, too, can exert far greater control over medical costs. In New York State, Blue Cross is shifting over to a fixed-fee method of reimbursing hospitals, with fees set for two years in advance. More such innovations are needed. The insurers must also simplify health insurance, and provide broader coverage. Walter McNerney of Blue Cross, fully aware that his system has encouraged excessive use of hospitals, believes that insurance coverage must reach 80 percent of medical costs before the bias in favor of certain types of care will disappear.

ADEQUATE CARE FOR ALL

Under the existing chaotic state of affairs, the goal of adequate care for all citizens seems utterly unattainable. Although millions of people are still denied adequate care, the proportion of our G.N.P. devoted to medicine has already climbed to 6.8 percent from 4.5 percent twenty years ago, and promises to keep right on increasing. In this situation, the public and Congress are certain to resist any proposals to shift massive new resources to medical care, especially in

view of all the country's other unmet needs in such fields as housing, welfare, and urban transportation.

The only hope, therefore, is to get more value from the money spent on medical care—to remove the glaring inefficiencies, to bring the proper incentives into play, and to make a maximum effort to supplement doctors with lower-paid para-professionals, as proposed in the article beginning on page 84. If this were done, the country might save enough from the elimination of waste to do a creditable job with that same 6.8 percent of G.N.P. The strongest evidence that this is possible comes from abroad. Countries such as Sweden and Britain, which enjoy lower infant mortality rates and morbidity rates for childhood diseases than the U.S., devote only 5 percent and 4 percent of their G.N.P., respectively, to medical care.

Harvard's Rashi Fein believes that "at least 10 percent of the $63 billion we spend on medical care is wasted." Howard Ennes of Equitable Life guesses that "we're losing 40 percent of what we're putting in." One benchmark of what good care *ought* to cost is provided by the Kaiser program, whose services currently cost about $120 a year per person, counting the nominal fees paid by members when they receive treatment. Making allowance for services not provided, the Kaiser experience indicates that a good job could be done for the non-aged, non-poor population for about $175 per capita—or about one-third less than what this group currently spends for the unsatisfactory care it gets.

These figures show, among other things, that a majority of the population under sixty-five does not need a government subsidy to pay its medical costs, provided employers pay a generous share of private insurance premiums also suggest that if an efficient system existed right now, some $10 billion to $20 billion a year might be available, in the form of savings, to provide better coverage for disadvantaged groups. Assuming that it would cost even as much as 50 percent more per capita to care for the poor, because of past neglect (or about $250 per person a year) $10 billion could pay all the medical bills for the approximately 35 million persons below or near the poverty line. For another $3 billion or $4 billion, medicare—which now pays 45 percent of the aged's medical bills—could be liberalized, and it could be extended to persons under sixty-five who are permanently and totally disabled.

To construct such a system would take at least five years, and require considerable capital investment and redeployment of medical manpower. But there is reason to believe that if the country has the will, good medical care for all is within our reach.

HOW TO SPEND $63 BILLION

In recent years the nation has been spending more on medical care than on education or social security. The $63 billion spent in 1969 even exceeded defense outlays less Vietnam Hospitals received 38 percent of the total medical budget, or $24 billion. Doctors got a 20 percent slice of the budget—$13 billion. Even some of the smaller sectors were pretty big: medical research totaled nearly $2 billion, and supported some nationwide enterprises. Included within the category of "other services" are such big terms as the purchase of eyeglasses, support of government public health programs, and some administrative costs.

	Percent
Hospital care	38
Other services and expenses	14
Drugs	11
Construction	4
Research	3
Dentists	6
Doctors' services	20
Nursing homes	4

THE SOARING U.S. HEALTH BUDGET

In less than two decades, the nation's outlays for medical care increased five-fold, to $63 billion in 1969. If the current rate of growth continues, they will reach $200 billion by the early 1980's. Both inflation and rising demand account for this extraordinary increase. Some 40 percent of the nation's health bill is now paid by government—federal, state, and local—through health programs for government employees, veterans, and servicemen and their dependents, as well as state and city hospitals and medicare and medicaid. Although the growth of

private health insurance provided by Blue Cross, Blue Shield, and commercial insurers has added to the demand for health services, these insurers together pay only a third of the nongovernmental portion of the nation's medical bill. Individuals pay the other two-thirds out of their own pockets.

Private insurance has artificially stimulated the demand for hospital care because it covers this phase of medical costs more liberally than others. As the chart on the far right shows, the biggest factor in rising health costs is the growing use of increasingly expensive hospitals.

MEDICINE'S COST-PUSH INFLATION

The price of medical care was already climbing twice as fast as the cost-of-living index when the medicare and medicaid programs went into operation in mid-1966. The introduction of those programs was like firing a booster rocket. As the chart shows, physicians' fees, which had been going up by less than 3 percent annually, began rising more than twice as fast. The steep climb in hospital charges became even steeper.

The explanation for the new rises lies not only in the added demand created by medicare and medicaid, which together pumped $13 billion into the medical system in 1969, but also in the way the programs are run. Physicians are reimbursed mainly on the basis of "usual and customary fees," a provision that encouraged them to raise those fees. Hospitals are reimbursed on what amounts to a cost-plus formula. Now, with both programs running ahead of forecasts, and alarmingly so in the case of medicaid, the federal government is trying to impose some controls.

Rising prices are the biggest single contributor to the nation's growing health bill. Back in 1950 the country spent $11.1 billion for personal health services, i.e., all medical expenses except for research, construction, and other special categories of spending. By 1969 the same figure had climbed to $54.2 billion. The rise in population accounted for 18 percent of the increase, and additional medical services per capita accounted for another 35 percent. But inflation accounted for nearly half the rise.

[From Fortune magazine, January 1970]

IT'S TIME TO OPERATE—CHANGE BEGINS IN THE DOCTOR'S OFFICE

(By Dan Cordtz)

When Dr. Sidney Lee, associate dean for hospital programs at Harvard Medical School, is asked what is wrong with American medicine, he has a prompt and characteristically blunt answer: "Doctors!" He has a good point. The nation's 313,000 active physicians are quite properly the main target for the critics of the health-care system. The doctors created the system. They run it. And they are the most formidable obstacle to its improvement. It is the doctor who decides which patients will be treated, where, under what conditions, and for what fee; who will enter the hospital, for what therapy, and for how long; what drugs will be purchased and in what quantities. The U.S. alone among the world's developed countries has given the medical fraternity such freedom. The profession not only can, but should, be held accountable for the way it uses its power.

The trouble with doctors is not that they are more avaricious than other people. Indeed, many of them are dedicated men, who work hard for their high incomes. The real charge against them is that they have been shortsighted, timid, and far too slow to recognize and adapt to change. Only recently did the leaders of organized medicine reluctantly recognize the fact that Americans regard decent health care as one of their rights—not a privilege, or a commodity to be sold by medical men in the open market. Motivated by groundless fears of oversupply, doctors have discouraged the expansion of their own ranks, until now they must acknowledge a serious shortage. Even if every effort were made, that shortage could not be alleviated for at least the next decade. Yet most doctors, far from taking the lead, continue to resist innovations aimed at making the health-care system more efficient and responsive to public needs.

In recent years a small but growing band of doctors—most of them young—have begun to level these very accusations at their profession. A handful are taking direct personal action. Some are working in health centers established by the Office of Economic Opportunity; others have launched similar projects on their own. Interns and residents in several cities have forcefully called attention

to deplorable conditions in public hospitals. Even more promising for the longer run, a profound change is evident in the attitudes of the nation's 37,750 medical students. Hundreds of the most earnest, intelligent, and vocal of them are clamoring for major reforms in the purpose and methods of medical education. They are demanding that the schools design both a more rational, effective health-care system, and more relevant training for a new breed of practitioner.

But it will take many years for the new generation of M.D.'s to make up a significant share of the medical fraternity, and in the meantime their influence is indirect and limited. Dr. Daniel Federman, an authority on the continuing education of doctors, asserts that "the change in student mentality has almost no counterpart among established physicians. They are more aware of the problem, but there is no evidence that they are doing anything about it." And Dr. Labe C. Scheinberg, dean of New York's Albert Einstein College of Medicine, warns, "Until the top practitioners join in the drive for change, everything else will be irrelevant". There are some small signs that the American Medical Association may be less resistant to change in the future. Nevertheless, most critics of the profession still believe that reforms will be forced on the A.M.A. by external pressures, not generated internally.

