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CLOSING OF PUBLIC HEALTH SERVICE FACILITIES, 1971

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HEARING BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON LABOR AND PUBLIC WELFARE UNITED STATES SENATE NINETY-SECOND CONGRESS

FIRST SESSION ON S. Con. Res. 6

TO EXPRESS THE SENSE OF CONGRESS RELATIVE TO
CERTAIN ACTIVITIES OF PUBLIC HEALTH SERVICE
HOSPITALS AND OUTPATIENT CLINICS

MARCH 8, 1971

Printed for the use of the Committee on Labor and Public Welfare



U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1971

59-9160

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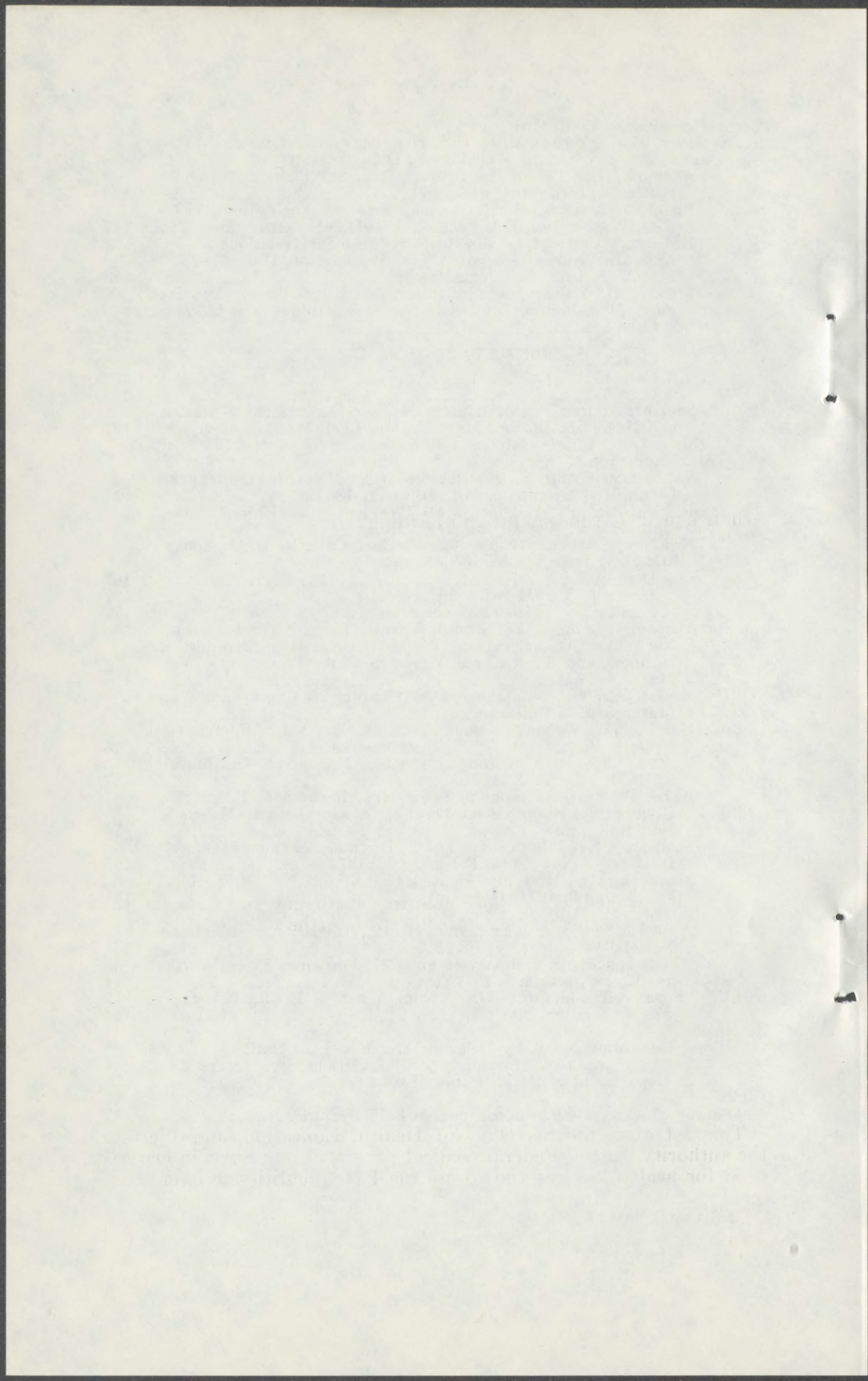
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CLOSING OF PUBLIC HEALTH SERVICE FACILITIES, 1971

MONDAY, MARCH 8, 1971

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C.

The subcommittee met at 9:30 a.m., pursuant to recess, in room 4232, New Senate Office Building, Senator Edward M. Kennedy (chairman of the subcommittee) presiding.

Present: Senators Kennedy, Dominick, and Beall.

Committee staff members present: Stanley Jones, professional staff member; and Jay B. Cutler, minority counsel to the subcommittee.

Senator KENNEDY. The subcommittee will come to order. Today we are holding hearings on the Public Health Service Hospital System and on the Emergency Health Personnel Act of 1970.

The Public Health Service Hospital System is one of the oldest and most venerable health institutions in America. It represents one of the earliest attempts by the Federal Government to respond to special health problems among segments of the American people—namely the merchant seamen.

The PHS hospitals and clinics have over the years broadened their services and have established affiliations and associations with other institutions in their communities to assure that they offer the best medical care possible. They have become community landmarks in the areas they serve.

The fiscal year 1972 budget confirms recurrent rumors that the administration is planning major changes in the operation of these hospitals and clinics.

These changes must not result in PHS failure to offer equitable health care to the Americans assigned to them for care.

Nor must this development result in the loss or misuse of these valuable health care institutions. The Senate will insist on assurances that neither of these tragedies occur.

We will also receive testimony today on the possibilities for improved health care for the poor, opened up by the Emergency Health Personnel Act of 1970, which Senator Magnuson introduced.

This act gives the Secretary of Health, Education, and Welfare the authority to send Federal medical personnel into areas in critical need for health services and to use the PHS facilities to offer these services.

Many of the PHS hospitals and clinics are located in or near areas which are critically short of health care. I view this new act

and the administration's intent to set aside fiscal year 1972 funds for its implementation, as giving us an opportunity to demonstrate the importance and relevance these PHS facilities can have in addressing America's health needs—especially the needs of the poor.

This subcommittee is in the midst of hearings on the health care crisis in this country. We have heard disturbing testimony on how the shortage of health manpower and facilities has driven up the costs of medical care, and how the maldistribution of manpower and facilities has deprived our cities and rural areas of the most basic health services.

The hospitals which serve the poor in the inner city are disastrously overloaded and in serious financial trouble. Witnesses have described outpatient departments in public and private hospitals where patients wait for hours for service and wards which hold many times their intended capacity of patients.

Given this situation, it would be unconscionable to give up any usable health services or to fail to use the Emergency Health Personnel Act to provide services—especially if these services could be turned toward our poorer citizens, who, of all Americans, suffer the greatest need for health care.

We want to explore every possible means of utilizing these hospitals and clinics and the Emergency Health Act.

On February 11, 1971, together with 29 of my colleagues, I submitted a Senate Concurrent Resolution that the Public Health Service hospitals and clinics should continue to perform their multiple responsibilities during the remainder of fiscal year 1971 and during fiscal year 1972.

I will introduce a copy of this resolution into the record at this point. A similar resolution with broad support was introduced in the House of Representatives by Congressman Clarence Long of Maryland.

The intent of the resolution is to allow Congress time to explore the capabilities of these facilities as an integral part of the health care delivery system in their communities and in the Nation at large.

Based on our hearings here today, we hope to report our resolution to the full Senate for appropriate action.

(A copy of the resolution follows:)

92D CONGRESS
1ST SESSION

S. CON. RES. 6

IN THE SENATE OF THE UNITED STATES

FEBRUARY 11 (legislative day, JANUARY 26), 1971

Mr. KENNEDY (for himself, Mr. MAGNUSON, Mr. MATHIAS, Mr. ALLEN, Mr. BAYH, Mr. BEALL, Mr. BENTSEN, Mr. BIBLE, Mr. BURDICK, Mr. BYRD of West Virginia, Mr. CASE, Mr. CHILES, Mr. CRANSTON, Mr. GRAVEL, Mr. HARRIS, Mr. HART, Mr. HARTKE, Mr. HOLLINGS, Mr. HUGHES, Mr. HUMPHREY, Mr. INOUE, Mr. JACKSON, Mr. JAVITS, Mr. JORDAN of North Carolina, Mr. MANSFIELD, Mr. MCGEE, Mr. MCGOVERN, Mr. METCALF, Mr. MONDALE, Mr. MUSKIE, Mr. NELSON, Mr. PASTORE, Mr. PELL, Mr. SPARKMAN, Mr. SPONG, Mr. STEVENS, Mr. STEVENSON, Mr. TUNNEY, and Mr. WILLIAMS) submitted the following concurrent resolution; which was referred to the Committee on Labor and Public Welfare

CONCURRENT RESOLUTION

To express the sense of Congress relative to certain activities of Public Health Service hospitals and out patient clinics.

Whereas the President declared in his state of the Union message that the improvement of national health care is one of his six great goals; and

Whereas the President has vowed to provide more medical services in areas that do not have adequate medical facilities; and

Whereas the Public Health Service was created by an Act of Congress in 1798, and the Congress broadened its responsibilities in 1956, in 1966, and in 1970 to provide comprehen-

sive health care for merchant seamen, coast guardsmen, and military personnel and their families, and preventive medical care for urban and rural areas with inadequate medical facilities; and

Whereas the Public Health Service facilities provide medical services to more than one-half million people annually who could not obtain these services in the overcrowded private hospitals or on a first priority basis in the Veterans' Administration hospitals; and

Whereas many Public Health Service facilities require only minor alterations to carry out their responsibilities; and

Whereas, despite the President's commitment to improve national health care, the President's fiscal 1972 health budget proposes a reduction in funds and personnel that is discouraging employees and prospective employees of the Public Health Service; and

Whereas, despite the expansion of Public Health Service duties in the Emergency Health Personnel Act of 1971, the Secretary of Health, Education, and Welfare is considering closing the Public Health Service hospitals and clinics;

Whereas, despite congressional creation of the Public Health Service, the Congress has not been consulted on ways to fulfill the responsibility of the Public Health Service to care for its patients without using Public Health Service facilities: Now, therefore, be it

- 1 *Resolved by the Senate (the House of Representatives*
- 2 *concurring)*, That it is the sense of Congress that the Public
- 3 Health Service hospitals and outpatient clinics should re-
- 4 main open at this time. The importance of health care

1 delivery in urban and rural areas is so great that the
2 Administration should fund and staff these facilities at a
3 sufficient level to allow them to perform their multiple
4 responsibilities during the remainder of the fiscal year 1971
5 and during the entire fiscal year 1972. During this interval,
6 the Secretary and the Congress should explore the re-
7 sources and capabilities of these facilities in their commu-
8 nities, to determine which facilities should continue to be
9 operated by the Public Health Service, which facilities
10 should be converted to community operation, and which
11 facilities, if any, should be closed.

12 It is the further sense of Congress that the hospitals
13 and clinics of the Public Health Service should be con-
14 sidered an integral part of the national health care delivery
15 system.

Senator KENNEDY. Our witnesses today should be very helpful to this end. They represent the Department of Health, Education, and Welfare, which operates the hospitals and clinics—the communities in which some of the facilities are located, and the merchant seamen, who have depended heavily on these facilities.

We also have with us representatives of the General Accounting Office to testify on the legal prerogatives of the Senate in determining the disposition of these facilities.

Gentlemen, we have a long day of testimony before us. Our agenda includes 13 witnesses. I request that you limit your statements as much as possible in order that everyone can be heard. If you are prepared to summarize your statements, we will, of course, print the entire text in the record.

Appearing with us today is the Senator from Washington the Honorable Warren Magnuson.

We want to welcome you, Senator Mangnuson.

STATEMENT OF HON. WARREN G. MAGNUSON, A U.S. SENATOR FROM THE STATE OF WASHINGTON

Senator MAGNUSON. Thank you, Mr. Chairman.

First of all, I appreciate the invitation to come before this committee, which has taken some expeditious action on this matter before, let me say, it may become too late.

I am pleased that you talked about the resolution you have available.

I want to voice my support, first, of the resolution, and opposition to closing of the public health service hospitals and outpatient clinics.

As chairman of the Senate Appropriations Committee on HEW, I believe it would be a serious mistake to close these hospitals and clinics at this time.

If the administration does close them I think it will be jeopardizing the health of nearly 1 million citizens who now rely on them for health care.

Furthermore, I will try and show in a moment that it would be impairing the education of critically needed health personnel.

The Senator from Massachusetts and I and the Senator from Virginia and all of us on that committee have for a long time stressed the fact that there are real problems of health in this country. If there is a crisis in health, it is in the delivery of health care, and in delivery you get right down to health manpower, the training and re-training of people.

So, in jeopardizing the health of at least 1 million citizens and impairing the education of these needed health specialists, I think this proposal would be endangering the national welfare.

I am sure that the witnesses following me will provide the subcommittee with ample testimony about what would happen nationally if these hospitals and clinics are closed. Consequently, I will limit the remainder of my remarks to two issues.

First, I want to tell you what the Public Health Service hospital and outpatient clinic in Seattle means to my State and the rest of the Pacific Northwest, and I bring this up because I think it would be typical.

It would be typical in Virginia and in all these other places. Second, I want to review briefly how legislation which was introduced in the

last Congress and signed into law by the President with the help of this committee and introduced by myself, affects the future of Public Health Service facilities here.

The Seattle Public Health Service Hospital is a general hospital, with a full time staff of 546, serving the needs of the Pacific Northwest in three vital ways:

First, it is fulfilling the traditional role of the Public Health Service by providing medical treatment to merchant seamen, members of the Coast Guard, military personnel, VA patients, and their dependents and other legal beneficiaries.

During fiscal year 1970, it cared for an average of 180 patients each day, and in the same period its outpatient clinic recorded 112,000 visits.

In addition to these patients several thousand Indians have received free care under the law, diagnosis and treatment referral services at a clinic held at the hospital 3 nights a week.

This clinic is staffed entirely by volunteers, many of them Public Health Service officers, and utilizes the hospital facilities on a promissory basis.

Operated in conjunction with an Indian self-help group, this clinic has made the benefits of modern medicine available to an often neglected group in the population whose poverty would otherwise bar them from obtaining any kind of health care.

Besides providing health care, the Seattle hospital has assumed a new important role in the training of critically needed health personnel.

This, to me, is the most important thing. Other PHS hospitals are equally involved with health training and education and many of them operate joint programs. For instance in Seattle the program is operated with the University of Washington Medical School and the Seattle University School of Nursing, community colleges, and a variety of other organizations.

A brief glance at the relevant statistics show how extensive that program can become as the involvement, for instance, and I say this is probably typical of the Seattle hospital—for example, 49—mind you, 49—of the hospital's doctors are also full members of the University of Washington School of Medicine faculty.

The hospital also provides 75 training positions for medical students from the university's medical school. It also provides 29 residencies and 19 internships from the medical school.

All 50 students in the various classes of Seattle University School of Nursing, are now receiving training at the hospital, and as a result the school has been able, then, to increase their enrollment.

The hospital has also made 61 training positions available for programs run by community colleges, the Neighborhood Youth Program, the WIN program, the Job Corps, and other organizations to train paraprofessional health personnel.

Obviously the closing of the hospital would be a severely destructive blow to the efforts of all these institutions and organizations to expand the number of health specialists and people who can work in various capacities in the delivery of health care.

I understand there has been some suggestion that these hospitals be turned over to the University of Washington or the city or the county or the State.

Now the current economic crisis in my State would make this impossible for the University of Washington to expand its own hospital to provide its own facilities to provide training now available at the public hospital.

Seattle University, which is a private institution, a Jesuit school, having a great deal of financial trouble, would be left with an insufficient number of training positions for its nursing students.

In view of these facts and in view of the Nation's critical need for doctors and nurses, I believe it would be complete folly for the administration to close these Public Health Service hospitals.

Now, besides providing direct patient care and cooperating in the education of needed health personnel, the Seattle hospital, for instance, is fulfilling a third great need.

That need is for scientific investigation and biomedical research into the causes and cures of disease. Utilizing three of the hospital floors, the University of Washington Medical School is currently engaged in an intensive investigation of cancer which is costing them \$1 million annually.

In addition to vital research, this program provides direct treatment for victims of the disease and valuable training in cancer treatment for future doctors.

Just a few weeks ago, the President declared his intention to launch a massive assault on cancer, and it would be totally illogical, then, for the administration to put an end to one of these valuable cancer research projects by closing this particular hospital, or any others in the country.

Besides cancer research, the hospital is investigating a wide variety of other diseases and health problems. For example, an infectious disease laboratory located there is the only facility in the Pacific Northwest which is equipped and staffed to perform many of the complex diagnosis procedures that must be performed on patients suffering from certain infectious diseases of the urinary tract.

This is the only one available in a seven State region.

The Seattle hospital is one of the seven PHS hospitals engaged in a 10-year cooperative study, joining together in the study of hypertension and kidney disease.

A rehabilitation medical unit provides extensive treatment for the crippled and handicapped and paralyzed, and also carries on a continuing program to develop better rehabilitation methods.

The list goes on and on, and so I think the closing of this particular hospital with which I am familiar and again I emphasize this is probably typical all over the country, would be closing the door in the faces of thousands of citizens needing health care and hundreds of young people desiring better training and clinical training for careers in health, and it also would be closing the door on these medical and scientific research projects that I just mentioned.

Now, we passed a bill last year which this committee is familiar with and which established the National Health Service Corporation, which was introduced by myself, but this committee did yeoman work in getting it through, and the President signed the bill.

It authorizes the Secretary of HEW to assign members of the Public Health Service Commissioned Officers Corps to areas which do not now have sufficient health personnel.

A key part of this law is its provision to use the existing PHS facilities to carry out this responsibility. In his health message to Congress, the President said he was going to implement and add to and push this new law. I was pleased to hear that, and I can assure the President, and I am sure this committee can, that we will do everything in our power to see that this is done, and I hope to be helpful to get the money to implement the program.

But he can't implement this law and meet this responsibility if he closes PHS hospitals and clinics. If we keep these facilities open and implement this new law, we will open a door to adequate health care to thousands of citizens who are now denied such care because they are poor, or live in isolated communities, or both.

So no objective could be more in keeping with the proud tradition of the Public Health Service and its commissioned officers nor could any objective be more in keeping with the President's pledge in his state of the Union message to make this the "healthiest nation in the world."

I thank you.

Senator KENNEDY. I want to thank you, Senator Magnuson, for your comments, especially since you are the author of the Emergency Health Manpower Act. You realize the extraordinary breadth and scope of that legislation in terms of meeting health needs today. I think that the administration has now suggested a \$10 million program. This would be only a drop in the bucket, but it at least shows the willingness and intention to utilize your legislation; and I think you've commented in your testimony today about how these facilities in the Public Health Service could be a vehicle by which the Emergency Health Manpower could be utilized and developed in certain circumstances as a model of delivery of health care.

I know from the record we received from Dr. Hogness, a very distinguished individual of the University of Washington Medical School, that it would take 4 years to phase out the training activities of the Seattle hospital; yet this proposal comes at a time when we are having extensive hearings on the importance of the need for health manpower. Obviously, this is counter productive even in terms of what the Administration hopes to achieve.

Senator MAGNUSON. I think that is true. It might even take more. But I look upon these places as sort of a gathering point for these people of the corps. They come there, get their training and they move out into fields of need.

I appreciate, and I know that the public health people are here, that we have a facility there that is in need of extensive rehabilitation, that is not as good as it should be. It was built a long time ago, almost 40 years. They do have perhaps the most beautiful location in town.

It stands on top of a hill with a tremendous view commanding the city. I drive by it every day when I am home, because I live just down the street about a mile. It is a somewhat dated facility and they have the concept of some large 24-bed wards in this hospital. But I say a cot in a large ward for a fellow who is sick is better than no cot at all, isn't it?

But they do this tremendous training and the Public Health Service Hospital has long gone beyond and expanded its original need for the merchant marine, and the VA hospital, which happens to

be down the street about one mile, and a more modern establishment, just can't handle their people, and the two of them work together.

Some day, we may want them to consolidate, but until that time comes, we had better keep what we have.

Senator KENNEDY. Finally, there has been a suggestion that what we really ought to do is turn these public health hospitals over to communities, and let them develop the kinds of associations or groups which would be in charge of administration, funding and financing.

In the recent days we have had hearings in this subcommittee on the genuine health crisis that exists among communities that are already in existence which are trying to provide health services, and concerning the facts that medical schools are on the edge of bankruptcy and that the public hospitals themselves are, in some instances, 150 percent of capacity. So there is extraordinary demand on already existing facilities and institutions which are attempting to provide health services.

Since the tax base in Seattle is used to help run the various public health institutions in that community, do you think the people are prepared to undertake an enormous costly additional health institution?

Senator MAGNUSON. Well, it seems to me that we have basically what I like to call a crisis in the delivery of health care.

I don't think we have the same crisis in research. I think by and large we are doing a pretty fair job in research, but not in the delivery of health care.

Now here is the big King County hospital right across the ravine from PHS that is almost breaking down financially, because the county is getting to a point where they just can't handle it. The State of Washington helps out significantly, but both of these units of government are strapped financially.

Now we have some excellent nonprofit hospitals in our town. One is the Swedish hospital; another is the Providence, run by the sisters. If I was going to enter into any community effort, I would think my first allegiance would be to those places, to help them.

But I don't see how any of these other hospitals, individually or collectively, could assume these responsibilities. Certainly not at anything close to current costs. At sometime in the future we might be able to phase out this facility, assume the care responsibilities elsewhere, but not today and not this year. Right now we need all the facilities we've got and more.

It has been suggested the university take it on. Well, the university has got to go down to the State legislature and get their money, and being a former member of the State legislature myself, that is a sort of uncertain process down there whether you get any money or not. Right now they face a cutback in their 1971-73 budget—a serious cutback.

The Senator from Virginia has been down to the legislature. In effect what they'd say is, "Well, it is doing pretty good now the way it is, and if we took it over, we would have to ask the Federal Government for money anyway, so why not keep a good thing going that we need, and do somethings to make it more efficient."

But research is not necessarily efficient, and health manpower training is expensive, and everyone out there is doing their very best, and doing a good job.

Senator MAGNUSON. I thank the committee.

Senator KENNEDY. Senator Beall.

Senator BEALL. I want to congratulate Senator Magnuson on his statement, because I think he said what is on the minds of many of us who have public health facilities in our State.

I would like to ask you, though, it seems to me one of the real problems we have today is the development of health manpower. Don't you think the Public Health Service hospital might be a proper instrument whereby we could experiment with the development of extensive use of paramedical type people, because they don't have to adhere to the State certification requirements?

These hospitals could do a lot of research in the use of new personnel, couldn't they?

Senator MAGNUSON. Yes, I do, and then we had in the HEW appropriation, we have always added a little to try to get people who are coming back from the military to continue their health career, perhaps with some additional training. This is being done right there in Seattle with one of the outstanding MEDEX programs. Part of their training takes place in this PHS facility.

Let me emphasize, that as outmoded as this particular facility might be, it is being fully utilized today for patient care, for biomedical research, especially in cancers, and for health manpower training. All of this could be more efficiently done in a modern facility, at a lesser unit cost perhaps. But a new building will take a long time. Until that day we must maintain this facility and hopefully keep all these programs going.

Senator BEALL. Thank you.

Senator KENNEDY. Thank you very much.

Senator MAGNUSON. Thank you.

Senator KENNEDY. Senator Packwood is unable to be with us today. We will insert his statement at this place in the hearing record.

PREPARED STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM THE STATE OF OREGON

Senator PACKWOOD. Word that the Department of Health, Education, and Welfare was considering the possibility of closing its network of Public Health Services hospitals and clinics around the country was, of course, met with a great deal of concern from all parts. I was among those concerned over the possible loss of this extensive health care delivery system. The loss can be gaged both in terms of the reduction in available teaching facilities and also in terms of elimination of medical facilities and services for the beneficiaries now served by the PHS system.

Oregonians use the Public Health Service hospitals in San Francisco and Seattle as well as the outpatient clinic in Portland. Portland's clinic alone averages 1700-1800 patient visits per month. It serves merchant seamen, active duty and retired Coast Guard and their dependents, PHS officers and their dependents, NOAA officers and crews and their dependents, Federal employees injured on the job in the greater Portland area. In addition, active duty and retired military and their dependents are served, the nearest military facility with a physician or dentist being 120 miles from Portland. The VA accepts

no active duty servicemen for care and provides only partial care for the retired.

The Portland clinic is staffed by three physicians, a dentist, two registered nurses, one technician, a dental assistant, an administrative assistant and three secretaries. The clinic sees men, women and children of all ages and stocks a wide assortment of medicine which the physicians dispense as indicated. It should also be noted that this clinic is the area center for yellow fever immunizations and is the area source of information regarding immunizations for international travel.