THE VANISHING FAMILY DOCTOR

At the heart of concern about the system is the intractable fact of shortage. Much more is involved in the nation's health, of course, than medical services. Environment, mores, and genetics also play large roles. And more is involved in the supply of medical services than the number of physicians. But their availability is extremely important, not only to the adequacy of care but particularly to perception of its adequacy. The National Advisory Commission on Health Manpower, in its report to President Johnson two years ago, cited three leading indicators of crisis: long delays in obtaining appointments for routine care; hours spent in waiting rooms, followed by hurried and impersonal attention; and difficulty in reaching a doctor at night and on weekends, except through hospital emergency rooms. All are obviously directly linked to the short supply of M.D.'s.

Since 1950, the number of physicians has grown about 25 percent faster than total population, and that margin is expected to increase as medical schools belatedly open their doors wider. But such over-all figures conceal some trends that have important implications for the availability of care. In recent years many doctors have turned away from patient care to work in research laboratories, industry, public health, and other institutions, to teach, or to serve as hospital administrators—all functions of great importance for the future. One-third of all doctors now devote themselves to such activities. As a consequence, the number of M.D.'s caring for private patients actually declined 10 percent relative to population between 1950 and 1965—to 92 for each 100,000 Americans. Specialization took a further toll. The doctor-patient ratio of those providing family care (general practitioners, internists, and pediatricians) fell by one-third—to 50 per 100,000. (In the 1930's, when almost all doctors were in patient care and 70 percent were general practitioners, a ratio of 135 per 100,000 was regarded as desirable.)

The geographical distribution is extremely uneven. In New York State, by the end of 1967, there were 200 physicians caring for each 100,000 residents. At the other end of the scale, Mississippi had but 69. Even within the most favored states, extreme distortions are common. Private physicians are as hard to find in some neighborhoods of New York City as in backward rural counties of the South. In general, doctors are plentiful only in the suburbs and in prosperous middle-sized cities; they are scarce in parts of large metropolitan centers, and in rural areas.

Most of the burden of expanding the pool of physicians falls on the country's 101 medical schools. In the past decade, sixteen new schools were opened. But the number of graduates next summer will total about 8,000—only a thousand more than in 1960. By 1975 more than 10,000 new doctors will be turned out annually. So lengthy is medical training, however, that even if the size of all schools were doubled tomorrow, there would be only an extra 9,000 fully qualified physicians seven or eight years from now. Today's shortage has resulted in a rapid increase in the immigration of foreign-trained doctors. They make up almost one-fifth of each year's new licentiates and more than one-fourth of the nation's full-time hospital staff. The Health Manpower Commission has expressed

serious concern over this trend, noting that foreign-trained doctors "have a lower level of proficiency by all criteria of professional competence."

Whatever the source, the supply in 1975 is expected to total between 370,000 and 380,000 doctors—a gain of 17 or 18 percent from 1965. The trend away from patient care and toward greater specialization, however, will almost certainly continue. And, in any case, the increase in demand for medical service will far outstrip the small projected gross gains in the doctor supply. The factors that have expanded demand dramatically in the past decade—increasing affluence, new infusions of purchasing power from private and public insurance schemes, more education and consciousness of health, rapid growth in the youngest and oldest segments of the population, and continuing urbanization—will continue to work, perhaps even at a faster pace, in the future. The Health Manpower Commission has projected demand for all physician services at $24 billion for 1975—double last year's amount.

Even if the supply of doctors could be increased more rapidly than anyone now believes possible, it would not solve much. The Health Manpower Commission declared that "if additional personnel are employed in the present manner and within the present patterns and 'systems' of medical care, they will not avert, or perhaps even alleviate, the crisis. *Unless we improve the system* through which health care is provided, care will continue to become less satisfactory."

WHERE THE SYSTEM FAILS

The most glaring shortcoming of the system is the unavailability of care to the poor, the isolated, and members of minority groups. A modest start is being made to deal with the deficiency through the OEO's fifty health centers, which group doctors, dentists, and supporting people in areas that formerly lacked any facilities or were dependent on hospital out-patient departments. Dr. Jack Geiger, now chairman of the Department of Community Health and Social Medicine at the Tufts Schools of Medicine, sold the concept of health centers to OEO in 1965. He opened the two centers that the OEO now operates. One of them is in Mound Bayou, Mississippi, and the other in Columbia Point, a public housing project in Boston. Eleven full-time doctors and 150 staff members serve 14,000 people at the Mississippi center. Besides providing medical treatment, they attack the environmental conditions that produce much of the illness they find. In the early days of the projects, Dr. Geiger wrote prescriptions for food to deal with widespread hunger and nutritional deficiencies. Since the center was established, he estimates, infant mortality in the target area has been reduced by almost two-thirds, but Dr. Geiger gives most of the credit to environmental improvements. "If I could do just one thing to improve the health of the people," he says, "I would double their per capita income."

Operations at Columbia Point are more conventional. There six full-time physicians and three others, who donate part of their time, care for 6,000 residents of the housing project. They work closely with welfare and other social workers in an effort to provide comprehensive family treatment. The emphasis is on preventive medicine, and the results have been dramatic: in two years the number of days spent in the hospital by residents of the project has declined by 80 percent.

Similar clinics have been started under private sponsorship or by individual doctors. One of the most noteworthy is Dr. David Brooks's Salud Clinic in Woodville, California—a rural community that previously had no health facility of any kind. There three physicians and a myriad of other health people (mostly local residents trained on the job) work on a communal basis. Each is paid $250 a month. Fees for patient care come from Medical, the state's Medicaid program. Most of the money left over after salaries are paid is plowed back into improved facilities or educational programs.

Dr. Geiger asserts that 800 such centers are needed immediately across the U.S. But he acknowledges that staffing is a serious obstacle. Government health officials and others are now looking closely at the lessons learned in Vietnam, where physicians have been removed from the front lines. They remain at secure, well-equipped rear bases, and the wounded—after emergency first aid by medical corpsmen—are quickly taken back by helicopter. Investment of money in transportation between rural backwaters and strategically located large hospitals would have many clear advantages over construction and operation of understaffed makeshift medical centers. "Most small towns without doctors won't get them no matter what," insists Dr. Richard S. Wilbur, assistant executive vice

president of the A.M.A. "The rural general practitioner in many areas is unsupportable and we shouldn't even try."

Others sympathetic to Dr. Geiger's aims are not sure that his should be the only approach. "We might be on the wrong track with those clinics," warns Dr. Charles E. Lewis of Harvard's Center for Community Health and Medical Care. "They might just turn into replicas of outpatient hospital clinics. It's like trying to fight this year's war with last year's weapons. And the costs of operation are phenomenal." Dr. Lewis argues for primary-care units in shopping centers and other areas where people congregate, many of them to be staffed by local people trained in taking information. The data could be fed into central diagnostic computers that would indicate whether the case seemed serious enough to warrant examination by a doctor.

HOW FEW CAN DO MORE

The poor and the isolated are by no means the only ones dismayed and discontented by the way medical care is now being distributed. Anger about medical costs and the inconvenience and impersonality of care is spreading among the majority of middle-class Americans. Given the fact that the shortage of doctors is going to continue, the medical profession must find ways to improve its productivity. Most critics have centered their attention on three potentially fruitful ways to accomplish this: more extensive use of professionals who are not M.D.'s, expansion of group practice, and broad-scale application of computer systems and other new technologies.

Technological innovations hold considerable promise. Duke University's Department of Community Health Sciences is doing research that may provide practicing physicians with the advantages of data processing in making patient-care decisions. The department sees as feasible such improvements as a computer-stored data bank of diagnostic information wired to a terminal located conveniently close to the doctor, enabling him speedily to check his diagnosis of a particular illness with the computer's data about the illness in question.

Duke has also pioneered in the so-called "multiphasic screening clinics," which are now in operation in fourteen locations across the country. As the Commonwealth Fund describes its operation, "This unit will conduct chemical and electronic tests necessary for physical examination. Since much of the equipment can now be automated, it can be operated by technicians and can process both patients and the clinical data collected on them very rapidly. Through the screening clinic, the physician, at no expenditure of his own time, can obtain an important clinical-information profile on his patient." Other uses of electronic equipment include two-way television hookups between hospitals and outlying field stations manned by nurses. One now links a medical station at Boston's Logan Airport with Massachusetts General Hospital.

CUTTING DOWN ON THE BOOKKEEPING

Group practice, if the group is of sufficient size, can relieve the physician of almost all of his nonmedical burdens. John R. Johnson, executive administrator of the Palo Alto Medical Clinic, estimates that the average doctor in private practice spends more than 25 percent of his time on business (bookkeeping, billing, ordering supplies, etc.). "If a doctor uses us right," he says, "he can reduce that to 1 percent." Economies of scale can also enable groups to provide time-saving in-house laboratory facilities and equipment. And group practice gives the doctor and his patient ready access to specialists in other fields. In spite of these advantages, however, only 12 percent of all practicing private physicians engage in any kind of group practice; just half of them are full-time members of comprehensive multispecialty groups. Many medical students express an intention to enter group practice, but the percentage of doctors doing so is not increasing much right now.

Part of the reason is money. Salaries for members of a group are usually well under what a hustling physician can earn on his own. Dr. John Knowles, director of Massachusetts General Hospital, tells of a large western group that is trying to recruit an orthopedic surgeon at a salary of $40,000—with no takers. "An orthopedic surgeon can easily make $80,000 a year on his own," Dr. Knowles explains. Further, a doctor just starting out may be reluctant to join a group because there are so few of them. If he finds his associates uncongenial, he may not be able to locate another. He will then have to launch his own practice after having wasted several years.

SPLITTING UP THE JOB

"Health-care teams" offer the brightest opportunity for improvement of productivity. At present, because of the wide gap between their education and that of others in the medical field, doctors routinely perform many tasks that are beneath their level of competence. Many of them could be handled better by persons trained less broadly but more intensively. If large numbers of such functional specialists were available, physicians could work largely as team leaders—keeping for themselves only the duties demanding the highest skills. Other members of the team, working independently or under the supervision of doctors, would be assigned responsibility commensurate with their education and training.

The mechanics of this eminently sensible idea are difficult to work out. What is required first of all is a detailed analysis of all the duties involved in caring for various types of patients. These must be evaluated in term of their critical nature, and the kind and degree of skill required to carry out each. They must be divided up in some rational way. Then educational and training programs must be designed, and candidates recruited by the attractions of good salaries and opportunities for advancement. Doctors must be persuaded to use such assistants fully. (The history of physician-nurse relationships is not encouraging on this point.) Finally, and perhaps most difficult of all, medical licensing laws must be changed, and common standards established across the country.

A number of promising experiments are now under way. Anesthesiologists, who are among the specialists in shortest supply, have sponsored a study of their duties, and have identified six different levels of required competence. Some of those functions are being parceled out to technicians with a master's degree in anesthesiology. (About 12,000 nurse anesthetists already do 45 percent of the anesthetic work in the U.S., so splitting up the job further may not encounter too much resistance.) Pediatricians have also formally recognized that much routine care can easily be carried out by nurses or other assistants.

Many schools have already launched experimental programs to train a variety of people in services related to health care. Several are training a new category, the "physician's assistant," who will perform an array of routine chores—measuring, testing, and giving therapy—that now consume much of the doctor's time and energy. At Duke University School of Medicine, and at the University of Washington School of Medicine in Seattle, the courses of training, which do not lead to a degree, are designed for persons with some previous medical experience, most of whom are medical corpsmen returning from military service. Another school, Alderson-Broaddus College in Philippi, West Virginia, has just started a four-year baccalaureate program that will recruit students directly from high school.

Twenty-nine students have already finished their two-year course at Duke. Dr. D. Robert Howard, director of the program, says that each graduate had more than a dozen job offers. The University of Washington took in its first fifteen students last June for a three-month crash course. After classroom work in the subjects where the men were least experienced—psychiatry, pediatrics, geriatrics, and chronic disease—they were placed in doctors' offices for on-the-job training. All fifteen are now working in rural areas where physicians are most hard-pressed.

Up to now, most of the early graduates have found jobs close to their place of training. If these programs are to move beyond the experimental stage, though, legal obstacles to mobility must be removed. The new people in medicine will have to move freely across the country, without encountering serious restrictions on their ability to apply their skills.

Recruitment may also turn out to be difficult. With the exception of a few hospital administrators, nobody but the doctor makes much money or has much opportunity for advancement in medicine. Thus many abandon the profession. In spite of the severe shortage of nurses, somewhere between 500,000 and 600,000 qualified nurses are currently inactive because of low pay and the lack of intellectual stimulation. People lower down in the medical hierarchy—technicians, nurses' aides, orderlies, etc.—are even harder to attract and keep. Those who are pressing the health-team idea hope that the barrier to vertical mobility in medicine can be lowered, and that salaries can be raised substantially as better trained people take over duties now performed by those higher in the pecking order.

THE NEED FOR SUPPORTING TROOPS

Ultimately, however, the future of the health-care team concept will depend on the willingness of doctors to accept and utilize paramedical personnel. The numbers of such people have been minuscule thus far, and most have been trained in areas of severe shortage. If their numbers grow rapidly, the early enthusiasm for them may dwindle. Already, a local medical society in California has brought charges of practicing medicine without a license against a neurosurgeon's assistant who—under instructions—removed stitches from a patient's incision.

The attitudes of the doctors may be based on fear of competition. But it is also true that patients themselves may resent being handed over to assistants. Obstetricians are probably the most overtrained, underutilized doctors in the whole profession. Only a tiny number of births involve the kind of complications for which they train so arduously. But it is still difficult to visualize large numbers of middle-class women voluntarily forgoing the comforting presence of an obstetrician at the maternal bedside.

A QUESTION OF QUALITY

Doctors also resist the kind of reorganization that health teams would require out of a genuine concern for the quality of care. But many members of the profession express reservations about the quality that the present primitive system delivers. "Medical care in the U.S." declares Dr. Jacobus Potter, associate dean of New York University School of Medicine, "is like the little girl with the little curl in the middle of her forehead. When it's good, it's the best anywhere. When it's bad, it's appalling."

Statistics suggest that there is lots of room for improvements. This country ranks fourteenth in infant mortality, twelfth in maternal mortality, and eighteenth in male life expectancy. The Health Manpower Commission found it "startling" that "despite the advances in medical science and the greater use of health services, there has been a barely perceptible increase in life expectany in the United States since 1954. For the male population, life expectancies have actually declined in some age brackets."

That uninspiring record is partly explained by the fact that there is a wide gap between the figures for the poor and minority groups in this country and the rest of the population. If the poor are screened out (and one wonders why they should be), our ranking among nations moves up substantially. Smaller, more densely populated countries also have simpler medical logistics. As for the life expectancy of American men, doctors rightly complain that they eat and drink too much, exercise too little, work too hard, and drive too fast—then expect an annual checkup to keep them alive and well.

Granting all that, a good deal of evidence remains that many doctors are bad medicine. One of the first analyses of medical-care quality was conducted in 1956 under the direction of Dr. Osler L. Peterson, then a staff member of the Rockefeller Foundation His team of doctors, watching North Carolina physicians treat patients in their offices, concluded that more than 60 percent of the therapy was below acceptable standards. In 1962 and 1964 a medical team from Columbia University School of Public Health and Administrative Medicine studied the care of a random sample of patients in ninety-eight hospitals in the New York City area. Forty-three percent of the treatment was rated less than "good"; 23 percent was labeled "poor."

Another sobering revelation came from the spotless, shiny operating rooms. Surgical quality, of course, is frequently a life-or-death matter. Dr. Arthur James Mannix Jr., a Fellow of the American College of Surgeons, wrote in the *New York State Journal of Medicine:* "Errors in judgment or technique concerning either the anesthesia or the surgery, or a combination of the two, contribute close to 50 percent of the mortality in the operating room." And one study rated more than 40 percent of the surgery performed as less than good." Further, much surgery is unnecessary. One-third of the hysterectomies reviewed in the Columbia studies were judged as having been done without any justification. An official of the A.M.A. says that the rise in tonsillectomies under medicade "verged on the scandalous." Critics have a sardonic label for such operations: remunerectomies."