The administration is to be highly commended for its desire to make the most efficient use of these facilities. I want to express, however, my continuing concern over the possibility that these services and facilities might be lost altogether to the health care needs of our people. I fully support the administration's efforts to obtain maximum benefits from these facilities, so long as the current beneficiaries are not left without an alternate, equally competent and convenient source of health care.

In view of the health care crisis all parts of the country are now facing, I would also urge in the strongest possible terms that these facilities and personnel not be abandoned, but instead be converted to locally controlled health centers. An alternative route might be to retain the PHS network under Federal control with an expanded role to include poverty areas, to match the newly expanded role of the commissioned corps.

A third alternative would be to employ these facilities and personnel to take on research and demonstration projects, to try out some of the new concepts which must be developed if we are to achieve our goal of solving today's and our future health care dilemma.

We are all concerned for the health of our PHS beneficiaries and for the welfare of all others who are potential users of the PHS network, or indirect beneficiaries. We can therefore look forward together with some anticipation to a satisfactory solution, balancing the interests of economy while at the same time providing improved and additional health care sources for our people. In short, I would urge the administration to be forward looking and to continue in its search to come up with efficient but constructive, positive alternatives to fully take advantage of this great health resource, the Public Health Service hospital and clinic system.

Senator KENNEDY. Congressman Long, why don't you please sit there, while we hear from Senator Spong and then Senator Mathias.

STATEMENT OF HON. WILLIAM B. SPONG, A U.S. SENATOR FROM THE STATE OF VIRGINIA

Senator KENNEDY. We want to express our appreciation for the appearance of Senator William B. Spong, of Virginia. He is a member of the Foreign Relations Committee and the Commerce Committee, and is a supporter of the Public Health Service hospitals.

Later today we will hear from Dr. Bernard Lidman, president of the Norfolk Medical Society.

Senator SPONG. Thank you, Mr. Chairman. I want to thank you and other members of the subcommittee for giving those who would be

directly affected by the closing of Public Health Service facilities this opportunity to be heard.

My own statement will be very brief since I know there are a great many witnesses here today and the subcommittee's time is limited.

I have already testified on this subject before the House Committee on Merchant Marine and Fisheries and as one of the sponsors, commented on the pending resolution when it was introduced in the Senate.

There is no need to repeat those points here except to emphasize my view that these hospitals and clinics should not be closed without provision of other adequate health facilities to take their place.

I do not believe such alternative facilities are available in many areas of this country today and certainly they are not in the tidewater area of Virginia.

I say this after undertaking a personal investigation of the alternative facilities in Virginia that would be available should the Norfolk hospital be closed.

At any rate, that is a matter which must be determined before any action is taken and that is the purpose of Senate Concurrent Resolution 6.

Mr. Chairman, I am pleased that the subcommittee will be hearing today from Dr. Bernard Lidman, president of Norfolk Medical Society, who will be speaking for the tidewater community. Other Virginians from that area plan to submit written statements and I would appreciate it if they could be made part of the hearing record.

At this time I would like to have made a part of the record, telegrams from Paul H. Kube, corresponding secretary of the Retirement Federation of Civil Service Employees; Comdr. Carl W. Bryan of the Disabled American Veterans; and Ernest R. Wood, secretary of the Fleet Reserve Association, Portsmouth, Va.

I am submitting also a resolution from the Norfolk Chamber of Commerce, Norfolk, Va. I believe a statement has also been presented by Mr. Brinkley of Norfolk, director of the Virginia Council on Alcoholism.

Mr. Chairman, I would like to commend you and Senator Magnuson in taking the lead in the Senate in the introduction of this resolution. I think it is essential, and I know that these hearings will provide the opportunity to show conclusively that, of all times, that this is not the right time to close these facilities.

Thank you very much.

Senator KENNEDY. Thank you, Senator Spong.

The record will include those items which you have requested.
(The information referred to follows:)

[Telegrams]

NORFOLK, VA., March 5, 1971.

Hon. WILLIAM B. SPONG, JR.,
U.S. Senate,
Washington, D.C.:

Statement for committee holding hearings on resolution to retain public service health hospitals. Primary objection of Chapter 26, Disabled American Veterans to closing public service health hospitals is proposed transfer of responsibility to Veterans' Administration hospitals. In telephone conversation this date director VA hospital Hampton, Va. states he has sent full report to you. VA Washington verifies Hampton VIR Hospital maintains waiting list of

veterans to be admitted. Respectfully urge consideration to ensure adequate funds and expansion of VA hospital facilities prior signing additional patients. Secondary objection is elimination of any medical facility when U.S. Navy hospital Portsmouth and all civilian hospitals in area maintain waiting lists for admittance.

CARL W. BRYAN,
Commander, DAV Chapter 26, Chesapeake, Va.

PORTSMOUTH, VA., March 5, 1971.

Senator WILLIAM B. SPONG,
*New Senate Office Building,
Washington, D.C.*

Members branch 37 fleet reserve assistant Portsmouth, Va., wish to go on record as to opposing closing of U.S. public health service hospital in Norfolk, Va. This is a bad time to cut back on any type of medical service, particularly the public health service. Trust you will support our plea.

ERNEST R. WOOD, *Secretary,
Branch 37 Portsmouth Va.*

CHESAPEAKE, VA., March 5, 1971.

Senator WILLIAM B. SPONG, Jr.,
*New Senate Office Building,
Washington, D.C. 5327*

The Public Health Hospital in Norfolk is a much needed medical facility. The closing of this facility would be a serious cutback in the medical services rendered to the Tidewater, Va., area. The already overcrowded conditions existing in the Civilians Hospital of the area, the Veterans Hospital Keoughtan, and the patient load at the Portsmouth Naval Hospital, would make it almost impossible for adequate patient care and services required of those using the facility. The shortage of medical facilities throughout the country and the Hampton Roads area in particular offer a serious threat to the health and well-being of all citizens. The closing of a facility such as the Public Health Service Hospital in Norfolk could only add to this threat. Urge Congress to make full investigation of medical facilities available to Hampton Roads citizens and that the Public Health Service Hospital remain open until this investigation is completed.

PAUL H. KUBE, *Corresponding Secretary,
3309 Foxgrove Lane, Chesapeake, Va. 23321
Retirement Federation Civil Service Employees Local 3.*



TELEPHONE 622-2312

NORFOLK CHAMBER OF COMMERCE

269 BOUSH STREET
NORFOLK, VIRGINIA 23510

March 4, 1971

Honorable William B. Spong, Jr.
United States Senate
Washington, D. C. 20510

Dear Bill:

Thank you very much for your recent telegram concerning Hearings on the Public Health Hospital facilities. I am enclosing a Statement of Position by the Norfolk Chamber of Commerce concerning this situation which was prepared a short time ago. I would appreciate it very much if you would insert the Chamber's statement in the Hearing record.

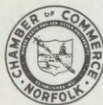
This is an extremely important issue here in the Norfolk community, and therefore, please do not hesitate to contact me if we can assist you in any way.

Sincerely,

Wright Harrison

W. Wright Harrison
President

WWH:bz



NORFOLK CHAMBER OF COMMERCE

269 BOUSH STREET
NORFOLK, VIRGINIA 23510
TELEPHONE 622-2312



UNITED STATES PUBLIC HEALTH SERVICE HOSPITAL

MEETING

Thursday, January 21, 1971

Norfolk, Virginia

Presentation by: The Norfolk Chamber of Commerce

The Norfolk Chamber has been asked to express opinions concerning the impact of a possible decommissioning of the Public Health Service Hospital. The Norfolk Chamber of Commerce has been in continual dialogue with all of the hospitals in the Norfolk Area. In recent years, several of its directors and top officials have been affiliated with local hospitals.

The Chamber understands the following factors to be of importance in studying the problem:

- The hospital facilities available to the Community are in a delicate equilibrium between medical needs of individuals and services available.
- The Norfolk Area Community contains an inordinately large segment of federal employees, active and retired, and their dependents.
- The Portsmouth Naval Hospital is equipped to handle hospitalization problems of members of the Armed Forces and their dependents as a major service to these persons.
- The Public Health Hospital within its limitation of 210 beds acts to supplement these needs of the Armed Forces.
- In addition, the Public Health Service Hospital has as prime beneficiaries seamen including Merchant Marines and fishermen involved with ships of five tons and over. It is a prime hospital facility for U. S. Coast Guard and for the Coast and Geodetic Survey.
- On a space available basis 58% of the outpatients are dependents and 55% of the inpatients are dependents.

- In the last three years the staff of physicians has been reduced from 53 to 33. This factor combined with a relatively small number of 330 employees makes this vital facility just barely capable of rendering its assigned service requirements.
- The responsibilities of the Public Health Hospital extend beyond the Norfolk Area, to the entire State of Virginia and the States of North Carolina, South Carolina and Georgia.
- In recent months the Norfolk Chamber of Commerce has endorsed the concept of placing new requirements upon United States Public Health Service Hospital concerning the treatment for drug abusers who cannot be accommodated in other public hospitals or private hospitals locally. A limited capability exists at the present time and is considered a vital need to the Community.

Impact of decommissioning of the U. S. Public Health Hospital:

1. Disturb equilibrium that now exists for medical attention needed in Norfolk area, thereby necessitating an equivalent installation to be provided from some other source such as another private or public hospital of comparable size or capability.
2. Denial of hospital services to special beneficiaries of Public Health Hospital which then would only be available to these persons at other hospitals.
3. Denial of an unusually well centralized hospital facility which has been a prominent fringe benefit for local citizens associated with the Federal Government.

Recommendation:

That the national legislators representing Norfolk be urged to maintain the U. S. Public Health Hospital as currently constituted and to sponsor funding for its operations and maintenance for the future. It is suggested that these legislators solicit support of national legislators from other areas of Virginia and from the states of North Carolina, South Carolina and Georgia.

STATEMENT OF HON. CHARLES McC. MATHIAS, JR., A U.S. SENATOR
FROM THE STATE OF MARYLAND

Senator MATHIAS. Thank you, Mr. Chairman.

I am grateful you called this hearing to eliminate this troubling question. I feel both from your own record in the field of concern for health legislation and that of your colleague and my colleague, Senator Beall, who I think is already very well versed in this particular subject, that we have some friends in court.

I have a prepared statement which I would like to submit and then comment very briefly. I also have a very impressive list of training programs affiliated with the Public Health Service hospital in Baltimore, which I would like to submit for the record, together with a list of various groups in the Baltimore area which have expressed their concern.

Senator KENNEDY. They will all be included in the record at the conclusion of your testimony.

Senator MATHIAS. Mr. Chairman, this problem arises from a brief statement in the budget, and from the accompanying explanations which indicate there was some concern on the part of the budget bureau that public health facilities were not being adequately utilized and thus that the administration would review the use of public health hospitals and would defer requesting funds to run them.

This was an unfortunate speculation, but it is no more than that; it is just a speculation in the budget that overall health expenditures might be reduced by finding satisfactory alternative methods of delivering the same services.

The explanation for the request for funds, in fact, says this specifically: "This figure includes funds to insure that beneficiaries currently served by the eight Public Health Service general hospitals will receive the care to which they are entitled, including care in community facilities or other federal hospitals, at Federal expense."

I don't think it necessary to read any further.

What we have seen since that language first appeared clearly indicates there is going to be no closing of the Public Health Hospitals this year, or next year. Now I think we ought to reassure the communities which are in such a state of concern over this, that these hospitals are not going to close; they simply can't close.

This kind of language shows a need for a long investigation and evaluation. These communities deserve reassurance, and I think we can give it to them.

The alternatives that have been suggested, that we use the VA hospital system, for example, are impractical. The VA hospitals themselves need a great deal of help, and it would be completely unrealistic to graft the whole Public Health Service load on top of what the VA hospitals are already doing.

I would question that the underutilization is as serious as has been charged. I am familiar with the patient load and particularly the outpatient load at the PHS hospital in Baltimore. If, indeed, there is underutilization there, this also represents an opportunity.

There are too many people in this country who are not receiving the kind of health care they need and deserve. If there is an underutilization, this is a great advantage. Let's put these hospitals to work.

I think we can reassure the public that they are not going to be closed. I intend, as a further effort toward this line to introduce legislation today to provide the funds not requested in the budget so that these hospitals can go forward.

Thank you very much, Mr. Chairman.

Senator KENNEDY. Thank you, Senator Mathias. I would be interested in whether you think these facilities ought to be turned over to some local groups in the communities, whether there are existing institutions in the greater Baltimore area or other teaching institutions that would be able to undertake the expenditures in terms of modernization or even in terms of utilizing these facilities to provide health care.

I think such suggestions have been made; and listening to the very splendid testimony of the people from Johns Hopkins last week—who talked about the financial plight of Baltimore's hospitals—I would be interested in whether you think that such a move can be a realistic alternative.

Senator MATHIAS. Mr. Chairman, I don't think there is a realistic alternative—and certainly not without a period of very careful planning, and with enormous Federal financial help. Today the Baltimore medical community has its back to the wall.

The Johns Hopkins Medical School, one of the greatest in the entire world, is running a deficit of \$2.3 million for the current operating year.

They have no means of making up that deficit. Part of it is generated by their attempts to broaden their program, to expand enrollment, and to serve the community better, but they can't be expected to extend that any further. In fact, just to keep going they will require massive Federal assistance.

That is why I say we are not able to close these hospitals or turn them over to local communities on the 1st of July.

Senator KENNEDY. Thank you very much.

Senator Dominick?

Senator DOMINICK. Thank you, Mr. Chairman. Senator Mathias, I did not get to hear your full statement.

Senator MATHIAS. I can assure the Senator that I have submitted my written remarks for the record.

Senator DOMINICK. My understanding of what you say, though, is that if these facilities would be closed because the local people could not take them over that you would be in favor of increasing the Federal funding so that they remain open.

Is that correct?

Senator MATHIAS. Absolutely. There are vital functions going on at these hospitals.

Senator DOMINICK. You are saying that they should stay open under some aegis.

Senator MATHIAS. It is vital.

Senator DOMINICK. If they should become public hospitals, I would presume that the provisions of the Hill-Burton Act which went into effect last year would provide for federally guaranteed bond issues at a subsidized interest rate, and that that would be available to them. Do you happen to know whether Johns Hopkins—well, I suppose that could not be done—but in this case, with a public hospital, whether that could be done?

Senator MATHIAS. You mean for the initial cost of takeover, modernization?

Senator DOMINICK. Well, for modernization purposes.

Senator MATHIAS. I very frankly can't give the Senator a direct answer on that, but I think that that is only a small part of the problem. You have to consider also the operating costs and such things as the community services now being rendered by the Public Health Service hospitals.

Let me give you one small example: The National Cancer Institute has on contract a massive program of research and treatment of cancer at Wyman Park. I visited this unit not long ago, and I inquired about consumer-patient access to that facility. Is it available only to retired military, or just people who have some contract right to these services?

Because this is a National Cancer Institute program, the answer is no. It draws from a much wider community. Anyone in the geographical circle served by Wyman Park, which is broader than just the State of Maryland, who is suffering from cancer is a potential patient in this cancer clinic. This is obviously a program which is of enormous importance to the people within this service area.

But it is also of importance because of its national implications, with the on-going work of the National Cancer Institute, aimed at improving the treatment and cure of cancer.

Senator DOMINICK. There is not any doubt that in the health problems we have around the country that we can certainly make use of every available hospital bed that there is, and the proposal to close them, as I understood it, is not the administration's position.

The proposal was to modernize them and turn them over to local control. I would agree with you that under no such circumstances should they be closed.

We fought this battle on the VA hospitals, one of which happens to be located in my State. We finally won it, but it took us a long time. That was 4 years ago, and you probably remember that fight.

I don't think this is going to be nearly as severe a fight, because it is one where we find we need to keep them open. I would agree with that.

Senator KENNEDY. Senator Beall?

Senator BEALL. At the risk of being parochial with my distinguished senior colleague from the State of Maryland, who has been a leader in the fight to keep the public health service hospitals in operation.

Isn't it a fair statement to say if it was desirable to turn these hospitals over to the State, for instance, that even in the case of Maryland, it would take a minimum of 2 budgetary years, or 4 or 5 years before this could be accomplished?

Senator MATHIAS. That is absolutely correct. This would require a long range planning process, in order to mesh out the discontinuation of Federal involvement. The local people would have to reshuffle their priorities to take it over.

I think it would be necessary to look ahead, as you say, for 4 or 5 years.

Senator BEALL. Even if that was desirable or practical, isn't it true that in the State of Maryland, the University of Maryland which is

the main publically operated hospital, the State is sorely pressed to-day just to keep it going at the level it should go, let alone the take-over of other hospitals?

Senator MATHIAS. That is absolutely true. I think that again it comes back to the point that you can't do this job without a continued infusion of Federal financial support.

Senator BEALL. I was interested further in your statement with respect to the suggested underutilization. I am not sure this exists, but it was interesting to note, and I think you can confirm this.

Didn't recent census tracts show that in Baltimore there were 170,000 people who did not get primary medical care? So there is great opportunity for the utilization of these facilities?

Senator MATHIAS. A very great opportunity.

Senator BEALL. Thank you, Mr. Chairman.

Senator MATHIAS. Mr. Chairman, I would say one other thing. I think perhaps out of every controversy of this sort there is some benefit to be derived.

In this case, the searchlight which has been turned on the Public Health Hospitals may be useful. There may be some things they are doing which could be done better. It may be that, they may receive help which they have long needed.

Modernization of the system is probably in order. So I would hope that your committee investigation would contemplate these areas, as well as the bare question of the survival of the system.

Thank you very much.

Senator KENNEDY. As you pointed out, the study for the modernization goes back to 1956, though no modernization work has actually been done.

I appreciate your comments.

(Information submitted by Senator Mathias follows:)

PREPARED STATEMENT OF HON. CHARLES MCC. MATHIAS, JR., A U.S. SENATOR
FROM THE STATE OF MARYLAND

MR. CHAIRMAN. I wish to express my appreciation to you and the members of the subcommittee for holding hearings on the vital question of the fate of our nation's Public Health Service hospitals and clinics. I am sure that you share with me the sense of urgency over the disposition of these important health resources. Many other senators and congressmen share this concern; almost one-third of the Senate joined in cosponsoring our resolution urging the Administration to continue operating the PHS hospitals and clinics.

In my own state of Maryland, concern about the PHS facilities in Baltimore has been so great that the State House of Delegates recently approved a resolution calling on federal officials not to close any of the PHS hospitals. That resolution was cosponsored by the entire 43-member House delegation from Baltimore City.

A fairly obscure passage in the proposed budget for next year states that the Administration is to consider whether the services offered by the PHS hospitals might be offered elsewhere at a saving to the taxpayers. This seems a perfectly reasonable question to ask regarding any government program. Indeed, all of us want the government to operate as efficiently and economically as possible.

Allow me to quote, from the explanation for the request for funds to provide services in HEW medical facilities: "This figure includes funds to insure that beneficiaries currently served by the eight Public Health Service general hospitals will receive the care to which they are entitled, including care in community facilities or other federal hospitals, at federal expense. This policy includes consideration of the potential for converting the PHS direct care facilities to community use." Since then, we have been assured by top HEW officials

that, if no such alternative arrangement can be determined, the President will request a supplemental appropriation to continue the operation of the PHS hospitals. I am told that this assurance was repeated as recently as last Friday in testimony given by HEW to this subcommittee's counterpart in the other body.

Increasingly, I think, it has become evident that there is no realistic prospect for making alternate arrangements. The Chairman of the House Committee on Veterans Affairs, Representative Olin E. Teague, has said he doubts the VA hospitals could handle the patient load from the PHS hospitals. And I agree, since VA hospitals themselves need all the help they can get. Indeed, the VA hospital system is already so overburdened in many places that it is turning away patients whose disabilities are unrelated to their military service. According to the executive vice president of the Maryland Hospital Association, private hospitals in the Baltimore area could not absorb the Wyman Park PHS hospital's load, which numbers over 115,000 patients annually.

Another alternative under consideration by the Administration, I understand, would be the transfer of PHS hospitals and clinics to community organizations or groups for use as community health facilities. For a number of reasons, this arrangement would be almost as unsatisfactory as closing down the hospitals altogether.

Abolition of PHS control would undoubtedly raise the prospect of a sharp reduction in the hospitals' vitally important public service programs. At present, 35 of the National Cancer Institute's 120 beds around the United States are located in the Baltimore PHS hospital. Continuation of this noted program would be seriously jeopardized by any transfer of hospital control.

Essential teaching, training and other manpower programs would also be called into question. In Baltimore alone, the PHS is involved in a very extensive array of manpower programs, including internships, residencies, and nurse training. The list of their training activities is so impressive, in fact, that I have appended it to my testimony.

Nor is the education of doctors and nurses the only manpower issue at stake. As government facilities where everyone is on salary, the PHS hospitals are a good deal less hampered by departmental rivalries than private institutions, and this has made it easier to experiment with new categories of health personnel, such as para-medics for which there is an ever-growing realization of need.

Direct service to the community by the Baltimore PHS hospital is evident in many programs, such as the provision of physicians to city schools and the development and administration of the Maryland Eye Bank.

Another probable result from loss of PHS control would be immediate dislocation of many of the hospital and clinical staff. Not only career civil servants, doctors, and other specialists, but large numbers of minority group staff would be subject to displacement. In Baltimore alone, \$3 million of the hospital's \$7.2 million annual payroll goes to black and other minority group employees.

What makes the fate of the PHS hospitals all the more critical, I think, is the recent enactment of the Emergency Health Personnel Act, which calls upon the Public Health Service to attack health problems in the ghetto and other doctor-shortage areas.

President Nixon is to be commended for requesting the full \$10 million authorized for this innovative program. But as the chairman of this subcommittee has aptly said, it would be a cruel irony for the Administration to move now to undercut the PHS hospitals at the very time when Congress has enacted this new health manpower legislation to meet the country's most desperate needs.

Indeed, this may be the worst possible time to sever PHS control over these facilities, many of which are strategically located near ghetto neighborhoods. Only last Thursday I announced that I would introduce a bill to provide a major new incentive for graduating doctors, dentists, and other health personnel to take up service in these doctor-deprived areas. My bill would establish a loan forgiveness mechanism whereby service with the PHS in these areas would operate to cancel federal education loan indebtedness at the rate of 25 percent per year.

I am therefore of the view that it would be extremely counter-productive to carve out the base, the PHS hospitals, to which these idealistic young health professionals would be attached.

One justification given for shaking off PHS control, we understand, is that the facilities are underutilized and do not serve a broad enough segment of the population. This, rather than being a problem, represents an opportunity. The present low occupancy can be turned to advantage for the care of the indigent.

Several PHS hospitals are eager for such assignments. After setting up a health evaluation service the Baltimore hospital could be ready to serve an indigent population of 25,000, according to its director, Dr. Edward J. Hinman. This plan, which has the enthusiastic approval of the Baltimore City Health Department, would provide ambulatory care to a black neighborhood which now has but one doctor and no dentists or drugstores.

There has of course been a great deal of talk about the poor state of PHS facilities. Further use of them would undoubtedly require extensive modernization. But the cost-factor, whether channelled through the PHS or through local authorities, would be essentially the same. The only question about modernization, then, is just how much longer we must wait.

A very significant question, relating to cost, is that of per diem expense. The average cost per day in PHS hospitals is \$65 to \$70 per day, which includes everything from doctors' salaries and laboratory tests to X-rays and drugs. The average daily charge in other hospitals, however, is something on the order of \$95 to \$115 for room and board alone. Transfer of control over these hospitals, taking them out of the hands of the PHS, might thus cost the taxpayers more, rather than less.

For all these reasons, and indeed many more, the wisest course of action, I think, would be to retain PHS operational management over all their hospitals and clinics. Not only would this accord with the five-year-old recommendations of a prestigious Presidential Science Advisory Committee, it would maintain an essential basis for extending, through the Emergency Health Personnel Act, critically needed health services to our nation's ailing poor.

I intend to introduce today a bill for authorization and appropriation of the necessary funds to maintain operation of PHS hospitals and clinics.

U.S. PUBLIC HEALTH SERVICE HOSPITAL—BALTIMORE, MD.

AFFILIATED TRAINING PROGRAMS

PUBLIC HEALTH SERVICE HOSPITALS—DISCIPLINE/SPECIALTY

Baltimore City Health Department, Alcoholism Center.—Alcoholism Counselors.

Baltimore Public Schools.—Nurses Aides and/or Orderlies.

Bryman School, Towson, Md.—Clinical and Laboratory Experience for Medical Assistants.

Catholic University School of Nursing, Washington, D.C.—Nursing Science Administration.

Catonsville Community College, Catonsville, Md.—Nursing.

Church Home and Hospital, Baltimore, Md.—Medical Record Librarian Students.

Colby Junior College, New London, N.H.—Medical Record Library Science Training.

Community College of Baltimore, Baltimore, Md.—Medical Record Librarian Students; Physical Therapy Assistants; Nursing.

Crownsville State Hospital, Crownsville, Md.—Medical Record Librarian Students.

Duke University Medical Center, Durham, N.C.—Clinical experience in ambulatory care including multiphasic health testing: Physicians' Assistant Trainees and Grads.