Doctors also do too little to police their own ranks. In 1968 the various state medical boards revoked the licenses of only sixty-four physicians. Fifty-nine more received revocations that were afterward stayed, allowing the doctors to continue practice. Another sixty were suspended temporarily. In the circumstances,

laymen find it difficult to identify low-quality medical men. They certainly cannot go by the visible evidence of a lucrative practice. Dr. John Knowles, director of Massachusetts General Hospital, asserts that the "marginal practitioner today is sometimes making three times what the best practitioner is making."

A STERN FACE TOWARD CHANGE

If the needed changes are to come, doctors will have to encourage and support them. Too often in the past they have fought against alterations in the system that they made, belong to, and run. The A.M.A. mounted the costliest lobbying effort in history against medicare—not because it saw the weaknesses in it that have lately come to light, but because of fear of *any* change. Still, though once medicare was inevitable, the doctors managed to relax and enjoy it. Just before the medicare bill was enacted, according to one expert researcher in the field, only 38 percent of New York State's M.D.'s favored it. After the program had been in operation for six months, 81 percent of them said that they approved. Such adaptability offers encouragement when future changes are considered.

That physicians have often set their faces so stubbornly against change is not hard to understand. It traces back to the fact that the overwhelming majority of them grow up, and later practice, in the middle and upper classes. In 1968, 41 percent of all medical students came from families with incomes above $15,000—the wealthiest eighth of the nation. Another 22 percent were from families earning between $10,000 and $15,000. The vast majority were science majors in college, and until recently few had much undergraduate education in the arts and humanities. With the rarest of exceptions, and those of recent origin, students are not exposed to the larger questions of medicine's responsibilities to society. Consideration is seldom given to innovations in the system or forms of practice. Thus it is difficult for most practicing physicians to appreciate the arguments of their critical colleagues—or even to understand what they are talking about.

During their training period, doctors go through what Dr. Lewis of Harvard calls "a greater socializing process than even the priesthood." For at least seven years they spend almost all of their waking hours with other doctors or would-be doctors, not only absorbing medical information but, in Dr. Lewis' words, learning how to act and think as well." Consciously or otherwise, most pattern themselves after the role models set by their instructors.

HUMANE, BUT ALSO HUMAN

When they are accused of "making too much money," doctors can with some justice point to the fact that medical education is tremendously expensive—even allowing for the fact that so much of it is government-subsidized. The Association of American Medical Colleges estimates the average bill for four years of medical school at $20,000. After they get their degree, moreover, most doctors spend three or more years as interns and residents. More than 90 percent of interns and residents still receive salaries under $6,000, although some hospitals pay far more. According to a 1968 study sponsored by the Department of Health, Education, and Welfare, doctors below the age of thirty-five typically earn less than other professionals except clergymen. And this is at a time when many are still saddled with debt from their medical-school days.

Later, not surprisingly, doctors make up for the lean years with a vengeance. According to *Medical Economics*, the median net income of self-employed doctors below the age of sixty-five in 1967 was $34,700. The figure understates the income of the well-established man. For, while it excludes interns and residents, it includes young doctors just entering private practice—and many of them report net losses for a year or two. Between 1955 and 1967 physicians' median income rose a startling 117 percent—20 percent in the last two years, as medicare and medicaid poured new money into the medical marketplace. Certainly one important consideration that make doctors oppose a reorganization of the health-care system is the fear that it may threaten their financial position. As Dr. Rashi Fein, the medical economist, recently told a congressional subcommittee, "Doctors may be humane, but they are also human."

With few exceptions, physicians are conscientious and dedicated to providing the best possible care *for their own patients*. But preoccupied with this demanding one-to-one responsibility, and limited by background and training, most are unwilling to recognize the flaws in the general system, and the unmet needs of many of their fellow citizens. The flaws, however, are now showing up everywhere—in the waiting rooms, in the hospital corridors, and in the figures on the cost of

care. Change has to come. If they want to guide its direction, physicians must quickly begin to supply some leadershhip. As Dr. Knowles warns, "If we want to keep our profession free, we have to control ourselves, and act in the public interest."

SHAKING UP THE CURRICULUM

A major reformation is under way in the nation's medical schools. It promises to be as far reaching as the one that transformed medical education half a century ago, and could have an even more profound effect on the practice of medicine in the U.S.

The first great wave of change followed the publication in 1910 of a massive report by Abraham Flexner calling attention to the chaos that existed in medical education at the time. Flexner condemned most of the more than 160 schools then in operation as outright diploma mills, or money-making enterprises conducted by bands of poorly qualified doctors. Response to the report was prompt: within twenty years the number of schools was pared to seventy-six, and they were firmly established within the university framework. Admission requirements and curicula were standardized. Medical education was molded into its present form.

But for the past two or three decades, while the country and its medical needs changed radically, most schools have remained virtually the same. The training of a whole generation of doctors has become increasingly inadequate and frustrating. Now, as in Flexner's day, agitation for reform is spreading across the country. Critics are pressing for admission of more students, particularly from minority groups; closer attention by the schools to the health needs of their own immediate communities; and greater concern with the health-care system.

But the real fervor of the vocal new generation of medical students is directed at improvement of medical-school curricula and teaching methods. A majority of schools still follow much the same rigid curriculum that evolved after the Flexner study. First-year students, whatever their educational background, spend their time in lecture hall and laboratory studying anatomy, biochemistry, and physiology. In the second year, still restricted to the classroom, they devote themselves to microbiology, pathology, and pharmacology. Lectures are frequently lengthy and repetitions recitations of facts and terms to be committed to memory. In the lab, students follow what one labels, "cookbook instructions." There is little correlation with clinical practice, and the only "patient" encountered is a dead one—the cadaver dissected in the anatomy lab.

Not until the third year do the survivors of this grind begin clinical training in the setting of the teaching hospital. Even at this clinical stage, according to an articulate student critic, "the pattern remains essentially the same: repetition, busywork, lockstep learning, conformity, passivity. The professor dispenses knowledge, the student, spongelike, absorbs it, squeezes it out on command."

A DISSATISFIED DEAN

The first steps toward changing this picture were taken by Western Reserve (now Case Western Reserve) University School of Medicine at Cleveland. When Dr. Joseph T. Wearn was asked to take on the job of dean in 1945, he insisted that he be permitted to choose eleven new department heads (out of a total of thirteen). Dr. Wearn then used his leverage to transfer power over curriculum from the departments, habitually jealous of their prerogatives, to a newly created general faculty. In 1952, after an exhaustive six-year study, Reserve introduced its new curriculum.

All teaching was made interdepartmental, with subject-oriented committees giving courses grouped around the human body's various systems—respiratory, cardiovascular, neurological etc. The first year was generaly devoted to normality, the second to abnormality. Basic science instruction was closely tied to clinical case exposure. Elective courses were introduced, and students were given two half days a week to develop their own medical interests. They were also required to complete a major independent research project. Most of the fourth year was made elective, permitting students to concentrate more intensely on clinical specialities. Many tests were eliminated, and grading was put on a "fail-pass-honors" basis.

Finally—and this was the most popular reform—students were put in direct contact with patients from the start of their first year. Each was assigned to an expectant mother. He got to know the family members, their living conditions

and problems. He followed the mother's prenatal care, attended the birth, and kept track of the child's care and development. Obviously, he was given no medical responsibility (although some students helped their charges to deal with hospitals, welfare departments, and other public institutions). But the innovation put him in close contact with doctors and patients, and the interaction between the two.

Western Reserve has since made further revisions, including a "track" system that permits students with different educational backgrounds or goals to follow separate lines of study. It has provided written and audiovisual materials that enable students largely to educate themselves at their own pace. Some Reserve students do not attend lectures at all. These innovations attracted more than 1,500 observers to Cleveland, and over the years several other medical schools initiated their own curriculum reforms. Since 1967, mounting student pressure has compelled most of the rest to re-examine their educational programs.

COMMUNISTS OR COP-OUTS

As a group, medical students have displayed astonishing changes in attitude over the past three years. Some of their complaints of educational "irrelevancy" echo those made by undergraduates. But, as a natural reflection of med students' greater age, education, and maturity, their approach is generally more sophisticated and constructive. Even the most "radical" of them are, with rare exceptions, reformers rather than rebels. They are taking a larger view of the role and responsibility of the doctor, and are asking for training that will enable them to assume these expanded duties.