Gettysburg College, Gettysburg, Pa.—Practical experience for Medical Library Students.

Good Samaritan Hospital, Baltimore, Md.—Medical Record Librarian Students.

Greater Baltimore Medical Center, Towson, Md.—Medical Record Librarian Students.

Johns Hopkins Hospital, Baltimore, Md.—Medical Record Librarian Students.

Johns Hopkins Hospital and School of Medicine (Dept. of Otolaryngology), Baltimore, Md.—Otolaryngology.

Loyola College, Baltimore, Md.—"Minimester" exposure to application of didactic book learning.

Maryland General Hospital, Baltimore, Md.—Medical Record Librarian Students.

Medical College of Virginia, Richmond, Va.—Hospital Administration Residency Training.

NCI-Baltimore Cancer Research Center, Baltimore, Md.—Collaborative research program in cancer treatment and laboratory investigation.

Provident Comprehensive Neighborhood Health Center, Baltimore, Md.—Medical Record Librarian Students.

St. Agnes Hospital, Baltimore, Md.—Medical Record Librarian Students.

St. Joseph Hospital, Towson, Md.—Medical Record Librarian Students.

State of Maryland Health Department, Baltimore, Md.—Occupational Therapy Assistants.

Towson State College, Towson, Md.—Collaborative Allied Health Training Program.

Union Memorial Hospital, Baltimore, Md.—Medical Record Librarian Students.

University of Alabama, Birmingham, Ala.—Hospital Administration Residency Training.

University of Maryland, Baltimore, Md.—

School of Medicine :

(1) Clerkship in general surgery.

(2) Training in physical diagnosis.

(3) Senior curriculum in ambulatory care.

(4) Clinical internship for graduating Physical Therapy Students.

School of Nursing :

Learning experience in care of cancer patients.

School of Pharmacy :

Cooperative educational and research programs.

University of Pennsylvania, Division of Physical Therapy.—Physical Therapy Students.

A. Jewish War Veterans Ladies Auxiliary of the United States, Department of Maryland.

B. The Baltimore City Republican Committee.

C. National Alliance of Postal and Federal Employees.

D. Association of Commissioned Officers National Oceanic and Atmospheric Administration.

E. Robert E. Morrow, pres. Maryland Medical Record Association.

F. Maritime Trades Department American Federation of Labor and Congress of Industrial Organizations, Paul Hall, president.

G. Baltimore Port Council.

H. B. A. Barringer, president Catonsville Community College.

I. National Association of Retired Civil Employees, Baltimore Chapter 600.

J. Deputy Commissioner of Health, Baltimore City Health Department.

K. International Association of Machinists and Aerospace Workers, District Lodge 12, Baltimore.

L. Greater Homewood Community Corp.

M. Neighborhood Development Corp. representing MUND Community.

N. Maryland Health Maintenance Committee :

Telegram attached :

[Telegram]

BALTIMORE, MD., *February 18, 1971.*

Hon. CHARLES McC. MATHIAS,
*Senate Office Building,
Washington, D.C.*

At its last meeting, the Maryland Health Maintenance Committee unanimously passed a resolution introduced by Mrs. Betsy Raymond of the International Ladies Garment Workers Union that all possible steps be taken to maintain the Public Health Service Hospital in Baltimore as an operational facility. We are particularly concerned with the successful implementation of the hospital's current plans to serve the communities in its vicinity by proving staffing and hospital backup for urgently needed comprehensive health care centers.

The Maryland Health Maintenance Committee is composed of representatives of organizations that are working to develop a network of viable group practice services available to enrollees from both publicly funded programs and private health centers in Metropolitan Baltimore and to make prepaid group practice health prepayment plans. Our current membership is :

Executive Committee members :

Philip Van Gelder, chairman, Labor Health Care Committee, Metropolitan Baltimore Council of AFL-CIO Unions (Chairman).

Hume O. Annan, director, Marketing Research and Program Development, Maryland Blue Cross (Secretary).

Herbert H. Rosenbaum, chief of special projects, State of Maryland, Department of Health and Mental Hygiene.

Alvin A. Akman, president, Retail Store Employees, Local 692.

Jerry B. Hanson, director of administrative services, Group Health Association, Inc., and an officer of Maryland Group Health, Inc.

Robert M. Heyssel, M.D., director, health care programs, Johns Hopkins Hospital.

Joseph I. Berman, M.D., chief of community medicine, Sinai Hospital.

Robert E. Farber, M.D., commissioner of health, Baltimore City Health Department.

Clarence H. Burns, president, East Baltimore Community Corp.

Charles G. Tildon, associate director, Provident Hospital, Inc.

Louis L. Randall, M.D., Garwyn Medical Center.

Members:

William McC. Hiscock, director, comprehensive health planning, regional planning council.

Frederic C. Hubbard, director, Baltimore City Hospitals.

William S. Spicer, M.D., associate dean for health care programs, University of Maryland.

University of Maryland Hospital.

Harle Barrett, M.D., director of intake services, University of Maryland Hospital.

Margaret B. Pollard, vice-president, Northwest Baltimore Community Corp.

Edward Bogier, health coordinator, M.U.N.D.

Rev. Robert G. Dever, Homestead-Montebello Community Organization.

Edward J. Hinman, M.D., director, U.S. Public Health Service Hospital.

Philip F. Wagley, M.D., Baltimore City Medical Society.

Stewart Davis, metropolitan planning council.

Edward Davens, M.D., director, regional medical programs.

Betsy Raymond, International Ladies Garment Workers Union.

Nicholas Montanari, United Steelworkers of America.

Oscar Camp, M.D., director, Eastpoint Medical Center.

PHILIP H. VAN GELDER, *Chairman*,
305 W. Monument Street,
Baltimore, Md.



HOUSE RESOLUTION NO. 6

By Delegate Arnick and the Baltimore City Delegation

House Resolution requesting the Secretary of Health, Education and Welfare to continue the Public Health Service Hospital in Baltimore City in operation, as well as suspending the closing of other Public Health Service facilities in the United States.

The Public Health Service Hospital at Wyman Park performs many vital functions in the area of medical service in the City of Baltimore.

At the present time, there are a total of 203 beds at this facility, covering both medical and surgical services. There is no other medical facility available to the residents of the Wyman Park area, numbering some 30,000 people.

Although primarily designed as a medical facility for active and retired merchant seamen in the Port of Baltimore, one of the largest seaports in the United States, the Public Health Service Hospital also extends its facilities to other Federal employees and to private citizens.

In addition, this very important facility contains a branch of the National Cancer Institute, consisting of thirty-five beds and performing vital work both in treatment and research in the field of cancer, one of our most dreaded and deadly diseases. Fifty percent of these patients are from other areas of the United States.

The Public Health Service Hospital is also doing research in the field of developing systems for providing medical care, particularly in the area of pre-paid medical care, which offers great promise in making proper medical care available at reasonable cost to people throughout the nation.

Another on-going project at this facility is the Heart Disease Research Program, which is being carried on with the cooperation of the Federal installation at Woodlawn, the Social Security Administration.

Last year, there were 108,000 out-patient visits to this facility, which employs 661 personnel and has an annual payroll of Seven Million Two Hundred Thousand Dollars (\$7,200,000).

The closing of this facility would cause great hardship to the area in which it is located, the City of Baltimore, and the State of Maryland, from the standpoint of public health and also from an economic aspect.

All that has been said of this hospital can be said of the seven (7) other hospitals and thirty (30) out-patient clinics throughout the United States operated by the Public Health Service and all of which performs vital functions in the field of Public Health; now, therefore, be it

Resolved by the House of Delegates of Maryland, That Mr. Elliott Richardson, Secretary of Health, Education and Welfare, is urged to give every possible consideration to continuing in operation the Public Health Service Hospital in Baltimore, Maryland, as well as the other Public Health Service facilities in the United States, as all of these facilities are badly needed; and, be it further

Resolved, That copies of this Resolution be sent to President Richard M. Nixon, Vice-President Spiro T. Agnew, Secretary of Health, Education and Welfare Elliott Richardson, United States Senators Charles McC. Mathias and J. Glenn Beall, Jr., and the Members of the Congressional Delegation from Maryland.

By the House of Delegates, January 18, 1971.

Read and adopted.

By order, James P. Mause, Chief Clerk.

Speaker of the House of Delegates.

Chief Clerk of the House of Delegates.

Senator KENNEDY. We will hear next from Congressman Long, and then we will hear from Dr. Egeberg. Dr. Egeberg is going to appear tomorrow, too, and we realize that there are needs other than the Public Health Service Hospitals and the cancer question, Doctor, so we will get to you very shortly.

We tried, by coming in by 9:30, to get the Members of Congress before 10 o'clock.

Mr. Long, we want to welcome you. Congressman Long, a Representative from the Second District in Maryland, is a member of the House Appropriations Committee. We appreciate his appearing with us to give us his views and support of the Public Health Service Hospital and clinic system.

STATEMENT OF HON. CLARENCE D. LONG, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Mr. LONG. Thank you, Mr. Chairman, I welcome the opportunity to testify before the Health Subcommittee of the Senate Labor and Public Welfare Committee on the crisis in the Public Health Service Hospitals and outpatient clinics.

I want to thank you, Senator Kennedy, for holding this hearing and for introducing Senate Concurrent Resolution 6—legislation similar to my own bill—House Concurrent Resolution 98—to keep all the Public Health Service facilities open through fiscal 1972, and during that interval, to have the HEW Secretary and the Congress explore the resources, capabilities, and position of these facilities in their communities to determine which, if any, should be closed.

I introduced this legislation, the first of its type in the 92d Congress, because of the Baltimore metropolitan area's need to keep its Public Health Service Hospital and outpatient clinic open.

The consequences of closing that hospital illustrate the need for careful study of the proposed closing by HEW and the Congress.

The fiscal 1972 budget confirmed rumors that I had been hearing for nearly 2 months about the hospitals. Only \$74.6 million will be available to operate the hospitals and clinics. This is a decrease of \$26.1 million from the fiscal 1971 budget.

Furthermore, the narrative reads:

The budget places emphasis on the use of service agreements with private and Federal sources for such care and the conversion of the existing facilities to community use.

In addition, the budget provides only \$15.1 million for salaries. The 1971 budget provided \$63,889 million for salaries. This is a decrease of \$48,774 million from the fiscal year 1971 budget. The 1971 provision was 6,242 employees. This is a decrease of 5,270 employees. The administration clearly intends to decrease their participation in the operation of these facilities.

The situation has changed somewhat since 54 of my colleagues joined me on January 29 in introducing House Concurrent Resolution 98 and House Concurrent Resolution 99. The administration seems to be considering two alternatives:

1. Closing the facilities because primary beneficiaries can obtain more economical health care in more modern facilities, and
2. Turning the facilities over to community operation.

Either alternative would have serious consequences for Baltimore that should be studied carefully.

For my constituents and the other residents of the Baltimore metropolitan area, closing the hospitals would create considerable hardship. The Maryland Hospital Association, which is united with all other

Maryland medical interests in its opposition to closing the hospital, has told me that there are 7,373 hospital beds in the Baltimore area.

Closing the PHS hospital would mean a loss of 238 beds. Moreover, two of the area Veterans' Administration hospitals have been ordered to eliminate a total of 124 beds by the end of fiscal 1972.

Closing the hospital and curtailing Veterans' Administration services would be a loss of 362 beds to the Baltimore area population. If the VA hospitals are unable to care for primary beneficiaries on a contract basis, an arrangement would have to be worked out with the community hospitals.

These hospitals are operating at 86.6 percent of capacity. If the PHS hospital beds are eliminated the occupancy rate would increase to 89.1 percent, according to the Maryland Hospital Association.

However, the ideal average occupancy rate is 85 percent. Furthermore, patient care in the Baltimore area hospitals is \$85 per day per bed—without counting the cost of attending physician's visits.

The cost of the Public Health Service Hospital is \$79.52 including doctor's visits.

Finally Maryland would lose the Public Health Service team, expertly administered by hospital director, Dr. Edward Hinman, the NIH Cancer Research Center, and the training programs for medical personnel which are operated in conjunction with the Johns Hopkins University, the Universities of Maryland and Pennsylvania, and local community colleges.

Private citizens would lose use of emergency room facilities when other city hospitals are full. Closing the hospital would prevent implementation of plans to provide low-cost health care to residents of the Homestead-Montebello area.

The second alternative now under consideration—community control—might create a hardship for the thousands of military personnel, their dependents, and retired military personnel who now receive economical health care at the hospital.

In fiscal 1970 these people accounted for more than 50 percent of the patients admitted to the hospital and for nearly 50 percent of the more than 100,000 outpatient visits.

Presently Fort Holabird, Fort Meade, and Aberdeen Proving Ground, also provide medical care for area military personnel and their dependents. However, with the closing of Fort Holabird, the other two bases cannot easily absorb former Holabird patients in their own crowded facilities—and would be hard pressed to consider caring for the thousands that the Public Health Service treats.

The Government absorbs the cost of their care in military hospitals and reimburses the Public Health Service for the cost at the Public Health Service Hospital, but only pays the reasonable charges on their bills—under the uniformed services health benefits program (commonly referred to as Champus)—if they go to a private hospital for treatment.

If the Public Health Service Hospital were community operated, the individual Champus beneficiaries would have to work out their own medical care arrangements with the hospital.

Senator KENNEDY. Congressman, your statement is really superb, because you have gone into a very careful detailed analysis which we need, which we have not had before, and which will be of great value in

terms of interpreting the Administration's budget and what that means in terms of personnel. Also, thank you for giving us the data in terms of the facility in the Maryland area.

Mr. LONG. I have now only a few more words to say.

Senator KENNEDY. Fine.

Mr. LONG. Similar problems are troubling my House colleagues in the 21 other States that have Public Health Service facilities. These problems do not seem to be bothering the White House very much.

Forty-four of my House colleagues joined me last month in requesting a White House level meeting with the congressional delegations and Governors of the affected States to discuss Public Health Service crisis.

The White House has not indicated its concern or interest in convening the meeting: yet eliminating the PHS services seems inconsistent with the President's state of the Union goal to make health care "available more fairly to more people."

In closing, Mr. Chairman, I want to say that I am heartened with the Senate response to this health care crisis, and I hope that Senate Concurrent Resolution 6 will receive early consideration on the Senate floor and that we can achieve an early resolution of this crisis.

Senator KENNEDY. Thank you, Congressman. I think you have fairly portrayed the two different alternatives that are available, and I think you have analyzed them in considerable detail. Also, your detailed analysis of what this would mean in forms of the local community is of great value.

I want to thank you very much and commend you for your continued leadership in the House of Representatives. I think you have been a great help illuminating this problem.

Senator DOMINICK. I have no questions.

Senator KENNEDY. The next testimony will be given by Dr. Roger O. Egeberg, Assistant Secretary for Health and Scientific Affairs, Department of Health, Education, and Welfare, and Dr. Vernon O. Wilson, Administrator of Health Services and Mental Health Administration, HEW. Prior to joining HEW, Dr. Egeberg served as dean of the school of medicine, University of California. Dr. Wilson served formerly as vice president for academic affairs at the University of Missouri. Both gentlemen have a history of public service in the field of medicine, and we welcome them here today to describe the HEW plans for the Public Health Service hospitals and clinics.

STATEMENT OF DR. ROGER O. EGERBERG, ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY DR. VERNON E. WILSON, ADMINISTRATOR, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION; AND BRUCE CARDWELL, COMPTROLLER, ASSISTANT SECRETARY, HEW

Dr. EGERBERG. Thank you, Mr. Chairman.

Senator KENNEDY. We want to extend a warm welcome to you, and apologize for the delay.

Dr. EGEBERG. Thank you. On my right is Mr. Bruce Cardwell, Controller for HEW.

I have been much interested in the testimony that I have been listening to, sir. I am sorry to seem to hurry. I did invite the British and Canadian Ministers of Health to a meeting out at NIH this morning, but I see where my primary interest is.

Mr. Chairman and members of the committee, at the request of the committee, we are here today to discuss our plans for the public Health Service hospital system. My objective is to be as direct and specific as possible in telling you what we are trying to do with the hospitals—what has happened thus far and what is likely to happen in the future.

I know that you have all been deluged with statements, rumors, explanations, and much more concerning this subject. You may read in the paper one day that the administration plans to close abruptly all of the hospitals. You may read the next day that the administration has changed its position and it will keep them all open.

On the third day someone may tell you that we plan to close some but keep others open. If we are to put this matter in proper perspective, it is essential that we clear the board of all these claims and counterclaims.

We must start with a clean slate. Please set aside or try to forget all of the confusing and conflicting reports that you may have heard about the administration's plans for the Public Health Service hospitals.

Having asked you to do that, we must then undertake to describe to you fully and frankly just what it is we have under consideration—exactly what we are doing and exactly what we are not doing.

Closure is not the issue.

CONCERN ABOUT THE EFFECTIVENESS OF THE PHS HOSPITAL SYSTEM

The first thing you should know is that the Department is deeply concerned over whether the present system of Public Health Service hospitals is the best means of fulfilling our responsibilities to merchant seamen and other Public Health Service beneficiaries. I hope that you share this concern.

I would like to spell out for you some of the reasons why we are examining the role of the PHS hospital system:

1. In recent years, there has been a steady decline in the Public Health Service patient load, particularly among our primary beneficiaries such as merchant seamen. There may, from time to time, have been exceptions to this, but this is clearly the overall trend, and indications are that it will continue into the future. This declining patient load is making it more and more difficult to justify and maintain all of the departments and services of a first-class, modern hospital. While the optimum occupancy rate for a hospital is 85- to 90-percent bed capacity, the current overall average for the PHS hospital system is below 70 percent, with the high being 78 percent at Galveston and the low being 65 percent at Seattle. Thus, not one PHS hospital is operating even close to the optimum utilization rate.

2. As a general proposition, the facilities themselves have become outdated. A large modernization program would be required to make them first-class, up-to-date facilities. Although this is not the primary element of consideration, the fact that it would cost between \$125 and \$175 million to finance such a modernization program is reason enough to at least stop and examine other alternatives.

3. Although there may be some who take exception to the contention that there is a serious doctor and health manpower shortage, everybody agrees that our current supply is neither properly distributed nor utilized with maximum efficiency. If one examines the share of this scarce resource that is working for the Federal Government, he must, I believe, conclude that the Federal Government has a special responsibility to make the best possible utilization of each and every doctor at its command. Thus, when I find underutilization of manpower in the Public Health Service hospital system—a system that is under the direct control of the Department that is supposed to be leading the way to improved health manpower utilization—I must explore alternatives that might lead to a more efficient utilization of this manpower.

WHAT WE ARE DOING NOW

I would like to make it very clear that what we are doing now is exploring alternatives for solving the problems inherent in the present system while fulfilling our responsibility to provide high quality medical care to merchant seamen and other beneficiaries. Our options are still open.

As a framework for developing options to consider, the Secretary has set down two very specific conditions which any proposal to change the PHS hospital system must meet.

1. We must, without exception, continue to provide care to our beneficiaries which is equal or superior to that now being provided.

2. No alternative that would eliminate hospital beds needed for medical services by the local community should be considered.

Given the Secretary's ground rules, we are exploring the following alternatives:

1. Conversion of the facilities to local control and use, with full reliance on contract care arrangements for the provision of services to PHS beneficiaries, with the converted hospitals being major sources for such contract care.

2. Conversion of the facilities to local control and use, but providing all of the required care for our beneficiaries through contracts with public and private hospitals with little reliance on the converted PHS facilities or VA hospitals.

The theme of community use of the PHS hospitals runs through these alternatives for a very good reason. When the primary beneficiary patient load declines, a greater proportion of the hospital capacity becomes available for other uses.

An analysis of our patient load data indicates that, if the hospitals were utilized at an optimum rate, only 40 percent of the available beds would be for primary beneficiaries.

If the doors were opened to community patients, these patients would, therefore, make up over half of the patient load. Our site visits were made in January and confirmed this estimate. Since, under

conditions of optimum utilization, over half of the patient load would be community patients, it is logical for us to seriously consider community operation of the hospitals themselves.

We will take two alternatives mentioned above to the communities for indepth discussion and review. I believe it is important at this point to make clear that the visits to each of the eight cities that were conducted by staff of the Health Services and Mental Health Administration in January did not cover these two alternatives.

Those visits were simply the first step in our review of this whole problem. They were intended to assess the general situation in each of the eight cities—to identify source of community interest and to examine firsthand the exact situation concerning patient load and staffing. I am afraid that the impression has been given that these visits were for the purpose of making choices and decisions. Let me emphasize that that was never our intention.

We are now at a stage where we believe we can examine in depth, with each of the local communities, their interest in an arrangement that would place the facility under local control. We are now prepared to negotiate with each of the communities. The following would be included in such discussions:

1. PHS beneficiaries currently eligible and receiving care in the facilities must continue to receive the same or improved services, either at the converted facilities or elsewhere in the area.

2. Special departments or services currently in operation in each of the facilities should continue. This would include coronary care units, kidney dialysis units, and the like.

3. HEW or other federally sponsored research and training activities operated at the facility would be continued to the extent that this might be mutually beneficial to the community and the Government.

4. Any public or private group wishing to take over the facility must show evidence of having the professional and financial resources to operate the facilities in a stable and efficient manner.

5. The local group would also be asked to link with the areawide planning agency in its region to assure maximum integration of the facility and its services with other health delivery resources in the community.

6. We would be prepared to commit at least a portion of the commissioned corps personnel currently assigned to the hospitals for some reasonable transition period. This is authorized under the Emergency Health Personnel Act of 1970. Thus, the local community would be assured of a basic cadre of experienced professional personnel.

7. The local community would, of course, be able to collect and retain third-party income related to services provided to non-PHS beneficiaries.

It is still too early to predict whether such negotiations will produce viable arrangements that would be acceptable to both the community and the Government, but we believe that they stand a good chance of being successful.

Our hopes are high because the conversion of the PHS hospital offers each community a quick way of augmenting its medical care resources.

Frankly, the cost implications of the alternatives I am presenting to you are still somewhat unclear. In this context, I would like to underscore a statement made by the Secretary during his discussion of the Public Health Service hospitals before the House Committee on Appropriations on February 17.

He said, "I want to emphasize that should our efforts be unsuccessful we will request whatever additional appropriations are required to provide medical care for our beneficiaries."

In other words, we are fully prepared to propose an amendment to the budget now before the Congress to cover the costs necessary to assure the provision of quality care to the PHS beneficiaries, if this cannot be done within the amounts already requested.

We ask this committee to give us the opportunity to pursue the alternatives I described earlier, with the understanding that what we are trying to do is improve not only the care of PHS beneficiaries, but improve the utilization of health manpower and facilities in all of the communities where the PHS hospitals now exist.

This concludes my prepared testimony. I will be happy to answer any questions you may have.

Senator KENNEDY. Thank you very much, Dr. Egeberg, for the statement which you have made.

I suppose the question which occurs to me and I am sure a number of other Members of the Senate is whether the public health hospitals will be closed this year.

Dr. EGEBERG. You mean between now and July?

Senator KENNEDY. Well, will they be closed between now and July, and then I will ask you between July and—

Dr. EGEBERG. No. We don't want to close them.

Senator KENNEDY. You don't expect then in terms of the remaining calendar year that they would be closed?

Dr. EGEBERG. No. I am sure this could not be arranged that quickly.

Senator KENNEDY. What about the following year. Senator Matthias brought this out, and I think it is important that we try and lay it out as clearly as possible for the people who are affected.

Dr. EGEBERG. They will not be closed at all if we can help it. They will be, we hope, transferred to the auspices of some strong local group, and how quickly we can go about that depends on how quickly the arrangements can be made to do as good a job or better than we are doing now.

Senator KENNEDY. If you can't find a strong local group within the community prepared to undertake the kind of extraordinary expenses which the Federal Government has been undertaking over the period of recent years, are you prepared to continue to request from the Congress the appropriations necessary to continue to operate these public health hospitals?

Dr. EGEBERG. We certainly are going to continue to see to it that the beneficiaries are taken care of. Now, it might be that a hospital in a certain area—

Senator KENNEDY. You can't say, then, that if there is not a local group that is strong financially and is prepared to underwrite these facilities, that you are prepared to continue to maintain the public health hospitals?

Dr. EGEBERG. Let me say one thing, and then my colleague will take over.

The point is that in some areas the beneficiaries have to come a long way to the hospital, and might do better being taken care of closer to their homes—

Dr. WILSON. There are two issues when you use the word "underwrite." I think that brought into relief two issues under discussion, one, the facilities themselves, which we would like to see turned over to someone in the community; particularly in those communities where the number of patients is apt to be greater from the community than from the seamen.

The other is the fiscal support of the beneficiaries we have. I think the statement is very clear that we intend to continue that fiscal support for the beneficiaries whom we have a responsibility for. So it seems to me that we have to sort out those two issues. We are not asking a local community to underwrite the beneficiaries for whom we are already giving care.

Senator KENNEDY. I don't think my question was whether you intend to free yourself from already existing responsibility under the Public Health Service Act.

That was not really the question, because I can understand from both what Dr. Egeberg has stated and the Secretary has stated that you are prepared to do that. You made that quite clear.

The question concerns these hospitals that are in existence. You are unwilling at least at this time to indicate that beyond this calendar year that they will exist as they are at present?

Dr. WILSON. That is a fair statement.

Dr. EGEBERG. I would like to add one thing. There are, perhaps, some circumstances under which one would close the hospital. The only circumstances that I can think of would be a situation where the beneficiaries could better be taken care of somewhere else, and where the local community did not have need for those beds.

Now, I think that the local community—

Senator KENNEDY. Who is going to make that decision? Is that going to be made solely within your department?

Dr. EGEBERG. I would think that would be up to the Secretary.

Senator KENNEDY. You must have studied this problem prior to the time you made reduction in personnel and in other resources. You must have made some kind of survey or studies in these respective communities.

We are trying to find out not so much what some prospective study is going to show, but what the present intention is based upon the studies that you have undertaken.

Other than a general statement that you expect to continue this for a year, you can't give us any kind of specificity in terms of the future.

Dr. EGEBERG. I would reemphasize the fact that we have two concerns. One, that there are beds available to a community that we don't want to see closed, and two, the primary beneficiaries of the system be taken care of as well as or better than they are being taken care of now.

Senator KENNEDY. If we use that criterion in Baltimore, we have had the statements from Johns Hopkins Hospital, where they are working at 125 percent capacity in the public facilities, that there is a shortage of beds in that community. I am just wondering if you can

identify now the communities where public health hospitals exist where there is not a shortage of beds.

Do you have that information?

Dr. EGEBERG. I think Dr. Wilson may. I would like to say in Baltimore we are using 170 out of roughly 240 beds at the present time, and I think half of those are not primarily beneficiaries.

Dr. WILSON. I think the most startling illustration we have had is in San Francisco. We have been depending really for our attempts to discover local need on the local comprehensive health planning groups. We have, I think, a similar but perhaps less impressive situation in the New Orleans area. San Francisco is the community that, by their own statistics, would appear to have more beds than they currently care to use.

Now, which of those beds would be discontinued under local aegis, whether they would be the beds in our facility which we currently operate or some other beds would, I think, be left up to them.

Senator KENNEDY. What do you find in terms of Boston, for example?

I have been through Boston city hospitals where you see patient after patient lined up in the corridors, and here you are talking about closing down a hospital in another part of the city.

Dr. WILSON. No; we are not talking about closing down the hospital. That is where we go past each other a little. We are talking about a hospital which has 150 beds of which only 126 are operative at the moment, about a 66-percent census, and wondering if there isn't a way to put that more firmly into the community service than it is currently.

That is really what we are proposing.

Dr. EGEBERG. May I give an example of San Francisco?

San Pedro Harbor and San Diego Harbor are among the largest harbors for seamen on the west coast, and yet they have to go to San Francisco or to Seattle to get their care; so that many of them could really be taken care of much better if other arrangements were made locally.

Senator KENNEDY. Why is it necessarily inconsistent that other arrangements could be made in addition?

Couldn't contractual arrangements be made to bring the services closer to the merchant seamen?

Dr. EGEBERG. I would say that the primary beneficiaries use up about 40 percent of the available beds, and if some of those were taken care of elsewhere, we could get down to maybe 30 percent of the beds being occupied by beneficiaries and that raises the question whether we should be running the hospitals or not.

That is one of the considerations we are trying to grapple with.

Senator KENNEDY. You don't, as I gather from your response, see an opportunity, even if you are down to the 30- or 40-percent utilization to provide the kinds of comprehensive health services that the President has indicated support for, and that the Congress has given to the executive in terms of legislation?

I am just wondering whether you look on it as an opportunity, or as a burden; for it seems that we keep getting down to percentages and underutilization of these facilities. You are looking on it as a burden rather than an opportunity. I would be interested in your reaction to that.

Dr. EGEBERG. I think the Government has to look at that in a broader perspective. One could always use a hospital for more teaching, and one could always use a hospital to demonstrate or search out better ways for the delivery of health care.

But we have one hospital system in the Government, 125 hospitals or 120,000 or 130,000 hospital beds, which is opening its doors to increasing numbers of patients and I think where one could solve many of the problems of training and problems of delivery of health care in the community.

Mr. CARDWELL. Mr. Chairman, could we go back to one of your earlier questions? I am not sure we answered it fully.

Senator KENNEDY. Yes.

Mr. CARDWELL. That question had to do with whether HEW after considering all the relevant factors, particularly those concerning the community would unilaterally decide whether, there was a need to maintain the hospital beds capacity that currently exists in the PHS hospitals.

I think our basic objective would be to promote a consensus, a consensus that first starts within the community.

Our hope would be that if that consensus did develop that it would be one that could be recognized and accepted by both the executive and the legislative branches.

The last thing we want to do is to decide this thing alone—I think we are trying to move this problem in the right direction.

Your question about underutilization versus some other alternative solution to the underutilization problem is a very good one, and it is one that we have thought through.

The Emergency Health Personnel Act of 1970 does give us an opportunity to bring community patients into the Public Health Service hospitals, and you could say that that is the answer to the underutilization problem. But it seems to us as you look down the road that we would become the minority tenant in those hospitals.

We asked a question, "Wouldn't it, under those circumstances make a great deal more sense to involve the community by making these viable community operations that can serve multiple purposes, including the beneficiary responsibility of the government?" We are saying we will fulfill this responsibility, no matter what. But we are also saying we want to sharpen the focus of these particular facilities for community use.

As to the question Senator Mathias raised, about the need for assurances that the facilities would remain in place as we now know them through 1972, there are two facets to that particular alternative.

If we were to sit here today and say, "We will pull back and we will leave everything exactly as it is for another 2 years," what we would really be saying is that we have made it more difficult for us to go into the community and negotiate an arrangement, because those forces that want to retain the status quo will move into that vacuum.

Yet, on the other hand, we don't want to appear unreasonable in what we will do or won't do. I think the Secretary has emphasized over and over again the three points that we think are most important.

One, that we will do nothing that would jeopardize the welfare and rights of the beneficiaries. If we see that that is going to happen, we will pull back and adopt the status quo in that particular circumstance.

Second, that if a community is able to demonstrate a need for beds, we will do nothing to compound that need. That is something that the people might disagree on, but I think Elliot Richardson will be fair-minded and objective about it. I don't think he will arbitrarily take an action that will close the hospitals. I think the words are backed by his goodwill in terms of those two objectives.

Third, we will back up any plan developed by altering the budget to support it.

However cost must, and will be a factor. For example, we can't develop any agreement that would triple the cost of providing services.

But we are prepared to pay some price for an interim arrangement that will in time produce an answer to our two objectives. To maintain our responsibilities to the beneficiaries and to move the program toward maximum community use, and we would ask the Senate to give us a chance to attain these objectives.

Senator KENNEDY. That is a very helpful answer.

I want to yield time to my colleagues, but first let me ask you this, Mr. Secretary. Your testimony today assumes that communities are going to pick up a major part of the responsibility and financial burden of these various facilities, and I think the record is quite clear from the Horning study that was made in 1965 that there is a need for modernization of these facilities, and that has not been done.

The need still exists today. You said in your statement that this was a consideration, not the primary one, but certainly one of the considerations in making this determination.

Over the period of recent days we have heard comments from those associated with great hospital systems such as Dr. English from New York, Dr. Ebert from Chicago, and others, who talked about the crisis in terms of resources within communities in attempting to meet the needs.

We have heard from medical schools and from the various public corporations in charge of running these hospitals. We hear from every different type of group that is associated with health delivery in these communities.

I would be interested in what material you have been able to gather that makes you believe that any of these local communities are going to have the resources, any access to resources, or the credit to go into the bonding market to borrow these resources, as desirous as they might be trying to provide quality health care for their own people.

We don't get any feeling of wealth from the mayors, who come and lobby us in terms of revenue sharing. We don't get it from the Governors or from the health personnel. I am interested in what information the administration has been able to gather to lead us to believe that you think it can be done.

Dr. EGEBERG. In the first place, broadly, we would expect to see that the hospitals are in reasonably good shape. The main loss in an older hospital is in efficiency.

But, second, we will be paying the costs of hospitalization, including physicians, for our own beneficiaries, and then the Government through medicare and medicaid and other sources would be paying for other people in the hospital. On top of that I dare say we will have to make an arrangement with the hospital or the group that is taking it over.

Now, as far as specific ideas are concerned, maybe Dr. Wilson would like to add something.

Dr. WILSON. It seems to me that one has to assume that no matter how that hospital serves the community, whether in our hand or in other hands, the State of the condition of the physical plant and the cost of replacing it remains a constant.

So I don't think it makes much difference whether we can find a responsible local group who would take it on, or whether we would attempt to continue it. Our responsibility is to help get that plant into reasonable condition, and the dollars will remain really relatively the same.

Senator KENNEDY. I take it your statement today indicates a commitment to do so, but there is nothing in your budget to indicate any sizable kind of rehabilitation and modernization of these facilities prior to their being turned over to a local community.

Dr. WILSON. I think without taking Mr. Cardwell's role, allow me to then make one comment. It seems from a program point of view we are really in a position of not knowing exactly what is required to change a physical facility until we know more about what the local community would do with that facility as part of their resources.

The range of suggestions for using these facilities to meet local community needs has gone from the extended care or nursing home to a full-care hospital. It seems to me the request for money for that kind of purpose should really await the intimate planning which we have not at the moment been privileged to conduct with the local group as we work with them to determine how this would fit into the local health care.

Senator KENNEDY. Finally, even with contractual arrangements for caring for beneficiaries under the existing program; with medicare and medicaid, which other public hospitals have as well; and with arrangements with medical schools for providing high quality care and treatment and for use as a training facility, Public Health Service hospitals are going to be going through extraordinary kinds of budgetary cutbacks.

When you hear Dr. English of New York talk about 400 drug addicts who are raiding one of the hospitals in New York City because they can't get decent care, you realize that people want treatment. Yet a crisis exists in the Public Health Service hospitals; our own Boston City Hospital lost accreditation a year ago. In St. Louis, Mo., a hospital lost accreditation. I have heard that a county hospital in Chicago is losing accreditation.

So I think the most demanding question to be asked of the administration is how you can possibly expect any Public Health Service hospital to function without a very heavy input of Federal funds. Obviously if the administration is prepared to make some of these arrangements which you have suggested, but on which you are not prepared to elaborate today, you will have a situation which I think is a great deal more realistic.

Dr. EGEBERG. I am aware that the financial aspect of this is basic to the other aspects. I think the secretary has an arrangement with and understanding of the whole Bureau of Management and Budget, and I think maybe Mr. Cardwell can reassure you a bit on that score.

Mr. CARDWELL. Well, to just review the situation, one of the basic considerations during the site visits is obviously going to be the capacity of and the interest in a specific manager or operator for taking over whatever financial liabilities might be involved.

The most significant of those, on its face, of course, would be modernization. This will vary from place to place.

As Dr. Egeberg made clear in his statement, we are prepared in the basic conditions of those discussions to commit ourselves to keep professional health services personnel in place in the facilities for an interim period. This will reduce personnel costs for the new manager during that period.

In addition, the new manager, of course, would, as Dr. Wilson pointed out, be assured of a certain level of support for the PHS beneficiaries.

Thirdly, he would, of course, be able to receive and retain all third party payment collections, which, in today's method of operations do provide offsets for depreciation and strengthen the prospects of funding future plant replacement and modernization.

These programs will, of course, as I think Senator Dominick pointed out earlier in one of his questions of Senator Mathias be eligible for Hill-Burton support.

This all comes at a time when the administration is conceiving of a hospital financing system that will depend largely on Federal guarantees and subsidies, and less on direct Federal funding.

It is too early to tell whether or not that particular policy will impair our opportunities to develop viable negotiations with prospective managers. But here again, this is one of the things we will be looking into.

Senator KENNEDY. Thank you very much.

Senator Dominick?

Senator DOMINICK. Dr. Egeberg, I have here some hearings dated September 10 and 12, 1969, in which Dr. English was testifying before Senator Yarborough. At that time, as I recall, and correct me if I am wrong, we did close two Public Health Service hospitals, one in Savannah and one in Detroit.

Isn't that correct?

Dr. EGEBERG. Yes, sir.

Senator DOMINICK. There was considerable concern at that time expressed by Senator Yarborough and others as to the effect this would have on the care given to the beneficiaries, and I want to ask if it has had any effect on that care?

Dr. EGEBERG. No. As a matter of fact, it would appear that many of those beneficiaries went to one of their other benefactors, so to speak, either the Veterans' Administration, or to their own insurance which they had as an employee benefit from their work.

Arrangements were made to take full care of them if they chose to continue to ask us for it, and particular efforts were made to see that that could be done.

But the number that sought help from us afterward was a much smaller number than before.

Senator DOMINICK. Those hospitals were in fact closed down, but left open for outpatient treatment; is that correct?

Dr. EGEBERG. Yes. We have 30 outpatient facilities around the country, so some of the beneficiaries continued as outpatients.

Senator DOMINICK. I want to make that point because obviously we are all concerned with both the financial problems and also the delivery of health care around the country, and here were two that were closed, and in fact that closing did not seem to hurt the primary beneficiaries, and did not seem to increase the health crises in those cities.

Am I correct in that?

Dr. EGEBERG. We found no evidence that it has.

Dr. WILSON. That is essentially correct.

Senator DOMINICK. Do you have any indication as to why the patient load has been dropping off in these public service hospitals?

Dr. EGEBERG. I imagine partly for the same reason that it has been dropping off, relatively speaking, in the Veterans' Administration hospitals. The beneficiaries have so many other sources of care now.

The alternative used to be the VA or a county hospital, but now medicare and medicaid exist as well as other means of taking care of them.

That is one reason for the reduced demand. In addition, I think that they find their own insurance is pretty good.

Senator DOMINICK. Do I understand you correctly that only 40 percent of the patients in the Public Health Service hospitals are primarily primary beneficiaries at this time?

Dr. EGEBERG. Not quite. If the hospitals were full, 40 percent would be, but the hospitals are not full, so it is about 50-50 as it stands.

Dr. WILSON. It is actually closer to 60 percent of the inpatients and about 40 percent of these who visit the outpatient clinics are primary beneficiaries if you take the exact number coming through, and the ratio continues to shift.

It is coming downward in percentage of primary beneficiaries in both instances—

Mr. CARDWELL. But this is an important factor to understand if we are going to answer the question that the chairman raised as to why we can increase utilization by drawing community patients in under the authority of the Emergency Health Personnel Act of 1970.

The thing we are concerned about there is that if we represent only 30 or 40 percent and the community represents 60 or 70 percent of the occupancy, it does not any longer make sense that the Federal Government should be in charge of that given plant.

This is, we think, a question that has not always been understood.

Dr. WILSON. Senator Dominick, may I add one further bit to that?

Senator DOMINICK. Yes.

Dr. WILSON. It is interesting to look at the 1962 figures compared with our 1971 figures for these purposes. We had roughly 1,800 primary beneficiaries in 1962. By 1971, these are at 1,000, and total patients were at roughly 2,600, and now down to about 1,600.

This is both primary and secondary.

Senator DOMINICK. What do you mean by a secondary beneficiary?

Dr. WILSON. These are dependents, perhaps, of military who can receive care on an as available basis. They are individuals, other than

the seamen or the Coast Guard or the Geodetic Survey people, but they do have the privilege of using the hospital if space is available.

Senator DOMINICK. I think that clears up that problem. I understand that the General Accounting Office says that under the Public Health Service Act, HEW is required to maintain the public health service facilities and provide the service required by the act.

So that perhaps there is a problem in the law as to whether you would be legally entitled to transfer control over to a local group.

Do you want to comment on that?

Dr. EGEBERG. I am going to give this one to Mr. Cardwell.

Mr. CARDWELL. Well, this is a basic question that has to be resolved. The Comptroller General on two occasions, in 1965 and again just last February, in examining the law, which, as you know, has quite a long history in this case, has given the Congress his opinion that the executive branch does not have adequate authority to unilaterally close down all of the hospitals, that the operation and maintenance of a hospital system is an inherent requirement of the law, and if one were to close down each and every facility, the executive branch would no longer have the system called for by the law.

Senator DOMINICK. If you then reach the alternative that has been suggested where all of those hospitals are transferred over to local control, what do we do about that?

Do we have to change the law?

Mr. CARDWELL. Well, at this point we have not examined the Comptroller General's most recent comment on this.

Our general counsel went back and examined the same question, and came to a slightly different conclusion. So at this point I think it is fair to say we do have a difference of opinion. Whether that difference of opinion will be sustained upon a later examination of the February opinion of the Comptroller General, it is too early to say.

Senator DOMINICK. In other words, the basic question is whether under the law you are required as a Federal institution to continue these hospitals or whether under the law you are simply required as a Federal institution to supply the services through some system?

Mr. CARDWELL. I think that is the basic question. The Comptroller General has obviously given careful thought to that.

I hold him in very high regard, as I know the Congress does, but we think it is a question that may have another side to it, and we want a chance to look at it a second time.

Senator DOMINICK. Suffice it to say, in order to quiet down some of the rumors that are going on, then, what you are saying is that for the foreseeable future these hospitals are not going to be closed, and you are exploring the possibility of local groups taking over the actual operations of the hospital even though you are going to continue to provide the financial support and the care for the primary and secondary beneficiaries.

Is that correct?

Dr. WILSON. Yes; that is right. We plan to continue that set of responsibilities, which we currently hold.

Senator DOMINICK. I think that is all I have at the moment.

Senator KENNEDY. Senator Beall?

Senator BEALL. To follow up on that a little bit, I think we all share your desire to have a better utilization of facilities, and I think we are

all interested in the improvement of the delivery of health care, but what really bothers us is the fact that this budget was reduced by \$21 million, and this \$21 million, apparently, would close the doors of the existing hospitals.

It seems to me that it is very difficult to generate a discussion about the possible changes of usage or change in ownership or the involvement of other governmental units in the continuation of those hospitals when that \$21 million is still out of the budget.

Using my State as an example, as far as the State of Maryland is concerned their legislature is in session now, it has 30 more days to go. There is no possibility whatsoever that the proper accommodations could be made that would lead to a state participation in the utilization of this facility.

As far as we are concerned, the \$21 million would be out and that would mean the hospital would be closed. Don't you think the department and the administration would be well advised to send up a budget amendment to assure the continuance of the hospitals for the next budgetary year so that you could have the proper climate for further discussions as to the utilization of facilities?

Mr. CARDWELL. Here, again, there are two ways of approaching the same objective. It is true that the budget does have a reduction.

Insofar as the operations of the hospitals in concerned, it is a reduction of \$14 million. The figure of \$21 million is accounted for by a loss in collections and other revenue.

That is how we got to the \$21 million figure that people cite. I can't speak for the Office of Management and Budget per se, but we do think we have quite a clear understanding with them, and that is that at the time we finish our reviews of each individual case and at the time we reach a conclusion about each case, we will then and there change the budget to whatever extent might be required.

We told the House last Friday we thought that could run as long as into the fall of this year before we really have the answers it would take to make whatever budget adjustments may be necessary.

This raises the question of, "Well, what do you do when this present budget expires on June 30, 1971?"

Our assumption has been that we would maintain the present budget in place into the first or second quarter or however long it might be necessary into 1971 through the use of the continuing resolution. We would propose to the committees on appropriations of both Houses whatever language in the continuing resolution might be necessary to assure that.

So to kind of sum up, we are committed to a budget adjustment if and when that becomes necessary, and we will send a budget proposal to the Congress as soon as we finish our reviews and have reached the point where we know what the answers are in all cases.

We do not believe that will be completed by June 30, 1971, but we would rely on the operation of the continuing resolution through the first part of the year 1972 or until such time as a final budget adjustment is made.

Senator BEALL. It still seems to me that it is very difficult to generate discussions when you are in this period of uncertainty. It would seem further that the discussions might be more successful if there was

some definite commitment, rather than saying we are going to have a continuing resolution.

In the case of Maryland, for instance, you might be more successful in generating some sort of bilateral actions.

Mr. CARDWELL. To be very frank with you, Senator, it is my personal judgment that without the impetus of the budget, the negotiations really won't take place.

Senator BEALL. You might be right; but if my mail is any indication, you have raised a red flag—

Mr. CARDWELL. I think where the red flag started was back in the late summer and early fall when the rumor started that we were abruptly closing all the hospitals. I do think our position has changed, and I think it is more realistic.

Senator BEALL. But it is the \$21 million reduction that causes that reaction.

Mr. CARDWELL. Yes, sir.

Senator KENNEDY. Thank you very much, Doctor. This has been very helpful. I think the assurances that you are giving to these communities that they are going to have a voice in these matters is terribly important. I am pleased that the administration is prepared to make additional arrangements if there is the possibility of developing some kind of community group.

I think this is consistent with the administration's proposal for health maintenance organizations and neighborhood health centers. I think the emergency health manpower provision provides extraordinary latitude to the administration, in terms of developing some pilot programs to meet the health crisis needs. We hope that you utilize that program in trying to find ways of providing comprehensive community health care for the various cities and other towns affected by it.

Dr. EGEBERG. We are very grateful for that attitude, and we will keep you posted, sir, in your committee.

Senator KENNEDY. Thank you very much.

Dr. EGEBERG. Thank you.

Senator KENNEDY. Our next witnesses are here representing the Office of the General Counsel of the U.S. General Accounting Office.

Mr. Paul G. Dembling serves as General Counsel of GAO, and Mr. John W. Moore serves as Assistant General Counsel. They are accompanied by Mr. Robert P. Wade of their staff. We have asked these gentlemen to testify in order to inquire into the authority of the Department of Health, Education, and Welfare to close existing Public Health Service hospitals and clinics, and the role of Congress in any such proposed changes in the manner in which we offer health services to Federal beneficiaries here.

We will have particular reference to the memorandum from Mr. Elmer B. Staats, Comptroller General of the United States, to the Honorable Edward A. Garmatz, chairman of the committee on Merchant Marine and Fisheries.

We will place this memorandum in the record at the beginning of this testimony.

STATEMENT OF PAUL G. DEMBLING, GENERAL COUNSEL, U.S. GENERAL ACCOUNTING OFFICE; JOHN W. MOORE, ASSISTANT GENERAL COUNSEL, GAO; AND ROBERT P. WADE, ATTORNEY, GAO; ACCOMPANIED BY SMITH BLAIR, LEGISLATIVE ATTORNEY, GAO

Mr. DEMBLING. Thank you, Mr. Chairman.

Senator KENNEDY. Do you gentlemen wish to make an opening statement?

Mr. DEMBLING. While I have a short statement here, I can offer it for the record and summarize it, if that is your desire. However, in order to conserve time, I can summarize it, and offer my complete statement for the record, and also offer for the record the February 23 opinion of the Comptroller General and the June 7, 1965, opinion which was alluded to earlier here.

(The information referred to follows:)

GENERAL ACCOUNTING OFFICE VIEWS ON CLOSING OF PUBLIC HEALTH SERVICE HOSPITALS



COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

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February 23, 1971

Dear Mr. Chairman:

Reference is made to your letter of January 25, 1971, directing our attention to a legal memorandum dated January 21, 1971, by the General Counsel of the Department of Health, Education, and Welfare which concludes that HEW does have authority to close existing public health service hospitals and clinics throughout the country. You cite our letter of June 7, 1965, to the Chairman, Committee on Merchant Marine and Fisheries, holding to the contrary, and ask our current views on this and the other questions posed and answered in the HEW memorandum.

The questions considered in the HEW memorandum are stated as follows:

"1. Does the Secretary of Health, Education, and Welfare have the authority to transfer PHS hospitals and out-patient clinics to non-federal owners?

"2. Does the Secretary of Health, Education, and Welfare have the authority to provide for the care of Public Health Service (PHS) beneficiaries at facilities other than those operated by the PHS?

"3. Can PHS beneficiaries be given priority in Veterans Administration (VA) hospitals ahead of veterans with non-service-connected disabilities?

"4. Can VA and PHS make cross-servicing arrangements to provide for the care of each other's beneficiaries?"

1. Authority to Transfer PHS Facilities to Non-Federal Owners
(Closing of PHS Hospitals).

In our decision of June 7, 1965, holding that the closing of all Public Health Service general hospitals was beyond the discretionary authority of the Department, we stated:

"The Surgeon General, who administers the Public Health Service, is empowered by the Public Health Service Act to 'control, manage, and operate all institutions, hospitals, and stations of the Service * * *' (sec. 248(a)).

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Our examination of the act does not disclose a substantive basis for restrictively construing the general administrative powers thus conferred. Rather, in the context of providing medical care, involving professional judgment, we consider inherent in the power to control, manage, and operate the Service's various health facilities, the discretionary authority to close and convert to out-patient clinics one or more of the Service's general hospitals. The closing, however, of all Public Health Service general hospitals, with general referral of beneficiaries to facilities outside the Service, would in our opinion be an unwarranted extension of the Surgeon General's discretionary authority."