The Student American Medical Association, until three years ago little more than a stepping stone to A.M.A. membership, has now declared its independence. It has attracted 24,000 members, of a total medical-school enrollment of 37,750. At its convention last year delegates passed resolutions critical of the fee-for-service concept of payment for medical care, and endorsed greater participation in group practice. Under the leadership of its president, Edward Martin, a student at the University of Kansas School of Medicine, S.A.M.A. has initiated a health-care project among the poor in Kansas City. The organization, Martin says, "is right in the middle of the student attitudes. The right calls us Communists and the left calls us cop-outs. We are progressively concerned and active, not liberal or conservative."

A bit more militant are members of the Student Health Organization, a loosely connected amalgam of autonomous local chapters that is sometimes inaccurately described as the S.D.S. of the medical schools. But even they hardly sound like bomb throwers. Lambert King, a student at the University of Chicago Pritzker School of Medicine and a leader of the Chicago chapter, says, "One of our biggest goals is to get more control of the decision making in health matters into the hands of community people and hospital workers."

[From Fortune magazine, January 1970]

IT'S TIME TO OPERATE—THE MEDICAL INDUSTRIAL COMPLEX

(By Harold B. Meyers)

Looked upon as a product, medical care in many respects eludes the graps of market forces. Price, choice, measurable performance, channels of expression for consumer discontent—all these elements are either missing or distorted because of the product's peculiar nature. But the market economy is very much present and at work in what is coming to be known as the "medical-industrial complex," the business of manufacturing and selling the varied equipment, from bandages to two-million-volt cobalt machines, that doctors and hospitals use. The demand for such products is so strong that many new companies, some of them giants in other fields, have joined the old-line manufacturers in a bid for new profits.

Fortune estimates that outlays for health care totaled $63 billion last year. An impressive share of those expenditures went for manufactured goods of all kinds. In 1967, the last year for which official figures are available, the value of medical-related items *alone* totaled more than $6 billion at the time of shipment by the manufacturers. Since then the market has been growing at a compound rate of 10 to 15 percent a year. Submarkets have reached some surprising totals: $185 million for all types of surgical dressings, about $100 million for hypodermic needles and syringes.

COMPONENTS OF A GROWING MARKET

Thousands of different products, supplied by hundreds of companies of all kinds and sizes, make up the total medical market for manufactured goods. This list shows the variety of companies being drawn to health products, and the way companies that were long in only one major market, like Abbott in drugs, are beginning to branch out. In some cases, medical products are handled by divisions of a large corporate entity, which have well-established identities of their own. Davol had long been a well-known manufacturer of surgical products before it was acquired by International Paper in 1968.

This sampler of medical markets is based on Census Bureau figures for 1967, the most recent available. The values given are as of the time of shipment by the manufacturer, and are regarded in the industry as understating the actual totals. Many of the listed companies are active in categories not included here—e.g., General Electric makes a new type of permeable membrane, and International Paper manufactures disposable gowns for surgeons.

Drugs still rank as the largest single medical submarket. But the growth of technical devices reflects the changes in medical care. According to Arthur D. Little Inc., the *total* market for medical technology, including electronic devices, probably exceeds $450 million a year.

(*Value of manufacturer's shipments*)

Drugs [1]	$4,143,029,000
Dental equipment and supplies [2]	198,100,000
Surgical instruments [3]	188,100,000
Surgical dressings [4]	184,900,000
Hypodedmic needles and syringes [5]	99,400,000
Medical furniture [6]	87,500,000
Surgical sutures [7]	70,300,000
X-ray equipment [8]	66,200,000
Electronics equipment [9]	54,200,000

[1] [3] Abbott Laboratories.
[1] [3] [4] [7] American Cyanamid.
[1] [2] [3] [4] [5] [6] American Hospital Supply.
[1] [5] Baxter Laboratories.
[3] [4] [5] Becton, Dickinson.
[6] Borg-Warner.
[3] [4] [5] [6] [7] Brunswick.
[8] [9] General Electric.
[9] Hewlett-Packard.
[3] International Paper.
[1] [2] [3] [4] [5] [7] Johnson & Johnson.
[1] [3] [4] Kendall.
[1] [3] [4] [9] Parke, Davis.
[3] [7] Philip Morris.
[2] [6] [8] Sybron.
[1] [3] Smith Kline & French.
[1] [2] Warner-Lambert.
[8] Westinghouse.

A big of this business goes to companies that have been in the field for a long time, such as Eli Lilly and Baxter Laboratories. But an array of other companies is now cutting in. When the American Hospital Association held its seventy-first annual convention in Chicago last summer, 495 commercial exhibitors took booths. Among them were companies rarely thought of as active in the health business, including Zenith and Motorola, I.B.M., and Addressograph Multigraph, Bigelow-Sanford and Monsanto. Many conglomerates—from Litton Industries to C.I.T. Financial—now have medical groups in their corporate families. Aerospace companies are involved in everything from computerized medical information systems (Lockheed) to life-support systems (United Aircraft). Even tobacco companies, for years the special target of medical researchers, are joining the chase for the health dollar. Philip Morris has formed a new division, ASR Medical Industries, that numbers sutures and surgical blades among its products.

One of the fast-growing older companies in the health-care industry is its largest distributor, American Hospital Supply Corp. When President Harry K. DeWitt joined the company as a salesman in 1941, its catalogue had only 100 pages. Today the company's catalogues contain more than 3,000 pages with listings for some 60,000 items, and DeWitt says: "I am grateful that I am no longer a salesman charged with having to know what all these things do." American Hospital Supply has been gradually increasing its own manufacturing capability,

and 45 percent of its sales now involve its own products, including rubber gloves, laboratory cages for animals, and an organ-preservation machine that sells for $15,300. The company's sales rose from $219 million in 1964 to $387 million in 1968. In the same period, earnings more than doubled, going from 33 to 67 cents a share. The company's stock, long a hot favorite of Wall Street, has sold at a price-earnings ratio as high as 50.

American Hospital Supply's rapid growth reflects the impact of two concurrent trends—increased government and private spending on health, and the greater complexity of modern medical science. Says DeWitt: "As treatment of diseases has become more complex, so has equipment become more complicated. There was no thought ten or fifteen years ago of cobalt machines, heart pacemakers, cryosurgical instruments for cataract removal, artificial hearts, artificial heart valves, or micro-surgical instruments for surgery performed under a microscope." In one recent five-year period the number of laboratory procedures commonly carried out in hospitals tripled, creating a demand for all kinds of arcane instrumentation in fields that DeWitt describes as the "ometries," "ologies," and "ographies" (e.g., chromatography, the separation of closely related compounds).

Johnson & Johnson, probably the world's largest maker of surgical dressings, is another old company that has changed and grown with its industry. In the 1959–68 decade, Johnson & Johnson's domestic sales went from $298 million to $580 million. Earnings more than tripled, rising from $15 million in 1959 to $50 million in 1968. Besides surgical dressings, the company makes a wide variety of well-known consumer products—baby powder, baby oil, and Band-Aids—as well as medical equipment and drugs. One of its new products, RhoGAM, is a vaccine against Rh disease, which has killed as many as 10,000 babies a year in the U.S. alone.

A TURN TO LEASING

Not long ago an X-ray machine was likely to be a hospital's single most complex piece of equipment. The medical market for such machines, dominated by General Electric, continues to be lively: an estimated $68 million a year. But today the range of electronic equipment required by a fully equipped hospital covers a broad spectrum, from patient monitoring to kidney machines and blood analysis—with computers doing the paper work.

Best known as a maker of propellers for aircraft engines, Hamilton Standard, a division of United Aircraft, came to medical electronics by way of the space industry. The company won a research contract from NASA in the early 1960's to develop and build a telemetry-type cardiac monitor for use by astronauts. Out of that research grew a variety of products for commercial sale, including a telephone monitoring system for cardiac patients. By using that $660 unit, a post-coronary patient can relay electrocardiogram data from his home to his doctor's office by telephone. A more complex version of the system enables a single nurse to keep watch over as many as four hospital patients without leaving her station.

Another outgrowth of Hamilton Standard's work with life-support systems for astronauts was the Simas pump, a computer-controlled heart pump. When a patient in the throes of a heart attack is put on the pump, the machine takes over much of the work of the heart. It was first used two years ago in Montreal on a forty-seven-year-old sales executive named Samuel London. At the time he was put on the pump—which had been under experimental study for two years by a heart specialist at the Jewish General Hospital—London's doctor gave him "less than a five percent chance of recovery." London was able to go home seven weeks later. Thirty-seven of the machines, which cost $9,900 each, are now in use by hospitals, and Hamilton Standard is at work, under a National Heart Institute contract, on a more advanced "circulatory assist device." This one will employ a special pressure suit, not unlike those used by the astronauts, which ambulance drivers or other relatively untrained personnel could put on a heart patient. The suit would help maintain heart action through a sequence of carefully timed pulsations.

The electronic equipment being offered to hospitals is expensive—a single X-ray unit can cost $100,000—and is subject to rapid obsolescence. To conserve their capital, some hospitals are leasing rather than buying the equipment. The chief advantage, as Milton H. Sisselman, vice president for coordination and planning at New York's Mount Sinai Medical Center, explains, is that dollars spent on leasing come out of operating funds, rather than capital funds. In

addition, all costs are known in advance. When General Electric leases X-ray equipment to hospitals, G.E. provides total maintenance. Borg-Warner—which became interested in hospital furnishings after one of its executives, convalescing from an operation, studied the shortcomings of his hospital bed—recently leased furniture for 142 patients' rooms to LaGuardia Hospital in New York.

93 PERCENT DISPOSABLE

The greatest change in health-care products in recent years has been the emphasis on items that are discarded after a single use. Becton, Dickinson & Co. (1969 sales $206 million) does 79 percent of its business in health products—and about 70 percent of that segment is represented by "disposable" items such as hypodermic needles, syringes, scalpels, and gloves. The percentage is even higher for Sherwood Medical Industries Inc., which is 85 percent owned by Brunswick Corp. About 93 percent of Sherwood's annual sales, which totaled $41 million in 1968, comes from disposable products. Most of the remainder of Sherwood's business represents sales of medical equipment and furniture, including examining tables.

Behind the demand for disposables lie two inescapable facts of medical life today. One is that a re-usable instrument or product carries a hidden, but unavoidable, risk of infection; no matter how careful the sterilization process may be, some obdurate germ may be lurking out of its purifying reach. Another circumstance, just as compelling, is of economic rather than biological importance. More than 60 percent of the typical hospital's budget goes for labor costs. To make a medical item ready for re-use is a demanding, time-consuming task—one that requires a considerable investment of labor.

In a talk before security analysts, DeWitt of American Hospital Supply detailed the steps that a "simple surgical drape" must go through before it can be re-used: "After the used cloth leaves the operating room, it often is pre-soaked to help remove any blood stains. Then it has to be washed. (And if contaminated, it must be washed separately.) Next it has to be inspected on a large lighted table where every hole found must be circled and patched. The towel clips used so frequently in surgery can make eight to ten holes per clip. Each of these holes must be patched. Next, the sheeting must be inspected for lint. To remove the lint, hospital employees use either a special roller or tapes of sticky paper wrapped around the hand and moved over both sides of the entire sheet." Even after all that laborious process is completed, the surgical drape must still be folded, packed, sterilized, and stored. So hospitals buy sterile, pre-packaged surgical drapes and discard them after use.

The demand for disposable fabric products has drawn many paper companies into the health-care industry. International Paper, Scott Paper, and Kimberly-Clark manufacture items like surgical drapes and surgeon's gowns out of nonwoven fabrics. Kimberly-Clark recently doubled its manufacturing capacity for the medical-disposable market.

But disposables, whether hypodermic needles or surgeons' gowns, can also create difficulties of their own. Suppliers must maintain large, conveniently located stocks of everything they offer, thus tying up capital in inventory. American Hospital Supply has installed an intricate computer-based ordering system to link its customers with its warehouses, and in the last few years has doubled its warehouse capacity. Further as Borg-Warner's President James F. Beré says, "disposing of the disposables" presents difficulties. A product like International Paper's Confil fabric remains strong when wet, which is important in medical use. Burning is about the only way to get rid of a Confil garment—particularly one that has been contaminated. But that adds to air pollution.

[From Fortune magazine, January 1970]

ITS TIME TO OPERATE—COSTLY MACHINES TO SAVE LIVES

Research and innovation in this age of technology have had their most dramatic impact on human welfare in the realm of health. The new artifacts of medicine are often as complex and impressive as those on that more visible frontier of technology, space, and they are considerably more relevant to the urgent needs of mankind. A few examples of the lifesaving equipment coming into use in hospitals in the U.S. are shown on these and the following pages. Not all of the concepts are brand new: linear accelerators were first installed in hospitals in the Fifties, and a form of pressure chamber was used by the ancient Greeks.

Like space hardware, the new devices are usually expensive. The hyperbaric pressure chamber (left) cost Mount Sinai Hospital in New York City about $800,000 to install four years ago. The linear accelerator on the page opposite is valued at $200,000, a new cyclotron would cost about $300,000 today, and the neurosurgery suite at Mount Zion Hospital in San Francisco $200,000. Once the equipment is procured, the costs have just begun. Mount Sinai is spending an estimated $550,000 annually to maintain and operate its pressure chamber. The widely used kidney machine can cost $15,000 annually per patient in upkeep materials and staff. Patients are unable to cover expenses on such a scale themselves, and with hospital endowments and federal subsidies failing to keep pace, hospitals are hard pressed for funds to operate these advanced facilities. Both in rural areas and city slums, patients die each year for lack of treatment that is within technical, but not financial, reach.

Other glamorous modern facilities, such as the heart-transplant operating rooms or intensive-care units installed by well-endowed but less busy hospitals, stand idle much of the time, their purchase motivated by prestige more than necessity. More than 700 hospitals, for instance, are equipped to perform open-heart surgery. Rational distribution of services would cut costs, and a more effective system of preventive care would do away with some of the need.

[From Fortune magazine, January 1970]

IT IS TIME TO OPERATE—HOSPITALS NEED MANAGEMENT EVEN MORE THAN MONEY

(By John M. Mecklin)

Not long ago, when Americans who were not charity cases entered a hospital, they faced the prospect of serious financial loss, or even financial catastrophe. Now the advent of private insurance plans and of government assistance through medicare and medicaid has changed all that. The doors of hospitals have swung open virtually to everyone. Only in relatively rare cases, where hospital stays are exceptionally prolonged, need a patient fear disastrous financial consequences.

But that indisputably progressive development has brought with it a new set of dangers. The hospital system itself is straining under the weight of the new loads imposed upon it. A new kind of financial catastrophe threatens—evidenced most graphically in the national average cost per patient day in general hospitals, which jumped from $48.15 in 1966 to an estimated $67.60 in 1969. Projections indicate that the cost will reach about $74 this year. In some of our great medical centers the cost of a patient day can run as high as $166, and that doesn't include the doctors' fees.

Such increases reflect the pressure of increased demand, stimulated by insurance coverage, on relatively static supply. The trend toward shorter hospital stays that accompanied improvements in the quality of medical care has now been reversed. The average stay in a hospital is 8.4 days, almost a full day longer than it was eight years ago. Big pushes on costs have come from the increased wages of notoriously underpaid hospital employees; in three years, labor costs have climbed sharply, especially in a few unionized areas such as New York City, where they have gone up more than 40 percent. Salaries of interns and residents have shot up, as can be seen by the experience of one of the nation's leading hospitals, Boston's Massachusetts General (overleaf). At the same time, new technology (see "Costly Machines to Save Lives," page 92) requires the investment of more and more capital. In sum, this hemorrhage of rising costs has sent insurance premiums soaring, and has presented legislators and taxpayers with the prospect of larger and larger outlays for government-sponsored programs. Medicare and medicaid alone are expected to pay hospitals more than $6 billion in 1970.

The inflation of some hospital costs might have been beetter contained by better management. But the managers of many hospitals were ill-prepared for the explosive new demand. Accounting methods have remained inadequate. Construction of hospitals over the years has been haphazard, so that costly facilities are often duplicated by neighboring institutions. Yet the system also faces an urgent need for some $7 billion in new capital to modernize existing plants, plus about $3 billion more for some 90,000 additional beds in poorly served communities. Hospitals cannot raise anywhere near these amounts by their own efforts.