We find nothing in the HEW memorandum that would persuade us to reach a contrary view at this time. The essential thrust of the HEW memorandum is to the effect that the early statutory authority to which the PHS hospital system owes its existence intended contractual arrangements to be the primary basis for seamen medical care, and that the building and continued maintenance of a Federal hospital system was not contemplated. We cannot agree that such a system was not contemplated.

The PHS hospital Service traces its origin to the act of July 16, 1798, for the relief of sick and disabled seamen, 1 Stat. 605, which provided authority to the President to (1) receive donations of buildings or land upon which hospital buildings could be erected (section 4), (2) to erect hospital buildings specifically for the care of sick and disabled american seamen (sections 3 and 4), and (3) to appoint Directors of the "marine hospital of the United States" (section 5).

The legislative history of the 1798 act indicates clearly that the construction of a marine hospital system was contemplated. One of the principle grounds of congressional opposition to the bill was the fear that costs of the hospital system authorized to be constructed would outweigh the benefits to be derived from such a system. See Annals of Congress, 5th Congress, 1797-1799 Vol. II pp. 1326-1392, containing the following remarks excerpted from the house debate on the bill:

"Mr. SMALL said * * * the tax will fall upon no member of this House, but will be exclusively drawn from the earnings of a small part of the community, who, in all probability, will receive no advantages from it for fifty years to come as large and splendid

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buildings must first be erected, in order to exhibit to the world a specimen of public charity. (Id. p. 1386.)

"Mr. PINCKNEY was sorry to differ from his friend from Massachusetts * * *. Relief to distress is the first thing to be attended to, and if after affording this relief, the tax produces a sufficient surplus, it is to be employed in the erection of suitable, not large and splendid--buildings, as hospitals. (Id. p. 1387.)

"Besides, said Mr. S., this bill proposes the erection of public hospitals * * *. (Id. p. 1389.)

"Mr. GALLATIN said * * * 1stitutions of the kind recommended in this bill might be used in other countries * * *. How far marine hospitals had been useful in Europe he could not tell; he knew there were many rotten public institutions of hospitals, etc., there * * *. There was one part of the bill which he said he could not consent to vote for, viz: That part which directs the erection of buildings, as he was convinced that persons of every description may be better relieved by being dispersed through the country, than by being placed in a hospital." (Id. p. 1392.)

Also worth noting are the numerous references throughout the congressional record describing the bill as one providing for the support or erection of marine hospitals. See id. p. 1345, 1383, 1386.

The obligation to provide medical care and the concomitant obligation to maintain a hospital system to provide it have been characteristic of the NHS ever since the passage of the 1798 act, and, on the basis of this act numerous hospitals were constructed and maintained throughout the country during the 19th and 20th centuries.

In 1861, Secretary of the Treasury Chase found that the number of marine hospitals "has been increased far beyond necessity or utility." Secretary of Treasury, Annual Report, 1861, p. 27. Subsequently, as noted in the HEN memorandum, the Secretary was authorized under the act of April 20, 1865, Revised Statutes, as amended June 27, 1866, section 4006, to sell or lease such marine hospital buildings and lands as he deemed advisable. Most important to note, however, is the fact that Congress in giving such authority insured that the basic hospital system would be maintained by prohibiting the sale or lease of the hospitals at Portland, Maine, and Cleveland, Ohio, and provided that no hospital would be sold or leased if the relief furnished amounted to twenty cases a day. Moreover, only a few years later Congress passed the act of June 29, 1870,

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16 Stat. 169, providing for a central administrative agency for the Marine Hospital Service and for the appointment of a supervising surgeon who was to supervise "all matters connected with the Marine Hospital Service," thereby making clear its intent that the hospital system continue to be maintained.

Today, under the Public Health Service Act of 1944, 42 U.S.C. 201 et seq., the statutory basis for the continued maintenance of the PHS hospital system, in our opinion, remains. We agree with the view expressed in the HEM memorandum that the Congress in enacting the 1944 act assumed that the then existing PHS facilities would continue to be utilized, and thus maintained. (See page 7.)

A reading of the act shows it to be replete with references to the PHS hospital system and that a major portion of that law's provisions would be inoperable absent such a system. In reaching this conclusion, we are in agreement with a legal opinion prepared by Assistant General Counsel E. J. Bourke, Department of HEM dated December 17, 1963, and published in the 1965 Hearings on the proposed closing of PHS Hospitals before the Committee on Government Operations. In relevant part, the opinion states as follows:

"As indicated below, this conclusion rests in part upon a specific provision in the Public Health Service Act and more broadly on a variety of indications in that act that Congress intends the PHS to operate its own medical facilities. We do not think this intention is substantively qualified by the fact that provision is also made in the Public Service Health Act for the Service to obtain care for certain of its beneficiaries at other public or private facilities at Service expense.

"We may begin with the obligation of the Surgeon General to care for seamen and the other listed beneficiaries 'at hospitals and other stations of the Service' (Public Health Service Act, sec. 322(a)). We know of no reasonable way to read this provision except as imposing an obligation on the Surgeon General to establish and maintain medical facilities of the Service for the care of those who by statute are entitled to it. This literal reading of the provision is the only one in accord with the long history of the Marine Hospital Service which began in 1798 with an authority to construct hospitals specifically for the

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seaman beneficiary. The obligation to provide medical care and the concomitant obligation to maintain a hospital system to provide it have been characteristic of the PHS ever since.

"There are other provisions of the Public Health Service Act which are not operable in the absence of Service hospitals, institutions and stations. Thus the authority to admit and treat for purposes of study persons not otherwise eligible is an authority that can be exercised only at institutions, hospitals and stations of the Service (sec. 301(f)). Also, the authority to provide medical, surgical, and hospital services to EDC beneficiaries can be exercised only at institutions, hospitals, and stations of the Service (sec. 324). Finally, the authority to provide for narcotic addicts may be exercised only at hospitals of the Service (sec. 341). While these provisions do not require the exercise of the authority conferred, it seems obvious that Congress intended the authority to be exercised in appropriate situations; to this extent, appropriate medical facilities of the Service are required.

"Finally, there are other statutory provisions that certainly contemplate the operation of an appropriate PHS hospital system. Examples are the Surgeon General's authority to manage and operate hospitals and to establish new ones (sec. 321), the authority to care for certain persons at hospitals of the Service where detained by Immigration authority (sec. 502), and the authority to admit into any hospital, institution, or station of the Service insane persons entitled to Service treatment (sec. 504).

"We would thus conclude that there is no question but that the Public Health Service Act represents the congressional intent that a hospital system be operated and maintained by the Service to carry out the obligations imposed by or implicit in the several statutory provisions noted. (Underscoring added.)

"The fact that legal authority is given to the Service under section 322(e) to procure care at other than its own facilities in the case of specified beneficiaries, in

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our view does not reflect a congressional intention to offer the Service an alternative to the operation of its own hospital system. Rather this is a supplemental authority designed to assure prompt and adequate medical care to selected beneficiaries where Service facilities are not available. This conclusion is clearly supported first by the terms of the act which call for authorization by the medical officer in charge on application--an individualized determination. It is also supported by the legislative history of section 322(e).

"Thus in codifying the statutes relating to PHS in 1944, the significant committee report, that of the House, stated with respect to this subsection:

"Subsection (e) would authorize treatment of Service beneficiaries in other hospitals, at the expense of the Service, as provided in regulations. This provision, which would afford a statutory basis for present regulations, is designed to meet overflow conditions and cases where beneficiaries may be remote from any Service facility."

As indicated in Mr. Rourke's opinion, 42 U.S.C. 248(a) charges the Secretary with the management and operation of "all institutions, hospitals, and stations of the service" (emphasis added), and authorizes the Secretary, with Presidential approval, to "select sites for and establish institutions, hospitals, and stations" as deemed necessary. We find no provision in the act which authorizes the Secretary to close down the entire PHS hospital system by means of the sale or lease of all Service institutions, or by means of the utilization of contractual medical care arrangements.

With respect to the argument raised by the Department that the Federal Property and Administrative Services Act of 1949 authorizes the Secretary to transfer all hospital facilities to nonfederal ownership should he find such properties to be excess to the needs of the Department, we cannot agree.

"Excess property" is defined in the act, 40 U.S.C. 472(e), as property of a Federal agency "not required for its needs and the discharge of its responsibilities, as determined by the head thereof." We find

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nothing in the legislative history of the Federal Property and Administrative Services Act to suggest that the Congress intended the authority to dispose of excess property to be used by a Federal agency as a means of relieving itself of its statutory responsibilities. In our view, the utilization of such act as a vehicle for closing down the entire PHS medical facility system, and thereby effectively terminating the hospital medical care role performed by the PHS for the past 170 years, would be wholly inappropriate. Such action would relieve the agency of the function of maintaining a hospital system which, as we have shown above, has heretofore been considered by the Congress to be an essential statutory responsibility.

It is therefore our opinion that under the 1944 Public Health Service Act, the Congress intended that the hospital system characteristic of the Service since its inception in 1802 with the Marine Hospital is to be operated and maintained by the Service in order to carry out the functions and duties imposed by the 1944 act. In light of the foregoing, the Secretary may not, in our view, use his discretionary powers under the 1944 Public Health Service Act or the Federal Property and Administrative Services Act of 1949 to effect the closing of all PHS hospital facilities by means of the transfer of these institutions to nonfederal ownership.

2. Authority to Provide for Care of PHS Beneficiaries in other than PHS facilities.

Consistent with the foregoing, we stated in our June 7, 1965, decision that the Public Health Service Act "in the absence of Public Health Service facilities authorizes the referral of such beneficiaries, at the expense of the Service, to public or private hospitals (42 U.S.C. 249)." As pointed out above, the legislative history makes clear that this provision is designed to meet overflow conditions and cases where beneficiaries may be remote from any Service facility. 78th Congress, House Rept. 1364, April 28, 1944, on H.R. 4524. Accordingly, we would see no legal objection to the referral of PHS beneficiaries to other public or private facilities, under such limited circumstances.

3, 4. Priority of PHS Beneficiaries in VA Hospitals and Authority to Arrange for Cross-servicing of VA and PHS Beneficiaries.

Regarding the priority of PHS beneficiaries in VA hospitals, we stated in a letter dated June 22, 1965, copy enclosed, to Chairman Fountain, Intergovernmental Relations Subcommittee, House Committee on Government Operations, that the rendering of a service by an agency

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under section 601 of the Economy Act of 1932, 31 U.S.C. 686, which authorizes Federal departments and agencies to place orders for goods and services with other Federal agencies, if it can be considered a function of the agency rendering the service, is at best a secondary or incidental function, and that section 601 certainly was not intended to be a basis for transferring a primary administrative function from an agency in which it is vested by Congress.

Since by statute the primary function of the PHS is to provide care for seamen and that of the VA to provide care for veterans, we could not then, and do not now, see a legal basis for admitting merchant seamen to VA hospitals ahead of veterans eligible for treatment of nonservice-connected disabilities.

Regarding the authority to arrange for cross-servicing of VA and PHS beneficiaries, we stated in our June 22, 1965, letter that the admission of merchant seamen to VA hospitals would involve interagency services under 31 U.S.C. 686, since merchant seamen are not beneficiaries of the Veterans Administration, and that "except as a humanitarian service in emergency cases," the Administrator of Veterans Affairs would otherwise not be authorized to admit merchant seaman. See 38 U.S.C. 610, 611. Accordingly, and provided that the VA is "in a position to supply or equipped to render" the services requisitioned in accordance with the requirements of section 601 of the Economy Act, we see no legal objection to periodic arrangements for cross-servicing of VA and PHS beneficiaries.

We trust that the above is responsive to your request.

Sincerely yours,

(SIGNED) ELMER B. STAATS

Comptroller General
of the United States

Enclosure

The Honorable Edward A. Carmatz, Chairman
Committee on Merchant Marine and Fisheries
House of Representatives



COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

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June 7, 1965

Dear Mr. Chairman:

Your letter dated April 13, 1965, requests our views on several legal questions which arose during the recent hearings of your committee on the proposed administrative closing of designated Public Health Service hospitals, announced January 19, 1965, by the Secretary of Health, Education, and Welfare.

To briefly summarize the situation, the Department of Health, Education, and Welfare contemplates closing, over the period ending with the fiscal year 1968 or 1969, seven of the twelve general hospitals of the Public Health Service. The hospitals to be closed are in Chicago, Memphis, Savannah, Boston, Galveston, Norfolk and Detroit. They are the smallest of the Service's general hospitals, having a capacity of 1,035 beds, or approximately 35 percent of the present bed capacity of the twelve hospitals.

The closed hospitals are to be converted to outpatient clinics which will refer Public Health Service beneficiaries in need of hospitalization to Veterans Administration, Department of Defense, or local community hospitals. Merchant seamen, the largest category of Public Health Service beneficiaries, are to be referred to Veterans Administration hospitals, and it is contemplated the Veterans Administration will give the merchant seamen a higher priority in admission to its hospitals than veterans with nonservice-connected disabilities.

The five remaining Public Health Service hospitals, located at Staten Island, Baltimore, New Orleans, San Francisco, and Seattle, are to be modernized and enlarged from a bed capacity of 1,937 to not more than 2,400, or an increase of about twenty percent. In the course of the hearings your committee was informed that a study was being conducted, by the Office of Science and Technology, to weigh the merits of transferring responsibility for the health care of American seamen, and the five remaining Public Health Service general hospitals, to the Veterans Administration.

In view of the foregoing the questions arose, on which our opinion is requested, "as to the authority of the Department of Health, Education, and Welfare to close any or all of the Public Health Service hospitals and to transfer a statutory responsibility to another government agency." Also, "The questions arose as to the authority of the Veterans Administrator to render hospital care to Public Health Service beneficiaries in preference to veterans of any category and under what authority, if any, can nonveterans be treated at Veterans Administration hospitals."

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The Public Health Service Act, as amended (42 U.S.C. 201, et seq.), contemplates the operation by the Public Health Service, Department of Health, Education, and Welfare, of hospitals and other stations for the care of certain beneficiaries, such as merchant seamen, and in the absence of Public Health Service facilities authorizes the referral of such beneficiaries, at the expense of the Service, to public or private hospitals. § 249. The act also states that any executive department, in accordance with the interdepartmental service provisions of 31 U.S.C. 686, may perform work or service for the Public Health Service. § 254.

The Surgeon General, who administers the Public Health Service, is empowered by the Public Health Service Act to "control, manage, and operate all institutions, hospitals, and stations of the Service * * *." § 240(a). Our examination of the act does not disclose a substantive basis for restrictively construing the general administrative powers thus conferred. Rather, in the context of providing medical care, involving professional judgment, we consider inherent in the power to control, manage, and operate the Service's various health facilities, the discretionary authority to close and convert to outpatient clinics one or more of the Service's general hospitals. The closing, however, of all Public Health Service general hospitals, with general referral of beneficiaries to facilities outside the Service, would in our opinion be an unwarranted extension of the Surgeon General's discretionary authority.

While we consider the proposed conversion of the seven smallest hospitals to outpatient clinics to be within administrative authority where the treatment of Public Health Service beneficiaries may otherwise be provided, we do not view the contemplated interdepartmental transfer of the remaining five Public Health Service hospitals, together with responsibility for the health care of merchant seamen, as encompassed by that authority. The accomplishment of the latter transfer of facilities and responsibility would require a Reorganization Plan, in the event the Reorganization Act is extended beyond June 1, 1965, or a legislative enactment. This view of the matter we understand is also entertained by the Department of Health, Education, and Welfare.

In considering your questions with reference to the rendering of hospital care by the Veterans Administration to nonveterans, we particularly noted the memorandum dated March 25, 1965, of the Assistant General Counsel, Veterans Administration, which appears on page 227 of your Committee's hearings. We concur in his position that the Veterans Administration may furnish, in accordance with the provisions of 31 U.S.C. 686, hospital care on a reimbursable basis to beneficiaries of other Federal agencies where facilities are available.

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Section 686 provides for interagency furnishing, on a reimbursable basis, of "material, supplies, equipment, work, or services of any kind that [the] requisitioned Federal agency may be in a position to supply or equipped to render * * *." In concluding that the Veterans Administration may furnish hospital care to nonveterans on a space available basis under a section 686 arrangement, we have not overlooked the existence of section 5003 of Title 38, United States Code, authorizing the Veterans Administration and the Armed Forces to enter into "contracts for the mutual use or exchange of use of hospitals and domiciliary facilities, and such supplies, equipment, and material as may be needed to operate such facilities properly, or for the transfer, without reimbursement of appropriations, of facilities, supplies, equipment, or material necessary and proper for authorized care for veterans." Section 5003 is in effect an extension of the scope of section 686 in that it provides for the mutual use or exchange of hospitals and the transfer of such facilities, etc., without reimbursement. Section 5003 is not in conflict with section 686, and is not viewed as precluding resort to the interagency service provisions of the latter.

However, the use of section 686 would require the Veterans Administration to be in a position to supply or equipped to render the requested services. See 23 Comp. Gen. 935. And we are of the opinion that the situation of being in a position to render service cannot be artificially created by the promulgation of an administrative regulation, under 38 U.S.C. 621, which would subordinate statutory beneficiaries of the Veterans Administration to beneficiaries of other agencies and constitute a relinquishment of the Veterans Administration's primary responsibility. See 38 U.S.C. 201, 610, and 5003; United States v. St. Paul Mercury Indemnity Company, 133 F. Supp. (1955) 726, 735, 736, affirmed 238 F. 2d 594; United States v. Alperstein, 183 F. Supp. (1960) 548, affirmed 291 F. 2d 455.

We believe the foregoing answers the questions submitted but we shall be pleased to consider any additional aspects you may wish to explore.

Sincerely yours,

Joseph Campbell

Comptroller General
of the United States

The Honorable Herbert C. Bonner, Chairman
Committee on Merchant Marine and Fisheries
House of Representatives

Mr. DEMBLING. As was made clear in those opinions, the General Accounting Office would view action by the Department of Health, Education and Welfare to close down the entire public health service hospital system as an unwarranted extension of the legal authority contained in the Public Health Service Act of 1944 under which the Secretary operates and manages these facilities.

In our view, such an action by the Secretary would run contrary to the intent of the Congress as manifested in the 1944 act.

Moreover, as pointed out in our February 23d opinion, this interpretation of the 1944 Public Health Service Act, is the only one in accord with the long history of the predecessor of the Public Health Service, the so-called Marine Hospital Service which was established by the act of July 16, 1798.

Whether the Public Health Service should be authorized to close the marine hospitals is a matter of policy for the Congress to determine, and one on which we would make no recommendation.

We agree, however, that Senate Concurrent Resolution 6, which expresses the sense of Congress that the present hospital system be maintained and considered as an integral part of the Nation's medical care facility is consistent with the present law and the long history of hospital use in this Nation.

That summarizes my statement, and I would like to offer the complete statement for the record together with the two opinions referred to.

Senator KENNEDY. They have been included in their entirety. Do I gather that you feel the administration could close the Public Health Service Hospitals with the exception of one and still be within its legal authority?

Mr. DEMBLING. Well, we put it in terms of the intent of the Congress to maintain a public health service system. Whether one could constitute a system is hard to reconcile with the basic concept of having some kind of a system. It was more directed to the fact that if they closed one or two, that might be within the intent of the Congress, but there has to be a system maintained under the law, as we interpret it.

Senator KENNEDY. Do you think it is completely within their authority to close eight?

Mr. DEMBLING. The closing of all eight would be an unwarranted extension of the legal authority. We felt as we read the law and the legislative history that this would be contrary to the intent of the Congress.

Senator KENNEDY. Would be contrary?

Mr. DEMBLING. Would be contrary, yes, sir.

Senator KENNEDY. Even providing for the beneficiaries in contractual kinds of arrangements?

Mr. DEMBLING. That appears to us as not maintaining a system. The long history of the public health service system starting in 1798, was always one where a system was spoken of, and considered.

The transfer of the authority, we felt, was not within that concept.

Senator KENNEDY. I know we are not getting into the legal niceties on this, but this is what we wanted to get from you. You think it is an unwarranted exercise of authority in closing eight hospitals. What about 3?

Mr. DEMBLING. I don't want to beg the question, but I think what has to be considered is what is a system within the concept of the entire Public Health Service. If a system could be maintained with three hospitals or four hospitals and it was considered so by the Congress, then you would have complied with the law as we interpret it.

Senator KENNEDY. Does HEW have the legal authority or power to turn these hospitals over to local community groups?

Mr. DEMBLING. Well, I don't know what their exact plan is, and we have not studied it. I first heard about it when Dr. Egeberg testified before the House Committee. We did make a comment with regard to transfer of such a hospital system to non-Federal ownership, if it were done under the Federal Property and Administrative Services Act of 1949.

This was the argument raised by the Department of HEW. The Department felt that the Federal Property and Administrative Services Act of 1949 authorized the Secretary to transfer all hospital facilities to non-Federal ownership should he find such property to be excess to the needs of the Department.

We cannot agree that this is within the authority of the Secretary, because excess property as defined in the act is property of a Federal agency not required for its needs and the discharge of its responsibilities as determined by the head thereof.

Therefore, we found nothing in the legislative history of the Federal Property and Administrative Services Act to suggest that the Congress intended the authority to dispose of excess property to be used by Federal Agencies as a means of relieving itself of its statutory responsibility.

So if the Department intends to use the Federal Property and Administrative Services Act to transfer the Public Health Services System to non-Federal ownership, we don't feel that that is within the intent of that act, sir.

Senator KENNEDY. If the property is considered by one agency to be excess property, another Government agency has first crack at it, but if it is considered excess by other Federal agencies, then is it available to private bidding?

Mr. DEMBLING. It is available to, as I recall, educational institutions and then for private bidding; yes, sir.

Senator KENNEDY. So in effect the Federal Government would be able to turn a facility or Federal property over to a community?

Mr. DEMBLING. Yes, I believe that is correct, Mr. Chairman. If the transfer is to be made under the Federal Property and Administrative Services Act, they would have to comply with the procedures prescribed in the act and with the regulations issued thereunder. This would be the excess property route.

Senator KENNEDY. The excess property route?

Mr. DEMBLING. Yes, sir. Now, there may be some other approach that the Department plans to take, but that was not spelled out by the testimony nor in any plan that we have seen.

Senator KENNEDY. That is very interesting, and very helpful. It is also very confusing. [Laughter.]

But I see some extraordinary kinds of legal problems, let alone having adequate delivery of health care and meeting responsibilities in this area.

Senator DOMINICK. Mr. Dembling, on page 2 in the first paragraph, you say :

As was made clear in these opinions, we view the action by the Department of HEW to close down the entire Public Health Service Hospital System as an unwarranted extension of the legal authority contained in the Public Health Service Act of 1944.

You refer specifically in there to the words "close down." As I understand it from listening to Dr. Egeberg, the closing down of the entire system is not one of the alternatives which is being considered.

What they are doing is saying that we are going to provide the services, but the operation or control of this may be in another group.

This is not, in other words, closing down a hospital. Now does that have any bearing on it?

Being a lawyer, I was interested in your words "closed down" which I did not think followed the picture as presented by Dr. Egeberg.

Mr. DEMBLING. I think that is correct, Senator Dominick. Our February 23 opinion was directed to the chairman of the Merchant Marine and Fisheries in response to several questions that he had.

When we were asked to appear before this committee, it was in those terms that we were requested to make our statement.

We were not aware at the time that there was any other consideration being given by HEW to maintain this system in any fashion.

So that was correct, those words were used, "to close down" the entire system is what we meant to say. We did not address ourselves to any other proposal that came about after we were notified.

Senator DOMINICK. So that you really have not had the opportunity then to determine whether or not under the existing law it would be possible to transfer operational control of these hospitals into the other groups through health maintenance organization or otherwise?

Mr. DEMBLING. I have not had a complete opportunity to look into all other proposals; however, as I stated earlier, we did look into the proposal of transfer of hospital facilities under the Federal Property and Administrative Services Act of 1949.

Senator DOMINICK. That is what we call the excess property law.

Mr. DEMBLING. Yes.

Senator DOMINICK. I can understand that.

Mr. DEMBLING. The only other consideration I might inject here, and that is not based upon a complete consideration of what HEW's proposal might be, would be that the legislative history of the Public Health Service indicates that the Congress intended throughout the long history of this system to maintain a system under Federal control and consequently there might be some conflict there if it were turned over to some other organization or local community-type organization in toto.

Senator DOMINICK. If, however, they had a federally paid hospital administrator, and the governing board was a local board which opened the hospital, not only to primary beneficiaries but to the public at large, this might fit within that concept?

Mr. DEMBLING. It might, sir.

Senator DOMINICK. All I can see is that we have some knotty problems here, legally and otherwise. Mr. Chairman, I wonder if it won't be of help to have Mr. Dembling review the statement of Mr. Egeberg and see whether or not changes would be made in the law.

Senator KENNEDY. If you would do that, we would appreciate it. I imagine that the testimony is not drafted as a legal document, and therefore it is going to put an extensive burden on you; but to the extent that you can provide us with whatever information on that point you can, it would be of value to the subcommittee, and we would appreciate it.

Mr. DEMBLING. We certainly will.