In the search for more efficient and productive use of existing facilities, some hospitals are generating imaginative new managerial approaches. They are using

scientific planning methods, and extending their use of computers into many new areas. A few institutions, such as Baptist Memorial Hospital in Memphis, have gone into sideline business ventures to boost their incomes, and thus reduce the fees they must charge their patients.

But basic structural reforms are needed to give the system permanent stability. The immediate requirement is certainly to revise the nature of insurance coverage, rewriting insurance plans so that they reward hospital economists and penalize waste. This, in turn, must be accompanied by widespread acceleration of a trend already started—toward construction of separate, hospital-connected clinics, and other facilities for less intensive, and therefore less expensive, care. Clinics to provide ambulatory care, both in rural areas and in the core cities, could vastly relieve the pressure on hospitals. Such changes will become more urgent over the next few years, as a new wave of demand for care, mostly from the poor, breaks over the present means for distributing it.

CASCADING BILLIONS

The main cause of the upheaval in costs, wage demands from the nation's 2,300,000 hospital employees, is neither surprising nor reprehensible. Hospital employees once ranked among the most underpaid workers in the country, earning as little as 35 cents per hour in some parts of the South. Unions began entering the field in a few urban centers in the late 1950's, touching off a series of bitter strikes. Some of the consequent wage increases were reinforced by belated extension of federal, minimum-wage laws into the hospital field in 1967.

With billions of new federal funds cascading into the system, hospital resistance to the unions has collapsed. In three years the minimum wage in New York City has gone from $69 a week to $100, and another big boost is likely later this year. Even nonunion hospitals have been forced to follow suit because of worsening shortages of trained people such as nurses and laboratory technicans. The impact has been staggering, since payroll represents about 60 to 70 percent of all hospital costs.

Still another factor is the seemingly insoluble dilemma created by the dramatic advances of modern technology. A heart transplant, for example, may require a team of as many as twenty-five doctors, and costs perhaps $50,000, plus thousands more in postoperative care. Transplants are still experimental, and so far are unlikely to keep the patient alive more than a year or two. To keep a leukemic child alive for one year can cost $30,000. Hemodialysis, a remarkable technique for treating a victim of kidney failure by flushing out his blood two or three times a week, costs about $15,000 a year in a hospital, or some $6,000 a year if it can be done at home. But it often permits the patient to return to a useful life for several years. Lack of facilities for dialysis, and lack of trained people, have permitted treatment in the last four years of less than 10 percent of patients who needed it. Some 70,000 others who might have been helped were left to die.

"If we were willing," says Dr. Hugh Luckey, president of New York Hospital—Cornell Medical Center, "we could perform about 75 percent of what we are doing now at half the cost by cutting out expensive special treatments. But the idea is unthinkable." An American doctor who recently visited the Soviet Union says the Russians have developed equipment such as dialysis machines, but that they seldom use it. He says the Russians told him, "It's cheaper to make new models," i.e., let the old ones die. Americans are reluctant to do it that way if treatment is available. Nevertheless, heavy spending on exotic treatments consumes funds and medical skills that might otherwise be used for badly needed help to, say, the thousands of tuberculosis victims in U.S. poverty areas.

FROM "PESTHOUSES" TO CITADLES OF SCIENCE

The weaknesses of management and organization now coming to light in many of the nation's 7,137 hospitals have their origins back in the nineteenth century. In those days, hospitals were supported by charity and were commonly known as "pesthouses," places to dump the indigent sick while the rich were cared for in their own homes where there was less danger of infection. As times changed, hospitals were transformed into citadels of modern science. But the old economic structure remained. Today 34 percent of the nation's hospital beds are in "voluntary," tax-free institutions that handle both paying and charity cases; 11.5 percent are in state, county, or municipal-owned establishments; and 2.9 percent are in privately owned hospitals operated for profit. The balance of 51.6 percent

of the beds are in various specialized institutions such as veterans' hospitals and facilities for psychiatric and tubercular care. The voluntary hospitals have emerged as the most important segment of the industry. They are the most advanced kinds of hospitals in medical skill, but their economics often are make-shift.

Initially, the voluntary hospitals relied almost entirely on private gifts for capital needs. More recently, the main sources have been government grants, and an allowance for depreciation and interest costs in insurance payments. But this has not been sufficient to meet the requirements of a swiftly changing industry, and many hospitals have been forced to hobble along with antiquated plant and equipment, which adds snbstantially to their costs. Being private institutions, voluntary hospitals are not required to account to the general public, and some of them still keep their books secret. Accounting methods often are an astonishing jumble (in some cases nurses do the paper work in their space time), although they have been improved by the standardized requirements of medicare and medicaid.

Too little of the task of managing is performed by professional managers. With a few exceptions, doctors tend to dominate hospital policy making. They often are indifferent to economic considerations, opposing moves to save money—including even such arrangements as using operating rooms on Sundays. Says one unhappy administrator: "A lot of doctors behave like fighter pilots."

The dictatorship of the doctors is particularly troublesome in small hospitals in isolated communities. Physicians are hard to recruit in such places, and they can get their way simply by threating to leave, Management shortcomings also are frequently exacerbated by the fact that hospital trustees, who have the final say in administrative matters, are often chosen purely for their prestige and money-raising capabilities. Such men can give the hospital little of their time. Curiously, they seem to permit inefficiencies that they would never tolerate in their own businesses.

Old-fashioned empire building also stimulates needless expenses. Fancy laboratory equipment, promoted by aggressive salesmen of hospital supplies, is too often bought by hospitals that will use the equipment very little—a fault that would not exist if there were more competitive restraints in the system. A study recently published by the federal Public Health Service reported that 776 hospitals maintained facilities in 1967 for open-heart surgery, but that a surprising 31 percent of them had not used their capability for a year. That is not only wasteful of expensive equipment, but also risky; open-heart surgery is a highly exacting procedure with constantly changing techniques, and a rusty surgeon is somewhat less than desirable. In 1968 in New York City alone, no fewer than twenty hospitals offered open-heart surgery. But just five of them did two-thirds of all such operations.

Though there are critical shortages of beds in some places, hospitals on the whole are underutilized. Of the 806,000 beds in general hospitals, an average of 20 percent are always empty. That slack is much more costly even than comparable vacancy rates in a hotel, because a hospital must keep trained people on duty twenty-four hours a day no matter how many beds are filled.

The range in prices in various hospitals around the country reflects the uneven level of hospital management. Rates for comparable facilities in comparable areas can vary by 10 percent or more. Nationwide, the number of employees per patient ranges from as low as 1.5 to more than four. There are valid reasons for many of these differences. The nation's 530 teaching hospitals (where interns and residents are trained) obviously require more staff. But the variations also reflect differences in relative efficiency that could hardly be found among competitive private enterprises.

SOME FIND IT PROFITABLE

In business, of course, the profit motive spurs efficiency, and some people believe it could do the same for hospitals. Recently, a number of corporations have been acquiring and forming chains of hospitals in order to run them for profit. Such companies, which include American Medicorp Inc. and Hospital Corp. of America, are planning to build at least forty new hospitals. The stock of some of the companies has sold at remarkable price-earnings ratios of more than 100 to 1. The number of privately run nursing homes has jumped astonishingly in three years from about 13,000 to no fewer than 23,000, mainly as a result of medicare. The stock of the nursing-home companies has sold at p-e ratios just as giddy.

The emergence of for-profit hospital chains could put some badly needed competition into the system. But for the present it is putting an added load on voluntary hospitals. Most private hospitals do no teaching, accept no charity cases, and perform only routine surgery, e.g., appendectomies. Thus they are able to make a profit on rates averaging 20 percent below those of the voluntary hospitals, while delivering care of an equivalent quality. The effect is to concentrate the most serious (and most expensive) patients in the volunteer hospitals, compounding their financial woes. A few states, led by New York, have banned for-profit corporations from owning hospitals.

On a more positive note, individual hospitals all over the country have been coming up with ingenious programs for making the existing system work better—quite apart from such innovations as the Kaiser plan. One approach, pioneered by Henry Ford Hospital—a 1,050-bed voluntary institution with a large outpatient clinic in Detroit—has been adopted by about a dozen hospitals elsewhere. It departs from the usual practice, where doctors other than the top administrators are associated with the hospital, but work on the basis of the fees they charge patients. Instead, all the doctors at Ford are full-time staff members, working on salary. The hospital collects all fees. The system creates an incentive to be efficient, since the staff has a stake in the success of the hospital's over-all performance. Unlike most voluntary hospitals, Ford has been able to do without charitable contributions since 1950.

Another exceptionally well-run voluntary hospital is Baptist Memorial in Memphis, which is administered by one of the best hospital managers in the country. Frank Groner has built Baptist into the biggest non-government hospital in the U.S. in number of admissions. One of the nation's largest in terms of beds (1,500) it is also the biggest year-round employer in Memphis, with 3,000 persons on its payroll. Groner has built up for the hospital a subsidiary conglomerate including a ninety-room hotel (with half its rooms occupied by outpatients), parking lots for 1,200 cars, a drugstore, and three office buildings (mostly for associated doctors). Such outside operations contribute about $1,250,000 a year to the hospital's income, and help Groner keep hospital charges per patient down to $60 a day—or about 10 percent below the average of other large hospitals.

New York City's 1,200-bed Mount Sinai Hospital is one of the finest in the world, and one of the most harassed by the high cost of excellence. It has the city's only hyperbaric chamber, for control of certain illnesses that respond to high oxygen pressure, e.g., one type of gangrene. In five years it has been used on only about 850 patients, including 450 surgical cases, but the equipment has certainly saved a number of lives. Testifying recently before a state committee on hospital cost reduction, Mount Sinai's director, Dr. S. David Pomrinse, said: "If the state is going to reduce financial reimbursement to hospitals, the state must also tell us—specifically—which of these services to eliminate . . . which patients we are to allow to die."

Mount Sinai's costs in 1969 came to a formidable $118 per patient day (compared with $85 in 1967). Pomrinse says that about 85 percent of the hospital's costs are fixed, and cannot be reduced without elimination of such facilities as the hyperbaric chamber. Within the remaining area, where it can try to economize, Mount Sinai operates in the style of a modern business, with an annual budget of $59 million. It was one of the first hospitals to adopt computerized management of financial statements, operating reports, and its payroll of 4,000 persons, as well as some computerized diagnostic work, such as cardiogram analysis. Mount Sinai uses an internal teletype system for rapid transmission of data, ranging from patient's bills to dietary instructions.

In its hotel services, Mount Sinai manages better than most hotels. Maids are alerted the moment a patient leaves, and his room is scrubbed and prepared for the next patient no more than ninety minutes later. Food service has been expedited through installation of an optical scanner. The machine checks patients' meals three times daily to avoid errors and to watch over special diets through a color coding system. Multiple-choice menus are prepared on an assemblyline basis, delivered through tunnels on electric carts in an average time of five minutes from kitchen to bed, and spot checked with pocket thermometers to make sure they are served hot. Pomrinse proudly reports that Mount Sinai's total daily "hotel" costs, including the room, food, sheets, and the like, come to only $19.38 per patient, or considerably less than a good New York hotel for room alone.

INSTANT HISTORY

Computers, of course, have long been used in hospital accounting. Now they are being introduced more directly to serve the cause of patient care. One such system, developed by National Data Communications, is being tested at Baptist Hospital in Beaumont, Texas. Complete data on each patient is fed into a computer through a push-button console when he is admitted to the hospital. The physician or nurse therafter registers all new information, such as prescribed treatments, so that everything about the patient can be obtained quickly by asking the computer for a display or print-out. The system also automatically performs such chores as printing the gummed label to go with medication as soon as the order is received; and telling the stock room when the supply of an item should be replenished. It can also be programmed to alert the nurse fifteen minutes before medication should be administered.

Computer technology is also being employed in an ambitious cost-information service run for the past decade by the American Hospital Association, the leading trade association. About 3,000 hospitals are subscribing to the service at fees ranging up to $480 a year. A detailed ten-page profile covering some 270 statistical indicators of the hospital's financial operations is drawn up, fed into a computer, and updated once a month. The computer print-out then provides a monthly reading on how the hospital is doing in each area, as compared with past performance. At the same time, the computer provides figures on how the hospital's operating data compare with national and regional median figures for hospitals of comparable size. The result is an instant picture of places where the hospital should be able to reduce costs or improve services. In some cases, subscriber hospitals have achieved savings of as much as $50,000 a year.

The federal government might also intervene in these ways:

Health insurance plans should be modified, perhaps by law, to provide the same amount of coverage for both inpatients and outpatients.

Community planning of hospital construction and renovation should be required to avoid further duplication of facilities, and to encourage mergers or conversion to other uses of unneeded plant.

Federal loans and grants should be made to replenish and maintain hospital capital needs, but only after the rationalization of facilities is assured.

DESIGNED FOR THERAPY

Better planning and better design of hospitals also promise new efficiencies. New York Hospital recently conducted a study showing that better architectural planning could cut a nurse's daily walking distance by as much as 50 percent. Hospitals generally are switching to single-room accommodations, partly because of patient demands for greater privacy, but also because of the discovery that being in a single room helps a patient get well faster. Memphis' Baptist Hospital has determined that a patient who needs eight days in a ward usually gets well in about seven days in a single room.

E. Todd Wheeler, a prominent Chicago architect, believes that a properly designed sick room could be used to support and even speed therapy. He says the sick room should be engineered to include devices not only for control of temperature and humidity, but also with variable light colors and intensities, and sound calculated to soothe—all of which would be prescribed by a physician along with the needed medical treatment. Wheeler thinks specific degrees of atmospheric pressure and ionization should be prescribed in some cases—there are indications that low pressure tends to have a depressing psychological effect while high pressure is exhilarating. Vital body functions of patients could be monitored routinely by sensors similar to the ones used by astronauts. "We know more about a man in space," says Wheeler, "than we do about a patient."

For all the pleasing prospect of such schemes, the solution to the hospital predicament requires long-term, major reforms. The Nixon Administration is working on possible techniques to create incentives for controlling costs. Walter J. McNerney, president of the Blue Cross Association, who is a chairman of a task force that Nixon set up to study health care, says, "We must find some means to get away from the economic weightlessness of hospitals under the present system by providing controls that in effect substitute for the pressures of the market."

The Administration's idea is to give hospitals a chance to earn extra income if they hold their expenditures below the level of comparable hospitals elsewhere. The amount of money that a hospital would be paid by medicare and medicaid

for specified services on the basis of advance estimates would be weighted for predictable new costs, and perhaps tied directly to the cost-of-living index. The hospital would be permitted to keep whatever it could save by performing those services at a cost lower than the estimate, without cutting the quality of care. But it would have to pay for any expenditures above the estimate. HEW is running pilot tests on three different versions of this plan in selected regions.

CARE OF THE POOR

Studies show that today the poor usually put health at least fourth in their priorities, after a job, education for the children, and housing. One of the nation's most aggressive leaders in the battle for better care for the poor has been Dr. John Knowles of Massachusetts General Hospital. Knowles estimated in 1968 that some 40,000 people in the Greater Boston area were suffering from untreated tuberculosis.

In various public statements, Knowles has repeatedly exhorted the medical world to serve the needs of the community as a whole, instead of catering only to patients who come to the hospital door. He estimates that hospital admissions from inner-city, impoverished communities could be cut as much as 80 percent by preventing disease before it happens. The need, says Knowles, is "the development of comprehensive service, hospital based, extending all the expertise and the resources of the hospital out into community health centers in conjunction with local care institutions and stimulated through federal legislation."

Something of the kind of operation that men like Knowles are looking for can be found in the huge system of 166 hospitals and 650,000 patients run by the Veterans Administration at an annual cost of $1.6 billion. Since they are primarily concerned with the care of veterans, V.A. hospitals are far from typical, with average patient stays of three to four weeks. But the system itself is widely admired among civilian hospital administrators. Through bulk procurement of supplies and advanced, heavily computerized management techniques, it keeps its costs to an impressive national average of about $40 per patient a day. But its main contribution to hospital doctrine has been the "whole man" concept—the idea that each eligible veteran not only should be treated when he comes to the hospital, but that it is the system's responsibility to try to prevent him from getting sick in the first place. To achieve this, the V.A. gives a total examination to every man admitted, to look for troubles of which he may not be aware. It tries to get veterans to come in regularly for checkups through repeated reminders of their right to free care.

In a number of other countries the medical system, including the hospitals, provides this kind of total care. The U.S. has the economic wealth to do just as well.

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