(The information referred to and subsequently supplied follows:)

GAO REPORT ON DR. EGEBERG'S PREPARED STATEMENT

We have reviewed Dr. Egeberg's testimony as you requested. Since it lacks specificity as to the method or methods to be used in the conversion which the Department of Health, Education and Welfare proposes, we do not feel that we could render a meaningful determination.

* * * * *

Regarding the question of whether HEW can use its authority under section 322, subsections (d) and (e), to enter into contractual arrangements with other public or private hospitals for the care and treatment of all PHS beneficiaries, we do not think these provisions afford a statutory basis for the contracting out of all such PHS medical care services.

As we stated in our opinion of February 23, 1971, the 1944 Public Health Service Act requires the maintenance of a working PHS hospital system. Since the contracting out of all such PHS medical care services would of necessity result in the elimination of the existing PHS hospital system, such action would, in our opinion, run contrary to the intent of the Congress as expressed in the act that such a system be maintained. In other words, we view the contracting authority as supplementing the requirement to maintain a hospital system.

Concerning Senator Dominick's thought of contracting out the operation of a hospital and providing services not only to primary beneficiaries but to the public at large, we think that legislation would be required for either the Public Health Service or one of its contractors to render the services to the public generally.

Senator KENNEDY. Let me ask one final question. Are there contractual limitations under the Public Health Service legislation which limits the Public Health Service from contracting out all of its services?

Could the public health system exist solely on contracts?

Mr. DEMBLING. I believe the Public Health Service does have contracting out authority. Whether it has the authority to contract out its entire operation is another question.

You get into a question of how far Federal agencies may contract out their own statutory responsibilities.

Senator KENNEDY. Could you, as an addendum to the request of Senator Dominick, give us what you think are the restrictions and the abilities for contracting out services?

Mr. DEMBLING. Yes, sir, we would be happy to.

Senator KENNEDY. We would appreciate having that.

Is there anything you other gentlemen would care to add?

Mr. MOORE. I have nothing, sir.

Mr. WADE. I have nothing, sir.

Senator KENNEDY. We want to express our appreciation to the GAO, which has been great service to us in Congress.

Mr. DEMBLING. Thank you.

(The prepared statement of Mr. Dembling follows:)

United States General Accounting Office
Washington, D. C. 20548

FOR RELEASE ON DELIVERY
Expected at 10:00 a.m. EST
Monday, March 8, 1971

STATEMENT OF
PAUL G. DEMELING
GENERAL COUNSEL
BEFORE THE
SUBCOMMITTEE ON HEALTH,
SENATE COMMITTEE ON LABOR AND PUBLIC WELFARE
UNITED STATES SENATE
ON
THE PROPOSED CLOSINGS OF PUBLIC
HEALTH SERVICE HOSPITALS BY THE DEPARTMENT OF HEALTH, EDUCATION,
AND WELFARE (S. CON. RES. 6)

Mr. Chairman and Members of the Subcommittee:

We appreciate this opportunity to appear before your subcommittee to present our views on S. Con. Res. 6 on the proposed closings of the Public Health Service Hospitals by the Department of Health, Education, and Welfare. The purpose of the resolution is to express the sense of the Congress that the existing facilities be maintained for the present and be considered as an integral part of the nation's health delivery system.

As you know, the proposed closings have been the subject of two legal opinions rendered by the Comptroller General; one in June, 1965 and the most recent one of February 23, of this year. Last month's opinion was rendered to the Chairman of the House Committee on Merchant Marine and Fisheries, in response to his request for our current views on this

matter. I have copies of this opinion, if you wish to have it inserted in the record.

As was made clear in those opinions, we would view action by the Department of Health, Education, and Welfare to close down the entire Public Health Service hospital system as an unwarranted extension of the legal authority contained in the Public Health Service Act of 1944 under which the Secretary operates and manages these facilities. In our view such action by the Secretary would run contrary to the intent of the Congress as manifested in the 1944 act. As we indicated in our February 23rd letter, that Act codified then existing Public Health Service laws which trace their origin back to 1798, at which time authority was given to the President to construct the first Marine hospital.

There are numerous indications in the 1944 Public Health Service Act that the Congress intended the Public Health Service to continue to operate and maintain its own medical facilities. The act is replete with references to the "institutions, hospitals, and stations of the Service." Section 321 provides authority to the Secretary to operate and maintain Public Health Service hospitals. Section 322 sets forth the obligation of the Secretary to care for seamen and other listed beneficiaries at Service institutions, hospitals, and stations; section 301 provides authority to admit and treat at "hospitals and stations of the Service" persons not otherwise eligible, for purposes of study; Section 324 confers authority on the Secretary to provide medical,

surgical, and hospital services and supplies to Bureau of Employee Compensation beneficiaries, another authority that can only be exercised at institutions, hospitals, and stations of the Service; section 326 entitles certain Coast Guard personnel and public health service officers to medical and surgical treatment and hospitalization by the Service; provision is also made for treatment of narcotic addicts and persons afflicted with leprosy at specially equipped Service hospitals (sections 331, 341, and 344); and section 328 provides for the sharing of facilities and resources by the Public Health Service hospitals and other community health care facilities. It seems clear that these provisions would be inoperable and meaningless in the absence of institutions, hospitals, and stations of the Service, and that there is no reasonable way to read these provisions except as imposing an obligation on the Secretary to establish and maintain such facilities for the care of those who are by the statute entitled to it.

Moreover, as pointed out in our February 23 opinion, this interpretation of the 1944 Public Health Service Act is the only one in accord with the long history of the predecessor of the Public Health Service, the Marine Hospital Service, which was established by the act of July 16, 1798. This act conferred authority on the President to construct hospitals specifically for seamen. The legislative history of that act clearly indicates that the construction of a marine hospital system was contemplated. As we stated in our letter of February 23, 1971, the obligation to provide medical care and the concomitant obligation to

maintain a hospital system to provide such care have been characteristic of the Public Health Service ever since the passage of the 1798 act. In enacting the 1944 Public Health Service Act, it seems clear that the Congress assumed the continued maintenance of the existing system as a necessary condition to the effective implementation of the act's essential provisions, as I have just outlined.

It should also be noted that in a legal opinion by the Assistant General Counsel of the Department of HEW dated December 17, 1963, he stated:

"We would thus conclude that there is no question but that the Public Health Service Act represents the congressional intent that a hospital system be operated and maintained by the Service to carry out the obligations imposed by or implicit in the several statutory provisions noted."

With respect to the authority of the Veterans Administration to provide care for beneficiaries of the Public Health Service, we pointed out in our February 23rd letter that we see no legal objection to periodic arrangements for cross-servicing of VA and Public Health Service beneficiaries. Since merchant seamen are not beneficiaries of the VA, the admission of merchant seamen to VA hospitals would involve interagency services under section 601 of the Economy Act of 1932, 31 U.S.C. 686, which authorizes Federal departments and agencies to place orders for goods and services with other Federal agencies on a reimbursable basis. Section 601 also requires that the requisitioned Federal agency be in a position to provide the services requested, which has been construed by

the Comptroller General to mean that the rendering agency can do so without necessitating construction or other capital expenditure which would be unnecessary if the requested services were not to be provided. In view of this and the fact that under 38 U.S.C. 611 the Administrator of the VA may furnish hospital care to non-VA beneficiaries as a humanitarian service in emergency cases, it is generally recognized that Public Health Service beneficiaries may under such circumstances be admitted to VA Hospitals on a space available basis. However, providing such services under the Economy Act is at best a secondary or incidental function of the agency rendering the service and section 601 certainly was not intended to be a basis for transferring a primary administrative function from one agency to another. Accordingly, the VA could not assume overall responsibility for Public Health Service beneficiaries under such authority.

Whether the Public Health Service should be authorized to close the marine hospitals is a matter of policy for the Congress to determine and one on which we would make no recommendation. We agree, however, that the S. Con. Res. 6 which expresses the sense of Congress that the present Public Health Service Hospital System be maintained and considered as an integral part of the nation's medical care facilities is consistent with present law and with the long history of the Public Health Service Hospital System in this nation.

Senator KENNEDY. The next witness is John Walsh, vice president for health affairs at Tulane University; Dr. Walsh, in addition to his present position at Tulane University, has served as coordinator of the health services program and as dean of the school of medicine.

He has served as assistant to the Surgeon General of the United States and is currently a member of the Louisiana Health Planning Council.

I understand you do not have a prepared statement, but we are delighted to have you with us.

STATEMENT OF DR. JOHN WALSH, VICE PRESIDENT FOR HEALTH AFFAIRS, TULANE UNIVERSITY SCHOOL OF MEDICINE, NEW ORLEANS, LA.

Dr. WALSH. Thank you, Mr. Chairman.

I am here as a representative of the Association of American Medical Colleges to speak in opposition to the closure or transfer of the Public Health Service hospital system to nonfederal auspices.

I think that you, Mr. Chairman, well defined the differences in philosophies today; that is, the approach of the administration, or at least of HEW, in looking at the Public Health Service hospital system as a burden rather than an unparalleled opportunity which may not, or may not as favorably be available to the Government in the future.

I would like to raise a few points along those lines. To begin with, this committee is well aware of the problems, the difficulties, the complications of our health care system today.

There is no question that this is probably the largest single problem facing public administrators locally, regionally, and nationally.

There is no question, that if we continue to provide health care in the manner in which we have been providing it, there will never be enough people or facilities or dollars.

This leads to the first reason why I feel this hospital system should be kept open, and that relates to its potential as a controlled laboratory for research in health services organization and delivery.

These hospitals represent an unusual opportunity although they are only a handful in number. With a relatively modest investment by the government we can have for the first time institutions that from the moment of their design through construction, and through operation, can present unparalleled opportunities for research in health care.

I am talking about in such areas as how should health facilities be constructed? Not only their configuration, not only the materials that are used, but what should be the spatial relationships of the services within these facilities?

They provide an opportunity in a sense to function as an underwriters laboratory in terms of equipment. You are all aware of the tremendous problems that face medicine today in terms of expensive, sophisticated equipment. Yet, we really don't have performance standards.

We don't have standards to say which are the best cardiac monitors. We talk glibly of using computers in hospitals, and yet there are literally dozens of types of input and output devices which will be available and are available on the market. In any computerized appli-

cation in a hospital, these terminals are going to have to be put in various locations in the hospital, and they are going to have to be used by professional personnel.

Somewhere, somehow, there has to be a laboratory to evaluate these. What are the most durable, most economical, most acceptable to the professionals?

This type of study is being done in a piecemeal fashion in institutions in the country today. But to my knowledge there is no institution which, aside from providing quality health care, is concerned with studying health services in terms of organization and delivery and similar problems of disposable supplies, control of supplies, types of supplies.

As pointed out earlier by Mr. Beall, the biggest saving, the biggest step that we can make in terms of improving health care is to solve the manpower problem.

These hospitals again represent a controlled environment, a laboratory to study, the utilization of existing personnel. What are staffing requirements? How much nursing time is really needed for a particular type of patient?

Are there new types of personnel, social work aids, various types of special aids which can be developed. Again, as I said, I think that the greatest potential for these hospitals is as a series of laboratories to study how we can best deliver health care most efficiently and most economically.

The controllability of their environment makes them unique and desirable for this purpose, just as their unusual mix of patients with respect to age and sex make them invaluable in this sense.

There is another reason why I oppose the transfer of these facilities to non-Federal auspices, and that relates to the Emergency Health Personnel Act. There are eight hospitals and 30 clinics, and as pointed out earlier, by you, Mr. Chairman, in none of these 38 cities are all citizens being provided with adequate medical care.

Basically this means that maintaining this hospital system and using it as a base, the Government can immediately act to provide health care in these 38 localities.

I think it was mentioned earlier this morning that Baltimore has 170,000 people who are not getting medical care.

It was also mentioned earlier this morning, I believe by Dr. Wilson, that there was not a real bed problem in New Orleans. I disagree with that.

Currently, both medical schools, LSU and Tulane, are developing plans for private hospitals, because there are not now enough private hospital beds to serve the needs of their faculty and their students.

Charity Hospital, which is one of the great hospitals of this world, on the average day turns away 20 or 30 people who should be hospitalized because there are not facilities available.

It is particularly hard for me to understand in the light of the authorities of the Emergency Health Personnel Act and in terms of section 328 of the partnership for health bill, that these hospitals have not been used to help provide care to the medically indigent in these cities.

Of importance, I think, and to be pointed out, is the fact that in each of these hospitals there is an ongoing team already funded

which would support and back up these personnel brought in under the Emergency Health Personnel Act. There would be a great multiplier effect in terms of amount of services offered for the same total cost.

Thus by maintaining these hospitals and clinics in operation under Federal auspices and using them in this way means that not only can the Government without delay implement the purposes and intent of this act, but it can do it at much less cost, and with a greater yield.

Speaking of costs, there is a third reason why I recommend that these hospitals remain under Federal control, and that is the economics of the situation. There is no question that in every city in this country in which there is a public health hospital, the cost of hospital days in the nonpublic health service institutions is approximately twice what it is in the Federal facilities. As pointed out earlier by the gentleman from Maryland, this does not include physicians costs, which are included in the public health service per diem cost.

Senator KENNEDY. Why is that?

Dr. WALSH. Why is what, Mr. Chairman.

Senator KENNEDY. Why double the cost?

Dr. WALSH. There are many reasons. In terms of the transfer to a nonprivate agency, the Government normally does not insure its facilities. Any private agency would. This would add \$100,000 or \$150,000 a year in the case of the New Orleans hospital.

The Government has a much more favorable discount rate in terms of purchasing than the nonprofit institutions which would run these.

The physician and dentist in the public health service are paid at a rate which is much less than we pay civilian physicians and dentists.

Now, there are other incidental reasons. Some are insignificant. The support of the Federal Government in terms of consultations, in terms of support services, the services of GAO, this sort of thing, which have to be purchased by a non-Federal operation.

There is no question in my mind that the transfer of these facilities and the obligation for the care of these patients to private or nonprofit institutions would result in a cost of one and a half to two times what it is now, and we would lose the golden opportunity to use them to solve some of the health care problems we have.

Senator KENNEDY. Why wouldn't it be worthwhile for us to try to find ways in which the Federal Government could bring down insurance premiums, or try to find ways for purchasing various goods needed by hospitals that will help bring these costs down?

Dr. WALSH. You mean generally?

Senator KENNEDY. Perhaps there is a variety of different advantages the Federal Government has that would help lower the costs.

Dr. WALSH. I think this really goes to the point of my argument, that these hospitals present this type of a laboratory environment to study just this type of problem. For example, we talk about utilizing personnel under the Emergency Health Personnel Act, we can say rather glibly that we will assign people to the ghettos but there is a lot more to it than that.

Such assignees need a team and an institution to back them up. Very importantly there are many questions that must be answered. How do we inculcate in these people a responsibility to continue to come back for their own health care?

What are the tradeoffs in terms of certain types of preventive health services?

Merely to go out and provide these services in a noncontrolled way, in a nondesigned, nonobjective, nonmeasured way, will not help us very much. Rather, we will tend to perpetuate what we are doing now, or we will learn indirectly, expensively, and over a longer period of time.

I would like to use these hospitals to see how we provide this care to these people under the best possible fashion.

There is another reason I would like to see these hospitals continue under Federal auspices.

Senator KENNEDY. I don't want to keep interrupting you, but is one of your points that public health can provide a measuring factor against some of the public hospitals, and perhaps even against the private hospitals in holding down costs?

Dr. WALSH. Yes, sir. As I said, even to determining performance standards for equipment. There is no real way today to evaluate medical equipment objectively and completely.

There is no way to determine that this type of terminal for a computer is acceptable over all the others, is not as noisy, is less expensive, is acceptable to the professional. This applies to all aspects—even floor buffers. You can go up and down the line. We need something like that if we are going to solve the problems of cost and of utilization of people and resources.

There is an opportunity to develop these hospitals, as specifically oriented toward health services research and development. There is another area of concern. That is the career role of the PHS hospitals in the Public Health Service. For recruitment and training and experience of career public health service personnel.

When health is the second or third largest industry in the country, when the Government is assuming an ever-increasingly large and responsible role in health care, it seems to me that more than ever we need knowledgeable, experienced, objective administrators working in the principal health agency of the Government.

I won't go into detail with respect to training. Mr. Magnuson described, this morning, the teaching role of these hospitals. Certainly internally in terms of the interns, residents, medical school teaching. In terms of the community teaching, their role is vital.

For example, the PHS hospital in New Orleans has trained 1,400 people under various economic opportunity programs and other programs.

The main concern is that if these hospitals are transferred, there is no certainty that the internal, let alone the external programs will be continued. So there is a very real reason to keep them open to assure this.

Reference has been made earlier to the community value of these hospitals. And it has a very broad spectrum. In some places they represent the locus of the poison control center. In other places, they have provided the major disaster teams, major sources of disaster relief. The important thing is that as a Federal institution, as a controllable institution, the PHS hospital can engage in programs and services in the community which private and nonprofit institutions cannot.

The PHS hospitals are above local pressures, above local interests. They are not composed of various divergent groups who may or may not implement a new or exciting program.

I think the last reason I would like to advance for the maintenance of these hospitals under Federal auspices is the problem of patient care.

Again, as you are aware, these hospitals are directed primarily to the care of the merchant seamen. They are not a large population, but they have been Government wards in the medical sense for 173 or 174 years.

These people are nomadic, transient. I think any of you who have had experience in terms of elective hospitalization realize what difficulties these patients would encounter in terms of seeing a physician or being admitted to a hospital when they are in and out of a strange town in a matter of hours.

It also relates to the Department of Defense dependents who, as pointed out earlier, would experience increased costs should these hospitals no longer be available to them.

So you are taking two large groups of people and you are raising barriers to their continuing to get good health care. It is all right to speak idealistically that they will get it from other sources. But it has been well established that when these other sources represent multiple rather than single sources, and require an increased outlay of expense on the part of the patient, the patient will not continue to get the same level of care.

Finally, I don't think any conclusions can be drawn in terms of what happened to the Public Health Services beneficiaries after the closure of the hospitals in Savannah or Detroit, because nobody studied them. Those who have appeared for care at various contractual hospitals and physicians have received treatment. Those who have not, we know nothing about.

So that I think it is an unwarranted assumption to postulate that the care of these patients has not deteriorated.

So, as I have said, then, in summary this is an unparalleled opportunity for the Government to make an unusually effective effort in attempting to solve our problems in the cost, the organization, and delivery of health care.

I would hate to see it go down the drain. Thank you, Mr. Chairman.

Senator KENNEDY. Thank you very much. I would think it might be useful for us to request from the Department that they review the closing and give us a study as to what the effect has been within these various communities.

Dr. WALSH. The unfortunate thing is, in a way it is like an audit. It will pick up the positive, but not the negative. They will be able to report what people went to what contract facilities how often at what cost.

But without considerable effort and dedication, HEW will not be able to tell you how many people were unable to obtain care, how many people did not go to physicians when they needed it, how many people neglected dental care or may be some of the less central or vital parts of health services because they had to go to multiple sources to get this care, or had to pay more money to receive it.

Senator KENNEDY. Your testimony is extremely compelling and very, very valuable.

I think it is of even greater significance and consequence this year because, as you pointed out in your testimony, the President has recognized that a health crisis exists in this country, and has proposed some rather extensive legislation to this subcommittee and other committees on how to address this problem.

There are others on this subcommittee who have proposed a rather dramatic change in the financing of delivery systems; therefore there is really a focus of intentions of the country around this question to a greater extent now than at any time before in the history of our country.

So when we talk about utilizing these facilities for innovative, creative and imaginative programs in the delivery of services and the opportunities to do so under the Emergency Health Manpower Act, it would seem that there is a great public interest served by their continuation. I think that you have made this case extremely well, and certainly you represent my view, and I think that hopefully the administration will listen to it.

Dr. WALSH. Thank you, Mr. Chairman.

Senator KENNEDY. Senator Javits is unavoidably detained this morning but provided us with a statement that will be printed at this time.

(The prepared statement of Senator Javits follows:)

**PREPARED STATEMENT OF HON. JACOB K. JAVITS, A U.S. SENATOR
FROM THE STATE OF NEW YORK**

Senator JAVITS. First, I would like to welcome to this hearing the borough president of Richmond, Robert T. Connor, who has taken a leadership role and joined me in urging the maintenance and improvement of the Staten Island Public Health Service Hospital to provide the needed medical services for the local Staten Island community. Richmond Borough President Connor has also made great efforts to explore alternatives to determine how the facilities could, if necessary, be most effectively converted to local control and use.

As a cosponsor of Senate Concurrent Resolution 6, which expresses the sense of Congress that our Public Health Service hospitals and outpatient clinics should be continued as an integral part of the national health care system and having regularly expressed to the Secretary of HEW my deep concern about the future of the Staten Island Public Health Service Hospital, I congratulate the chairman for having initiated this hearing.

At a time when the Nation is faced with a health care crisis—about which the President, the Secretary of HEW, many Members of Congress and I have expressed grave concern—I believe the Staten Island Public Health Hospital and other Public Health Service hospitals and clinics should be strengthened and modernized in order to better perform their traditional function and allow them to undertake new missions.

I would recommend these professionally excellent facilities be given a new mission—in accord with present and future national health care

needs—so that they might, for example, pioneer and develop model health care delivery systems and serve as demonstration centers for experimental programs utilizing corpsmen and other paramedical personnel to provide health services.

Senator KENNEDY. The subcommittee now calls on Mr. Robert T. Connor, who is president of the Borough of Richmond, Staten Island, N.Y.

Mr. Connor is a member of the Board of Estimate of New York City, a former member of the City Council of New York and former vice president and general manager of the largest privately owned marine terminal in New York City.

**STATEMENT OF ROBERT T. CONNOR, PRESIDENT, BOROUGH OF
RICHMOND, STATEN ISLAND, N.Y.**

Mr. CONNOR. Mr. Chairman, permit me at the outset, to commend you, Senator Kennedy, for taking the time for this hearing on a matter which affects the economic welfare of the citizens of the country, and particularly of the residents of the Borough of Richmond, which presently has 300,000 residents and is growing alarmingly fast.

It is the fastest growing borough of New York City and one of the fastest growing in the country.

Having been on what I would call the receiving end of many, many of these hearings, I shall be mercifully brief, and I have omitted part of my statement.

While I realize that your subcommittee will be looking into the status of public health hospitals throughout the country, my prime concern obviously is that of the Public Health Service hospital that is located on Staten Island.

I think it would be helpful if you had a picture of the hospital which my aide will give you.

(The photograph referred to follows:)



Mr. CONNOR. Incidentally, this hospital is the largest of all the Public Health Service hospitals throughout the United States. It has accommodations for 636 beds and has an annual payroll of approximately \$13.6 million dollars.

There are many reasons why the Public Health Service hospital on Staten Island should be maintained as a hospital facility. The prime reason, of course, is that there is an acute shortage of hospital beds on Staten Island.

Incidentally, the Borough of Richmond, Staten Island, and the county, are all used interchangeably.

At present, we have four hospitals operating on the island, three of them are eleemosynary and one is proprietary.

Each institution is operating at a capacity in excess of that for which it was constructed. This in itself creates a health hazard, since all too often patients are compelled to remain in beds located in the hallways.

In addition, doctors are constantly compelled to advise their patients who need hospitalization that they cannot be admitted since there is no space for them.

This is the non-Federal hospital. I would next like to bring to your attention the fact that the Public Health Service hospital on Staten Island employs over 1,000 people and there is only one industrial concern on Staten Island that employs more.

And, incidentally, there is not too many more in the center city of New York that in one unit employ more people.

While we are discussing in essence the question of the degree to which the physical health of the residents of Staten Island will be

affected by the closing of the hospital, nevertheless I would like to also indicate that the economic health of the community will be seriously affected if this facility is closed.

Unfortunately, the city of New York in the past few years has been subjected to a diminution of an employable base within the city and to some extent on Staten Island. To eliminate the flow of thirteen and a half million dollars into the economy of New York City would create a very critical economic situation.

The unions and their members likewise are concerned about the possibility of the closing of this hospital. When I first was apprised, in December of 1970, by Mr. Felix J. Russo, president of Local 888 of the American Federation of Government Employees, that he had heard reports that the hospital might close down, I wrote to the Honorable Elliott L. Richardson, Secretary of Health, Education, and Welfare, urging that the hospital remain open.

Following this, on January 20, 1971, I appeared and testified before a conference arranged by Secretary Richardson at the U.S. Public Health Service hospital on Staten Island.

I clearly pointed out to Secretary Richardson's representative the need for the continued availability of this institution for hospital care.

Next and specifically in regard to the public health service hospital on Staten Island, I would like to mention the extensive work conducted by this hospital in the field of research.

In the late 1950's a cardiovascular research program was started. Since then a large staff of professionals with knowledge and expertise in this field, using the most advanced equipment, has performed a very worthwhile service to the country and received a national reputation for their research work in the cardiovascular field.

Another major research program that has been going on at this hospital, is the renal disease program.

While it can be argued that both of these research programs could be moved to another institution, nevertheless I think we all realize that when there is such a relocation, there is a decided attrition in the number of personnel who will agree to relocate.

Next I am pleased to report that the hospital has constantly and consistently been conducting training programs within a wide spectrum of health care.

They include training courses for nurses, pharmacy aides, dietary interns, radiology technologists, marine physician assistants and laboratory assistants as well as courses in manpower development training and many other subjects.

Some of these have been conducted exclusively at the hospital, while others have been conducted in conjunction with Wagner College, Richmond College, and other institutions throughout the island.

During the past 15 years over 5,000 students have been trained through the services rendered by the public health service hospital.

The city, with its 8 million people, cannot afford to lose this valuable training service.

Next, I would like to report to you that the support for the continuation of service at this hospital has been unanimous.

It includes the support of the Honorable Jacob M. Javits, senior Senator from New York; Congressman John M. Murphy, of Staten Island, and the Staten Island Advance, an S. I. Newhouse publication which has twice editorialized in favor of the retention of this hospital.

It goes without saying that the residents of Staten Island likewise enthusiastically support the retention of its hospital.

Although I am not a lawyer, I have been advised that there is some legal question as to the authority of the Secretary to close down this facility. It is my understanding that U.S. Comptroller General Elmer Staats has so ruled.

I am sure, however, that your committee will look deeply into this question.

I would be remiss to merely report to you some of the reasons why this facility should not be closed and fail to suggest for your consideration avenues that might be explored that would lead to a favorable decision to not only maintain the facility to the extent that it is needed for Federal hospital purposes and for research and training, as Senator Kennedy has so aptly indicated, but also make it available for use by the general public then in order to relieve a very serious problem of hospital bed shortages that now exists and has existed for some time on Staten Island.

The president of the Richmond County Medical Society has already indicated that the medical society would anxiously look forward to the release of a portion of the hospital for general hospital use.

In addition, I have received word that while the unions would rather see the hospital maintained solely as a federally operated institution, nevertheless they would cooperate to the greatest extent possible in providing staff for general hospital services if a decision in cooperation with the hospital and the medical society is made along these lines.

Finally, I realize that the presentation I have made to you is in effect only a thumbnail sketch of the problem of one federally operated hospital in the United States.

I and the members of my staff will cooperate with your committee to the fullest extent in rendering any additional facts or information concerning the Staten Island based hospital as is needed, and I sincerely thank you for the opportunity for making this report to you.

Permit me again to express my appreciation for the work of your committee in looking into this problem.

Senator KENNEDY. Thank you, Mr. Connor.

Did you hear the representatives of the Department talk about the local universities undertaking responsibility for organizing and running the hospital facilities?

Earlier last week, we heard the extraordinary kind of financial burdens that are already burdening the taxpayers of New York in order to maintain the present hospital system.

I am just wondering whether you, as the president of the Borough of Richmond, feel that people in that community are willing to assume additional kinds of tax burdens to attempt to run this kind of a facility.

Are there any resources available locally?

Mr. CONNOR. Senator Kennedy, I think you have cut through a large amount of fat and gotten to the muscle of the problem.

There is no question that this is the tripping factor.

However, I think that there might be and I am not using weasel words on this at all, nor am I avoiding the question, I think it might be worth experimenting on a gradual basis, in other words, go to the shallow end of the pool, to determine whether the community might be able to finance some of this.

You are absolutely right, the costs are astronomical, the concern words on this at all, nor am I avoiding the question. I think it might be well to see whether there is the proof of the pudding there to determine, as I say, on a gradual and small basis.

For example, in that picture I showed to you, it indicates a number of wings in this hospital. Incidentally, when I mentioned to you that the total bed capacity is in the neighborhood of 639 or something like that, the census indicates there are only about 400 beds regularly utilized by primary beneficiaries, and it is to the eternal credit of the administration of the hospital, they have been quite liberal in interpreting the rules as to who they can care for.

They have always been highly concerned with the community. I just wonder whether it might be worth attempting to see, and still the Federal Government would have to be in this, obviously, to some extent financially, whether on a test case and in relatively smaller area it might be possible not only for community participation, but to see whether there won't be the financial resources from the private sector.

I don't know if there is total ability to foot the bill. I think there might be partial, sir.

Senator KENNEDY. Something that always concerns me is that we start these programs in local communities where they only put up a small percentage the first year, but assume more of the burden as it goes along. I think this is a very dangerous trend, because looking down the road 2, 3, or 4 years, demands upon communities and cities are going to be even more extensive than they are at the present time.

I am always a little reluctant to lull various groups in on this without giving them the assurance that there will be resources available to them on a permanent basis.

I want to thank you, Mr. Connor, and let me just finally ask this: Have you made these representations in terms of the shortage of medical beds to HEW?

Mr. CONNOR. Yes, sir.

Senator KENNEDY. You heard earlier today that they are going to review this themselves, and you have brought up some worthwhile testimony and comments.

Mr. CONNOR. I think what you have perhaps done today—I don't want to use the term "smoked out"—but brought out pertinent factors that many of us in the communities were not aware of.

I think this is helpful to us to come up with more responsive answers to the HEW people.

I want to thank you very much.

Senator KENNEDY. Thank you very much, Mr. Connor.

We have four more witnesses; the subcommittee will recess until 2 o'clock, and then we will hear from them.

(Whereupon, at 12:30 p.m., the Subcommittee on Health recessed, to reconvene at 2 p.m.)

AFTERNOON SESSION

(The Subcommittee on Health reconvened at 12:10 p.m., Senator Edward M. Kennedy, chairman of the subcommittee, presiding.)

Senator KENNEDY. The subcommittee will come to order.

The subcommittee welcomes Dr. Bernard Lidman, president, the Norfolk County Medical Society, Norfolk. Va.

He is former president of the staff of Norfolk General Hospital, and a member of the American Medical Association.

STATEMENT OF DR. BERNARD LIDMAN, PRESIDENT, NORFOLK COUNTY MEDICAL SOCIETY, NORFOLK, VA.

Dr. LIDMAN. Thank, you, Mr. Chairman.

Mr. Chairman, I consider it an honor and a privilege in having been asked by Senator Spong to represent the physicians of tidewater Virginia at your hearing today and hope to be able to give you an impression of the opinions of the medical community in our area.

As president of the Norfolk County Medical Society, I represent directly some 360 physicians in the Norfolk area; but I think that I may say, without hesitation, that my medical expression will be concurred in by some 600-700 physicians in the Norfolk, Portsmouth, Virginia Beach, Chesapeake, and Newport News and Hampton communities. We physicians in the tidewater area comprise some one-sixth of the physician population of the State of Virginia.

It is most difficult for anyone in my position to visualize the area surrounding the great port of Hampton Roads, without our Public Health Service hospital.

The PHS hospital has served, and continues to serve, a most important function in the delivery of health care services, on both an inpatient and outpatient basis, to a large and increasingly important maritime community, consisting of American seamen and Coast Guardsmen, in addition to other beneficiaries such as dependents and retired uniformed service personnel.

The workload maintained by the Norfolk PHS hospital is of critical importance to our communities. To compensate for the possible loss of inpatient beds at the PHS hospital, the city of Norfolk would have to add, or build, overnight, some 200 beds. This figure has been given to us by the administration of Norfolk General Hospital, the largest community service hospital in the State.

DePaul Hospital, now in a stage of expansion, could not assume an increased patient responsibility at this time. Nor could the Veterans' Administration hospitals at Kecoughtan and Richmond, Va.

On an outpatient basis, the PHS handles approximately 100,000 visits a year. The outpatient services of the Norfolk and Portsmouth hospitals could not assume this burden, in addition to their presently overtaxed services.

I would like you to know that prior to the statement of Secretary Elliott L. Richardson with reference to the closing of the entire PHS hospital system, the Norfolk County Medical Society had established good lines of communication with the director of the PHS hospital; and the executive committee of the Society had offered the hospital, through its director, all of the facilities of the society.

We had hoped, in the future, to be able to assist in the training and teaching programs, and had hoped that the PHS hospital might serve our communities by acting as a part of a nucleus in the teaching programs of the projected Eastern Virginia Medical School.

In the entire Tidewater area, we have inadequate facilities for the control or handling, either on an inpatient or outpatient basis, of a very real and growing drug-abuse problem. The staff at the PHS hospital has demonstrated a very real desire to help us in coping with this problem, and we have every hope that they will be able to do so in the future. We still plan on calling upon the PHS hospital for its assistance.

To consider removing the medical facilities which our PHS hospital provides in our area would be a serious and regrettable error.

The physicians and public officials in our respective communities are deeply concerned about the problem that you gentlemen face today, and I would like to leave you with the knowledge that we give the Norfolk PHS hospital our unqualified support.

Thank you for the opportunity of appearing before you.

Senator KENNEDY. Thank you very much, Doctor. I am wondering if you could develop briefly the kind of drug-control activities that the PHS is involved in.

Dr. LIDMAN. At the present time, it is not directly involved in the program, sir. We had just established rapport, shall I say, with Dr. Garfield, the director of the Public Health Service hospital, directly; and indirectly through the United Drug Abuse Council in the tide-water area, and he had consulted with his staff. In December and January of this year, when the bomb blew and the string was pulled, we stopped our direct lines of communication along those lines.

But in talking with Dr. Garfield and the administrator, Mr. Driscoll, at the Public Health Service hospital within the last 7 to 10 days, they still want to cooperate with the drug abuse council and the medical society in helping to cope with the drug-abuse problem.

We hope to do it on an inpatient and an outpatient basis. The hospital in Norfolk is advantageously situated, in that it is within the city limits.

In other words, we have a building facing on one of the major boulevards in the city, from which someone could step from the steps of a bus, step off the sidewalk into this building and be on Federal property, and not city property.

We think this probably is a decided advantage.

Senator KENNEDY. A number of us have urged the utilization of the Emergency Health Manpower Act, and one of the many features of the program is that it would encourage the administration to provide additional kinds of services to the disadvantaged and poor in areas near a public health hospital. Public health doctors would only be able to do that with the understanding and approval of county medical groups.

Dr. LIDMAN. Yes.

Senator KENNEDY. I am sort of hitting you from left field on this, but I am wondering, what would be the general reaction? Can you speak for yourself or your organization as to what might be the reaction of the medical society in this instance?

Dr. LIDMAN. I think we would be perfectly willing, certainly in a maritime community such as ours, one which is in the process of developing a huge model cities program, in which we have an estimated some 40,000 to 50,000 people who are disadvantaged; medically indigent, at least, and in which area I have been told by the Director of

the Public Health Service hospital, the hospital expects to supply physicians and surgeons to staff and man the outpatient departments and the clinics in this model cities area when it is built.

I think we would welcome their assistance.

I don't think at the present time, with the knowledge that I have with regard to the staffing of the Public Health Service hospital in Norfolk, that they could begin to do so, that is, on an outpatient basis, because the hospital down there, if I may put in a plug from right field, sir, is woefully understaffed.

I think they need something like 30 or 35 physicians and they are now operating with some 23 physicians.

Again, I think this is a matter of internal politics, or what have you, in the Public Health Service.

I think the specialized physicians that the medical director needs are available in the Public Health Service. I think it is a question of getting them shipped down there, but I think the medical director fully expects to engage in the care of the medically indigent when requested by the city, and he has the assurance of the Norfolk County Medical Society that we will cooperate with him in every regard.

You see, sir, some members of the county society act in a consultative capacity to the Public Health Service hospital, quite a few of the members: orthopedic surgeons, neurological surgeons, cardiologists, and internists, visit the Public Health Service on an twice a week as consultants, and they are active in the running of the hospital and feel that it performs an important function in our community.

We feel that we probably could not do without them.

Senator KENNEDY. You might have heard this morning that there is a desire of the administration to maintain benefits to those protected by the public health hospitals, and I want to ask if there is a question in your own mind what form this continuation of medical benefits would take.

One of their prime suggestions is that we turn the public health hospitals over to the local community. What kind of financial resources do you feel are available within the community for continued operation and for modernization and support of the public health hospital in your town?

Dr. LIDMAN. I don't think I can give you any sort of an authoritative answer, sir. I am not familiar with the budget of Norfolk, Va., to that extent—I am not supposed to be.

But it would seem to me it would take a tremendous amount of money to attempt to run a hospital of this size, presently some 240 available beds.

Formerly, during World War II, it was about 440 beds. It would be difficult to run it on a city basis. I don't know if the city would be willing to do that.

Senator KENNEDY. Have your tax rates been going up?

Dr. LIDMAN. Appreciably, let's say. We are not bleeding yet, but the tourniquet is getting tighter. We are in a peculiar situation at home, sir, if I again may digress for just a moment.

We are in the process of trying to raise funds to build a school of medicine which we sorely need in the eastern part of the State. This would cover the peninsula area of Virginia and the northeastern part of North Carolina.

I don't have to tell you the sort of funds involved here. This runs into \$40 to \$50 million. We are pretty well on our way. Ex-Congressman Hardy is chairman of the building fund committee, and he has got it pretty well going. He is from the second district.

But to attempt to, say, dump the public health services hospital on the city at this time would impose a tremendous burden on the city. I think we can go through a few minor earthquakes on the eastern seaboard before they could possibly or probably consider assuming that sort of burden, and as I say I am speaking directly off the cuff, sir, I have no knowledge of any figures.

I am giving you a general idea.

Senator KENNEDY. I think that is very helpful and that you are well within bounds in making that comment. Could you make any general comments about the various facilities giving health care to the poor in the Norfolk area?

Do you have any neighborhood health centers down there?

Dr. LIDMAN. They are just starting to build them, sir, but we physicians in Norfolk have traditionally and historically given of ourselves for 100 or more years in the free clinics of the area.

This is something that is rarely publicized, as you know; but we still do, we still contribute of our time. I was telling the gentleman in the rear a few months ago, I stopped a few years ago, after I had 25 years of it. I thought 25 years of it was enough.

But for 25 years I contributed two afternoons a week.

Adequate medical services are available in Norfolk, Va., to the medically indigent. What has happened is that the core area of the city is supplied by hospitals which are near the core area of the city, but so much of the present position of the city is outlying and this is what the model cities program is going to develop. That will take in some of what used to be the suburbs of the city.

It is difficult to transport these patients from the outlying areas to the major hospitals within the city. But we are managing to do it, and I think we afford reasonably good medical care.

Actually, the city and State are supporting the medically indigent patients, and did in the past, until title 19 went through, and what the city and States did not supply in the way of funds, the hospitals picked up; and the private, paying patients picked up the rest of the tab.

Senator KENNEDY. Thank you very much, Doctor.

You were awfully good to come up. I know this has interrupted your day in its entirety, and the reason you are doing it extends far beyond your own personal interest. Therefore your testimony carries a great deal of weight. It is important to have the views from different parts of the country.

So I want to thank you very much.

Dr. LIDMAN. Thank you very much, sir.

Senator KENNEDY. Our next witness is Dr. James Kimmey, Executive Director of the American Public Health Association.

**STATEMENT OF JAMES KIMMEY, M.D., EXECUTIVE DIRECTOR,
AMERICAN PUBLIC HEALTH ASSOCIATION, NEW YORK, N.Y.**

Dr. KIMMEY. I have a prepared statement, which, if we could have submitted for the record, I would just like to summarize it.

Senator KENNEDY. Fine.

Dr. KIMMEY. I represent the American Public Health Association, an organization of 26,000 individual members who are interested in health of the public. Our membership includes both professionals and consumers.

We are glad to have this opportunity to appear today and talk about the relationship between the Emergency Health Manpower Act which we supported when it was proposed here last year and the proposed changes in the Public Health Service hospitals.

Our prepared statement says "Closure," but in light of the administration's statements of Friday and this morning perhaps it is only redirection.

It seems to us that though these two things are legislatively and administratively separate, they come together in three critical areas.

One is in relation to the problem of distribution of health manpower. The second is on the accessibility of quality services to the people, and the third is on the promotion of a career Federal service for health workers.

The Emergency Health Manpower Act, as we saw it last year when it was up as a legislative proposal and as we still see it is an important initiative to begin to redress some of the maldistribution problems that have been well documented before this committee in the past.

We feel it can provide for accessible services to people, and can be a significant element in revitalizing what can best be described as a sagging Federal health service.

So we are pleased with that aspect of the President's health message and the expressed intent that this act should be implemented at the \$10 million level in the coming year.

One has to weigh this against the proposed changes in the PHS hospitals, and it seems to us that closing or markedly restricting these hospitals would place an increased load on the services and facilities within the communities in which they are located.

Thus, I would have to disagree with Dr. Wilson's statement this morning which held that the community is not being asked to underwrite primary beneficiaries.

Even though the Federal Government may be paying the bill for these people, they become competitors for already inadequate available care in the community.

The community is being asked to underwrite it to an extent through increased demand for services that are in short supply even though it is not being asked to underwrite the primary beneficiaries financially.

Second, it would seem that reductions in services provided by PHS hospitals would decrease services to a substantial portion of the population other than the primary beneficiaries.

The secondary beneficiaries from other agencies of government, and the communities themselves, would lose services. The impact would not only effect primary beneficiaries under some of the changes that have been discussed.

Third, we feel that this proposed change in the hospitals would lead to further devitalization of the Public Health Service, an organization that is certainly already reeling under the budget decreases and increased politicalization in appointments, and so forth.

We hope the testimony of Dr. Egeberg this morning indicates some flexibility in the matter of the future of the PHS hospitals.

We would want to stress the importance of the community's role in the deliberations that are going to take place. There was discussion this morning about involvement of the comprehensive health planning agencies, area wide and State, in the decisions made over these hospitals.

There have been efforts at public hearings around the country to secure community input on the issue of the hospital closing. Mr. Connor, for example, appeared at the hearings on Staten Island. It should be noted that these hearings, though they were a first step, began after the 1972 budget was at the printers, and one wonders how much impact they had on decisionmaking.

I would like to raise a couple of other questions. First of all, the divesting of Federal Government responsibility for the Public Health Service hospitals seems to us to promote fragmentation of one of the few models of unified medical care to civilian populations that we have available today.

These institutions have the advantages of unified financing, unified procedures, and staffing, and as I understood the proposal this morning, this is to be replaced with a patchwork of provisions, including the Emergency Health Manpower Act, contracts, Hill-Burton, title 18 and 19, funds, private health insurance, and so forth.

It is just this kind of patchwork financing that has contributed to the increase in hospital costs on the outside, and one might anticipate an increase in costs to these institutions under these circumstances.

The Emergency Health Manpower Act was mentioned as a possible source of support. It would seem inconsistent to see those funds siphoned off to support the Public Health hospitals.

We expect that the EHMA would be used to bring young physicians into a community health situation for a period of time, where he might get to know the community and perhaps choose to stay there.

I think using the Emergency Health Manpower Act funds to fund those hospitals is not desirable. They are specialty institutions, like a university hospital, and do not represent a meaningful community experience.

Likewise, Hill-Burton was mentioned this morning, as a possible source of support to the communities in taking over these institutions. The Hill-Burton authority, I believe, was meant to extend and expand facilities for communities.

One has to question, perhaps, as a part of the process of community involvement in the decisions on the hospitals, whether these funds should be used to revamp a "gift" of the type that is being proposed here. The community's needs may not be contiguous to the location of these institutions.

I am not really sure that if Staten Island, where I happen to live, were to be given the PHS hospital in the neighborhood where it is located that it would be effective in terms of response to the community needs.

In short, Hill-Burton, the Emergency Health Manpower Act, titles 19 and 18, all were meant to extend services, and not to be used in patchwork fashion to bail the Federal Government out in a period of tough financing.

Those are my comments. If there are any questions, I will be glad to answer them.

Senator KENNEDY. You are very helpful, and obviously you represent an organization which has followed the whole problem very closely; therefore, it is of particular value and help.

What is your impression about the possibility of recruiting doctors to work within this public health hospital system which would provide health services in the urban, inner city areas, as well as the rural communities?

Could you give any kind of a response to that?

Dr. KIMMEY. I think chances are better now than they have been in years past.

Senator KENNEDY. Why?

Dr. KIMMEY. I think we have a different type of individual coming out of medical schools. As isolated as medical schools often are from their communities, the students have been, I think, brought alive on social issues by the ferment on campuses.

So we are getting a different kind of individual coming to the point of beginning their service careers. I think you will have a better chance of recruiting them, if you can make it possible for them to take part in this kind of activity.

The matter of whether these people will be retained in these positions is another question, and one which the Emergency Health Manpower Act does not answer at this point. Until we have had experience with the act, I don't think we can say what kind of impact that kind of an approach is going to have particularly on rural areas, and urban ghetto areas.

Senator KENNEDY. How do you see these facilities working in meeting the health needs of the poor?

Dr. KIMMEY. The PHS hospitals?

Senator KENNEDY. Yes, if you utilize the Emergency Health Manpower Act?

Dr. KIMMEY. Earlier when I was commenting on some of this morning's testimony, it sounded as though I felt the Emergency Health Manpower Act should not be used at all in connection with the hospitals, and that is not true.

I don't think the personnel allocated under the act should be used within the hospital walls. I think these people should be directed toward activities, out in the community where people live, where they can live with the problems, see them, and relate them as family physicians, and not as the outreach worker from a hospital.

On the other hand, anyone that goes out in this kind of situation, whether they are in a store front clinic, or in an office up over the Chinese restaurant, or whatever has got to have back up. I think the Public Health Service Hospitals in the cities they now serve could provide the kind of back up these individuals needs, in terms of consultations, referral and professional stimulation.

Senator KENNEDY. In your understanding of where these public health hospitals exist, are you optimistic or hopeful that their local communities would be able to undertake the kind of financial burden that would be necessitated if we were to shift from the public health hospital system to local control, even with the continuation of medicare and medicaid?

Dr. KIMMEY. I don't think they can. As Senator Dominick said this morning, this is a very complex problem. It also comes at a very complex time in history.

The Congress has before it a number of proposals for universal health insurance of various kinds which might change this whole situation a year or 2 years or 3 years from now, depending on what develops. Under present circumstances, I think it would be impossible for most communities to come up with the kinds of financing that would be required.

I think it is unrealistic to think the community boards could do the kind of patchwork financing job that is being recommended.

If we had universal coverage, and adequate startup time to restructure health care delivery systems, these hospitals might be important building blocks. I think Dr. Walsh's testimony this morning was very much to the point. Here is a closed system of institutions in which you could try innovations in terms of allied health personnel, different relationships between outpatient, inpatient, and community outreach services, and so forth.

These kinds of experiments could be started tomorrow, and in a time we are entering a debate on universal coverage, we might learn a lot about the various theories about what the health system should look like by using these particular hospitals and institutions as laboratories.

Senator KENNEDY. Could you tell us this: Earlier today, we heard about the underutilization of beds in a number of Public Health Service hospitals, and the point was made that one of the principal reasons for this utilization is an insufficient number of personnel to provide full and adequate care for those people.

Could you make any comment on this?

Dr. KIMMEY. I think the gentleman from Norfolk pointed this up in his testimony a minute ago, where that hospital has 23 physicians and probably needs 35. I think it is all very well to say that only 60 percent of your beds are occupied, as was said this morning, but that sort of leaves you with the assumption that this is because there is not a demand.

I am not sure this is true.

These institutions have had problems with staffing and with financial support for staffing in the past. I think you have to weigh both sides.

Senator KENNEDY. Is there any way you or your group could review that particular question or problem and report back to us what you find?

Dr. KIMMEY. We have never done anything like that, but we are an organization in the throes of change, and we would like to take a crack at it.

Senator KENNEDY. I think it would be useful.

I think if we knew, for example, how many medical personnel were assigned to these respective hospitals, we could correlate with the utilization.

Dr. KIMMEY. I was going to say, if you ask HEW for the data, they will give it to you, and we will be glad to try to interpret it.

Senator KENNEDY. Thank you very much.

Dr. KIMMEY. You are welcome. It was a pleasure.

(The prepared statement of Dr. Kimmey follows:)

Statement
Before the Subcommittee on Health
Committee on Labor and Public Welfare
United States Senate
by

James R. Kimmey, M.D.
Executive Director
American Public Health Association

Mr. Chairman and members of the committee:

I am Dr. James R. Kimmey, Executive Director of the American Public Health Association, national organization of health professionals and consumers dedicated to securing the best of health for the American public. We are pleased to have been able to present our views on the relationship between the Emergency Health Manpower Act of 1970 and the projected closing of the hospitals and clinics operated by the U. S. Public Health Service. These two items have a degree of inter-relationship that may not be apparent at first consideration, but both are intimately tied to two issues:

- (1) The distribution of health manpower to segments of the population that are presently or potentially under-served.
- (2) The development and maintenance of a core group of highly motivated health professionals in career service with the Federal government.

The policies of the American Public Health Association hold that health is a basic human right and that every individual should have access to primary medical care of high quality. We feel that the Emergency Health Manpower Act represents a significant initiative toward achievement of these goals. We feel the gain represented here is severely compromised by the projected closing of the PHS hospitals and clinics as presently projected.

The Emergency Health Manpower Act is, in our view, an attractive alternative to other kinds of national service for young health professionals, paraprofessionals, technicians, and other health personnel. With the requirement for local participation in determining assignments of such individuals, the Act, creatively administered, could begin to alleviate the problem of maldistribution--particularly in rural areas and urban slum areas. Many factors--including marginal facilities, poor income, and cultural gaps--now operate to deprive large segments of the population of ready access to trained health workers. As a new generation of health workers--one with more demonstrated social commitment than has been true in the past--enters the workforce, the Emergency Health Manpower Act would provide a means for providing them an outlet for their concern, a close look at the needs of these isolated areas, and, hopefully, interest them in continuing in work or practice situations that are now unfilled. Further, we anticipate that this type of program may well serve as a needed stimulus to a faltering and demoralized Federal career health service. As Federal interest and participation in health programs of all kinds grows at an unprecedented rate, it seems unfortunate indeed that the creative leadership required for program administration and guidance is being compromised by a failure to recruit and develop dedicated young health professionals who see career service in government programs as an important and fulfilling activity.

Thus it is that we view with concern the current moves to close or administratively relocate the Public Health Service Hospitals and Clinics. These institutions provide needed services to thousands of beneficiaries each year. These services would be compromised by closure of the hospitals and clinics, or their transfer to other Federal agencies with rather fuzzy mandates to provide services to the beneficiary groups. The beneficiaries would either be thrown into the already overburdened delivery systems of the major cities where these facilities are located, or placed lower in the priorities of delivery organization whose major concerns are veterans or military personnel. Worse yet, they may well become a part of the large segment of our population who do not have any meaningful access to adequate health services. In this case, not only the direct beneficiaries would be deprived of services, or forced to avail themselves of less accessible and acceptable services, but the nation as a whole stands to lose. The Public Health Service Hospital system has historically been the training and testing ground for individuals who later became the guiding figures in Federal health activities ranging from direct research to administration of medicare and medicaid.

These two actions by the Administration--support of appropriations for the Emergency Health Manpower Act and threatened close of the hospitals and clinics seem to us highly inconsistent with one another. If there is an adequate case for closure for the hospitals, and viable alternative sources of services to the beneficiaries and the nation at large, it has yet to be presented to the Congress or to the public.

In closing, let me touch on two other concerns with these two bills. First, the APHA urges that funds be appropriated to fully fund the Emergency Health Manpower Act, and that these funds and the personnel made available be used to extend services to areas that are now inadequately served. This goal would not be served if, for example, personnel working under the provisions of the Act were used to replace individuals already working in these areas under other Federally-funded programs, such as the OEO and HEW neighborhood health center programs. This is a new program, and the needs are such that services should be extended to new areas.

Second, we feel that the issues raised by the proposed closure or reorientation of the hospitals and clinics transcend Federal needs and fiscal considerations and are intimately tied to the health progress and priorities of the communities in which these facilities are located. Even if a case can be made for the Federal government divesting itself of its responsibilities for its beneficiaries, it seems to us that more adequate opportunities should be offered the communities to make their views known on closure, and on their potential uses for the facilities. In a time of great expressed concern for local decision-making in relation to Federal programming, the existing local bodies at interest in this matter should be completely involved in the decisions to be made.

Thank you for this chance to comment on these matters. If you have any questions, I will be happy to answer them at this time.

Senator KENNEDY. The next witness is Earl Clark, codirector of the Labor-Management Maritime Committee. He was the former president of the New York-Cuba Mail Steamship Co.

We know the hour is late, but we are looking forward to your testimony.

STATEMENT OF EARL CLARK, CODIRECTOR, LABOR-MANAGEMENT MARITIME COMMITTEE

Mr. CLARK. Thank you, Mr. Chairman.

Mr. Chairman, I recognize the hour is late, and also the fact that having heard testimony throughout most of the day, the statement which I have here and which I would ask permission to file in the record, follows considerable of the same ground.

So in the interests of saving the committee's time and moving on with it, I would like permission to file this in the record.

Senator KENNEDY. It will be printed in the record at the end of your testimony.

Mr. CLARK. The maritime community, both labor and management, so far as I know, are unanimous throughout the country in supporting the marine hospitalization program as it is now covered in the Public Health Service.

I think there is perhaps some lack of knowledge, certainly not on the part of the committee, as to the extent of seaman care in these hospitals.

Up to 1913 the total beneficiaries were for the most part associated with the maritime community. This is no longer true. It has not been since 1913.

I then should like to offer for the record, unless the committee already has the data, a tabulation on the seamen versus the nonseamen in the hospitals, in the outpatient clinics, and so forth, which I just secured from the Public Health Service this morning. If you don't have this data I should like to submit it for the record.

Senator KENNEDY. I wish you would, Mr. Clark. It will be printed. (The information referred to follows:)

SURVEY OF SEAMEN VS. NONSEAMEN IN PHS HOSPITALS

RECAPITULATION

<u>American Seamen</u>	<u>1969</u>	<u>1970</u>
ADPL (hospitals)	1004	912
OUT-PATIENT Visits	274,289	273,927
 <u>Seaman and Non-Seamen</u>		
ADPL (hospitals)	1820	1722
 <u>Seamen and Non-Seamen</u>		
OUT-PATIENT VISITS TO ALL HOSPITALS	763,809	812,180
 TOTAL FOR ALL 30 OUT-PATIENT CLINICS	799,483	820,635
Seamen	235,777	Seamen-229,274
Non-Seamen	563,706	Non-Seamen-591,361

AMERICAN SEAMEN

	<u>ADPL</u>			<u>OUT-PATIENT VISITS</u>	
<u>Hospitals</u>	<u>1969</u>	<u>1970</u>		<u>1969</u>	<u>1970</u>
Baltimore	63	52	)	17,507	18,162
Boston	46	44	)	12,639	13,335
Galveston	96	96	)	18,818	19,285
New Orleans	200	195	)	45,559	45,410
Norfolk	57	65	)	15,419	15,800
San Francisco	188	177	)	68,189	68,812
Seattle	77	64	)	29,323	29,346
Staten Island	<u>277</u>	<u>219</u>	)	<u>66,835</u>	<u>63,777</u>
TOTAL -	<u>1004</u>	<u>912</u>	)	<u>274,289</u>	<u>273,927</u>
All Hospitals			)		

AVERAGE DAILY PATIENT LOAD - Hospitals
(ADPL)

	1 9 6 9		1969	Comparison
	<u>Seamen</u>	<u>Non-Seamen</u>	<u>Total</u>	1970 <u>Total</u>
				)
Baltimore	63	134	197	)
				)
Boston	46	69	115	)
				)
Galveston	96	26	122	)
				)
New Orleans	200	112	312	)
				)
Norfolk	57	70	127	)
				)
San Francisco	188	81	269	)
				)
Seattle	77	121	198	)
				)
Staten Island	<u>277</u>	<u>203</u>	<u>480</u>	)
				)
TOTALS-	1004	816	1820	)
All Hospitals				)
				)
				)
				)
				)

OUT-PATIENT VISITS TO ALL HOSPITALS IN 1970

<u>Hospitals</u>	<u>Seamen</u>	<u>Non-Seamen</u>	<u>Total</u>	)	1969 Comparison <u>Total</u>
				)	
Baltimore	18,162	78,447	96,609	)	87,793
				)	
Boston	13,335	45,027	58,362	)	56,175
				)	
Galveston	19,285	25,992	45,277	)	43,632
				)	
New Orleans	45,410	100,037	145,447	)	138,447
				)	
Norfolk	15,800	77,185	92,985	)	85,704
				)	
San Francisco	68,812	49,762	118,574	)	110,957
				)	
Seattle	29,346	82,774	112,120	)	103,128
				)	
Staten Island	<u>63,777</u>	<u>79,029</u>	<u>142,806</u>	)	<u>137,973</u>
				)	
TOTAL -	<u>273,927</u>	<u>538,253</u>	<u>812,180</u>	)	<u>763,809</u>
All Hospitals				)	
				)	

Mr. CLARK. I would like to place in the record a list of beneficiaries in the Public Health care hospitals. I think that matches up with the statistics I have just offered.

Senator KENNEDY. Very good.

(The information referred to follows:)

BENEFICIARIES OF PHS HOSPITALS

American Seamen/Other Seamen and Related Categories

American Seamen

Owners, operators of documented commercial fishing vessels
 Trainees
 MSTs Personnel
 Alaska Native Service
 Army Corps of Engineers
 Army Signal Corps
 Fish and Wildlife Service
 Other Federal Seamen
 Cadets, Maritime
 Motorboat operators
 Applicants for positions as food handlers aboard vessels

Uniformed Service Personnel

National Oceanic and Atmospheric Adm. (NOAA)
 Commissioned officers, crew members, active and retired, and dependents
 Coast Guard
 Officers and enlisted men, active and retired, and dependents,
 applicants for enlistment
 USPHS officers, active and retired, or candidates, and dependents
 U. S. ARMY, NAVY, AIR FORCE, MARINE CORPS, officers and enlisted men,
 active and retired, and dependents
 Armed Forces applicants for enlistment
 National Guard Officers (dependents not eligible)
 Foreign NATO personnel attached to Army, Navy or Air Force, and
 dependents
 Dependents of deceased commissioned officers

Other Beneficiaries

Federal Civilian Employees
 Discontinued Federal Programs
 Other beneficiaries of Federal Government Agencies
 Special Study (cancer, heart, by referral of private physician)
 Miscellaneous
 Foreign Seamen
 Immunization and Inoculation
 Emergencies

Mr. CLARK. I should like also at this time to have permission to submit for the record a national resolution which was approved by the Propellers Club, nationwide, because it represents the combined aptitude of not only shipbuilding but ship operations, labor and management, throughout the entire maritime community, and I think it might be helpful if you had that.

(The information referred to follows:)

THE PROPELLER CLUB OF THE UNITED STATES

Position No. 5

SAVING THE PUBLIC HEALTH SERVICE HOSPITALSBACKGROUND

In December of 1970 the Secretary of Health, Education and Welfare indicated that the Administration was considering closing eight general PHS hospitals and some 30 out-patient clinics. This announcement charged inadequate quality of PHS hospital care and expressed an unwillingness to spend \$140 million to modernize or replace existing facilities. In this is seen the strong hand of the Bureau of the Budget - for years the motivating force behind PHS hospital closings. The Bureau attempted to close these hospitals in 1965, but the Congress of the United States saved them and called for their modernization. Since then forces within government have sought their demise through attrition and disregard of Congressional intent. Any inadequacy in quality of care must be laid to this negative administrative practice. Now alleged inadequacy of care is being utilized as a further excuse to close the hospitals and clinics. The submitted budget for 1972 applies the meat axe to these hospitals, decreasing patient care allocations by \$21.8 million and employment by \$48.8. The budget would force hospital closings at Baltimore, Boston, Galveston, Norfolk, New Orleans, San Francisco, Seattle and Staten Island.

Meanwhile, national health care is one of the "Six Great Goals" in the President's 1971 State of the Union message. PHS hospitals should be utilized to achieve this goal. The fields of cancer research, drug addiction and scores of other areas of unmet national health needs call for expansion and modernization of these hospital facilities, not their elimination. Congressman Garmatz, Chairman of the Merchant Marine and Fisheries Committee of the House of Representatives, has introduced a concurrent resolution in the Congress, directed toward achieving such objectives. It deserves the support of all health-conscious citizens.

POSITION

The Propeller Club of the United States (1) deplores all attempts to close the Public Health Service hospitals in the face of the unmet health needs of the nation, including those of merchant seamen; (2) respectfully requests the President of the United States not to accede to such attempts within his Administration; and (3) fully supports the concurrent resolution now before the Congress in defense of these hospital services.

Mr. CLARK. Mr. Chairman, I would like to speak just for a moment about this problem of deterioration. In 1964 our organization produced a two-volume book which I am sure the Senator has in his office—it was submitted to you—which describes the condition of the hospitals at that time. There was an order at that time to not only retain the hospitals after the hearings in the Senate and in the Congress, but to modernize them.

I remember I personally testified before seven different committees of this Congress at that time when the hospitals were up for closing.

Now, nothing was ever done, to my knowledge, to modernize those hospitals, except that plans were drafted, and I believe some moneys were appropriated for the drafting of plans.

I have seen some of those plans for the hospitals, and I believe you will find it accurate that they never got beyond the actual drafting of the plans stage.

Those hearings, as I remember it, expressed the will of the congress—the hearings as published—that the hospitals be modernized. During this whole period it has not been, so to our way of thinking the wishes of the Congress at that time have not been carried out.

The astounding thing to me is that one of the reasons given in the testimony I have heard here today is that they are in a deteriorated condition and that is one of the reasons why they wanted to do something with them when they proposed closing them.

So that the very condition that has been promulgated since 1965 is now being used as a reason for closing these hospitals.

In 1965, there was a comptroller's decision, which I interpret very clearly, from what our attorneys have said, to mean that this hospital system cannot be closed, so the only way that they are going to continue to deteriorate it is by attrition and a further piecemeal closing.

The Memphis hospital was closed back about the time that those hearings were being held, as was the Chicago hospital, and about a year ago we came up with closing the Savannah hospital and the Detroit hospital.

So that with the closing of Detroit, there are no hospitals left whatsoever in the interior of the country, no general public health hospitals.

How long is this going to be going on?

I don't know, but I want to congratulate this committee and particularly the chairman in his decision to clarify beyond the clarity which was received from the Comptroller General by the House Merchant Marine and Fisheries Committee, because I think there are questions left unanswered, Mr. Chairman, and I believe what the committee has brought out this morning certainly should reveal something further as to what the legal applications of the law are with respect to these closings.

So I am glad to see that.

In the written statement that I have submitted for the record, we take a position very similar to that which has been expressed by Dr. Walsh.

We would like to associate ourselves with Dr. Walsh's testimony, and I remember when he was in charge of the hospitals around the

country that he certainly took a converse view to that which is now being expressed by those who want to close them.

I would like to associate myself, with Mr. Bernard Lidman's statement from the Norfolk Medical Society, and for the most part with Dr. James Kimmey.

I will try to conclude this as quickly as I can, with a couple of other remarks. We support an expansion of the hospital beneficiaries in terms of what the public needs for health are today.

We don't hold that the hospitals must be kept open solely on the basis of merchant seamen, but we cannot understand why everyone is saying we lack beds, we lack hospitals, we lack facilities and we have the drug addiction problem, we have the cancer research problem, we have the heart disease problem, and why, in the face of these statements almost nationwide, almost uniformly recognized by every organization that deals with this subject that we are in short supply, and on the other hand not benefit by the continuation of these hospitals under the national aegis?

Now I can see that if we start piecemealing this thing by turning over these hospitals either in part or in whole to the local communities we are going to be in more trouble, Mr. Chairman, than we are now.

One does not need to read too far to know the condition which many of our cities are in. You have heard testimony on this here today. How are they going to provide the money?

The first thing I think will happen is, they will come back to the Federal Government for the money to carry their share of the burden in the very hospitals we are turning over to them.

It may be principally Federal money before it is over, anyhow, so why do we do this thing? Why do we proliferate it, as the distinguished speaker just ahead of me said in his testimony?

Why do we proliferate when we know the cities are in that condition? Our association came in and supported another bill—I forgot the title of the bill—it was numbered S. 4106—but it had to do with nurses and doctors in the inner city where they are needed so badly.

The whole maritime community supported that. We know the need is there, and that program was put under the Public Health Service. You have a real dichotomy on your hands.

You put that under the Public Health Service. Now if we consider proliferating and turning it over to the cities, I think we have a real contradiction there.

There is still another contradiction, and that is that Congress has passed a bill which is presumably going to increase the American merchant marine. We are going to build about 30 ships a year for 10 years, and the whole philosophy of that bill was to restore our merchant marine. So I can't go along with those that say that even the merchant marine caseload will continue to drop.

Presumably, it ought to increase as we get more ships, and as we begin to rebuild our merchant marine.

With those comments, I will be glad to answer any questions, but our association, and I think those who are associated with me in other capacities, would strongly urge that the services of the hospital be expanded to meet the needs of the Nation and not proliferated as between Federal and local communities.

Thank you, sir.

Senator KENNEDY. Thank you very much.

This is very helpful, Mr. Clark.

We inquired earlier about the effect of the closing of some of these public health hospitals last year and in the past. What has been the effect of the other closings on seamen?

Mr. CLARK. Mr. Chairman, the closing of the Memphis hospital had a direct effect on the inland waterway people more than it did on the ocean-going seamen, although there were ocean-going seamen there because their homes were in that locality.

I can give you the views from the labor side of our house. They said many of those people simply did not get medical care. Some of them just evaporated. Some of them said, "Well, we can't get into the veterans' hospitals," and let me say this to you, there was a recommendation that seamen be placed in veterans' hospitals made in 1965, and which they tried to apply in Memphis. However, there was also a ruling of the Comptroller General, that seamen had to take a back seat to nonservice-connected disabilities cases.

Now we know that in the veterans' hospitals service, the service-connected disability cases are handled promptly, but in that non-service-connected disability group, there is a waiting list that is tremendous.

Now if you can imagine a seaman needing emergency care having to go on the waiting list when his ship leaves 5 days from now, you can see what that does.

As to those people they tried to take care of in the veterans' hospitals in Memphis. I don't know what the result was. I know a lot of them disappeared in thin air, and my colleague, Mr. Hoyt Haddock, says many of them simply did not get the care.

When they closed the Chicago hospital, they said, "Well, they can go to Detroit."

Well, these people, many of them, did not have any way to get to Detroit. It is not too far, but it is not a very short distance, either, when you have to put out money to get to Detroit and leave your family when there is a hospital under your nose.

I think many of them did not get to Detroit. But now Detroit is even closed. So I don't know what happened to them. But I know labor says many of them simply did not get the care, and I think there is perhaps a hope on the part of some that this will happen in these closings. The people just won't get the care.

Senator KENNEDY. Besides the services you get from the public health hospitals, do you have other instances of insurance arrangements?

Mr. CLARK. Our association does not. There are of course, pension and welfare funds, but that does not cover this area and many of these seamen are not old enough to come into that category, and the seamen—they can't go into the hospital unless they have been at sea in the last—I think it is 90 days.

Certainly in those organizations I represent, I don't know of any insurance plan as such. It has been talked about, but I don't know of it.

Senator KENNEDY. But there are no existing insurance plans that cover them?

Mr. CLARK. I won't answer that categorically, Senator. I don't know.

Senator KENNEDY. Could you submit later on information on that point?

Mr. CLARK. I will check this and put into the record what my review indicates.

(The information subsequently supplied follows:)

MEDICAL INSURANCE PROGRAM FOR SEAMEN

Concepts on medical and hospital benefits for seamen through insurance programs were propounded back in 1965 when the hospitals were threatened with closing. Such proposals were principally by opponents of continued PHS care.

Such proposals have been put forth before and found impractical for seamen. The only existing insurance program in the maritime field that could be identified were some self-insured benefits provided by licensed officers only, and these benefits pertain only to dependents, not to seagoing personnel.

Senator KENNEDY. What is your reaction to the suggestion that we provide for the seamen by these contractual agreements?

How do seamen make out under those circumstances?

Mr. CLARK. Senator, in this book written back in 1965, we showed that.

The contract care, first of all, was intended then only in the areas where there was an overflow from the public hospital service. It was not intended as a substitute.

I cannot tell you that the contract care was bad. What they do is contract with a physician in remote areas, like in Alaska, but more particularly in this country where they are not in close proximity to the PHS hospitals, but you pay through the nose for it.

I don't have the up-to-date cost figures, but we did give the figures back in 1965, and the contract care was at that time two or three times that of the total cost based upon a per capita distribution cost in the Public Health Service hospitals.

Senator KENNEDY. Would you at a later date, give us the figures that you do have on the contract care?

Mr. CLARK. As I say, I don't have up-to-date figures on that, but I will submit what I can secure for you.

(The information referred to follows:)

AVERAGE PER DIEM COST FOR NON-FEDERAL CONTRACT CARE

Average in-patient per diem cost for non-Federal contract care in fiscal year 1970 was \$125.18.

Average overall in-patient per diem cost in PHS general hospitals for fiscal year 1970 was \$58.44.

Breakdown by PHS general hospital—

Baltimore	\$83.06	New Orleans	\$45.33
Boston	57.30	San Francisco	57.14
Norfolk	58.34	Seattle	70.01
Galveston	52.44	Staten Island	57.96

Mr. CLARK. I am sure I can get those very readily.

Senator KENNEDY. Let me ask you finally, what special health care needs do seamen have which hospitals respond to?

Mr. CLARK. One of the very heavy types from the point of view of caseloads among seamen are broken bones, falls, injuries, and what not.

That is true of the orthopedic category. I would say the largest group of treatment is perhaps in the injury cases.

I might say to you that earlier in our history, one of the fundamental reasons for the hospital program back in 1798, was that seamen were considered a very bad risk at the portal cities because they brought in various types of diseases.

They attempted to argue in 1965 that this had greatly diminished, and it has diminished some but I checked with some of the doctors here today, Dr. Walsh in particular, and this still is a problem.

So you do have the importation of disease problems, although I think the first category, the injury category, is the biggest risk.

Senator KENNEDY. Thank you very, very much, you have been very helpful to us.

Mr. CLARK. Thank you.

(The prepared statement of the Labor-Management Maritime Committee by Earl W. Clark and Hoyt S. Haddock, codirectors, follows:)

STATEMENT

of the

LABOR-MANAGEMENT MARITIME COMMITTEE

before

SUBCOMMITTEE ON HEALTH

COMMITTEE ON LABOR AND PUBLIC WELFARE

UNITED STATES SENATE

on

SENATE CONCURRENT RESOLUTION 6
TO SAVE THE U. S. PUBLIC HEALTH SERVICE HOSPITALS

March 8, 1971

Mr. Chairman and Members of the Committee:

We appreciate the opportunity to appear before this distinguished Committee and to submit this statement of the Labor-Management Maritime Committee with reference to Concurrent Resolution 6 in the Senate of the United States directed toward saving the U. S. Public Health Service hospitals.

The Labor-Management Maritime Committee, composed of major steamship lines and seagoing unions, has long supported the U. S. Public Health Service hospital program, including its marine hospitalization services.

In connection with the current hearings, the Co-Chairmen of our organization, Mr. Joseph Curran, President of the National Maritime Union, and Mr. Spyros S. Skouras, President of Prudential-Grace Lines, speaking for our Governing Body, have directed that full support be given not only to the retention of the PHS hospitals but to their modernization as well.

We have taken full note of the Concurrent Resolution introduced by the distinguished Chairman of this Committee and supported with similar action by other members of the United States Senate. We wish to support wholeheartedly this entire movement sponsored by so many members of the Congress.

In 1798 when the first "marine" hospitalization act was enacted, the beneficiaries were seamen only. This is no longer the case and has not been for most of the twentieth century. Beginning in

1913 and thereafter, beneficiaries have also included recipients in the non-seamen categories. In fact, shortly after the turn of the century the name of the hospitals themselves was changed from "marine hospitals" to "Public Health Service Hospitals" in recognition of this fact. Subsequently, the marine hospitalization program became only one of several categories of beneficiary care, although it remained a major one. The Federal responsibility for seamen's medical and hospital care in the Public Health Service Hospital program is a matter of law fully enunciated and vividly interpreted in a ruling by the Comptroller General on June 7, 1965, and recently reaffirmed by Comptroller General Elmer B. Staats on February 23, 1971.

We hold, therefore, that the continued efforts of the Bureau of the Budget and the Department of Health, Education and Welfare are not in keeping with established law enacted by the Congress of the United States but rather in direct conflict therewith. Yet these agencies have persisted in disregard for both the letter and the spirit of long-standing legislative enactments.

Aside from the legal aspects, there appears to be a real contradiction in the current approach to national health problems by the particular agencies now seeking elimination of the PHS hospitals.

On the one hand is a national recognition of the need for greater governmental involvement in improving the nation's health. One of the six great goals in the President's State of the Union message was improvement of national health care. On the other hand,

certain government agencies proceed toward the closing of badly needed facilities in the face of recognized nationwide shortages of beds, nurses and available hospital services. This is a dichotomy of the first magnitude.

The Public Health Service Hospital program should be enlarged. The services should be expanded and the facilities modernized, as is called for in some of the proposed Concurrent Resolutions now moving through the Congress. The field of cancer research, as portrayed in the President's State of the Union message, is one to which the PHS hospital program could address itself. Drug addiction is infesting the health of large numbers of our citizens and needs more direct and responsible attention. These two citations are in no way limiting. The Public Health Services should be given broad responsibilities in these and other areas of national health need. It makes little sense to eliminate a ready and going hospital system like that of the PHS when we know other hospitals will have to be created to handle these unmet needs.

After the PHS hospitals were saved by Congress in 1965, the order of the day was to expand and modernize them. This was never done and did not get beyond the drafting stage. The reason was clear and evident. The same government agencies that today advocate their closing made little effort to carry out the will of Congress and, in fact, dragged their feet, permitting attrition and neglect to further deteriorate the facilities and the general

program. They now use the very "deteriorated" condition they helped create as a justification to close the hospitals and thus achieve the original goal they espoused. Nor was the Congress apparently even consulted in current efforts to close them. This was made amply clear in the proposed Concurrent Resolution introduced by the Chairman of this Committee.

The Labor-Management Maritime Committee is not without knowledge of the developments in the area. In 1964 it published a two volume book entitled "Medical and Hospital Care for Merchant Seamen" with which many members of the Congress are familiar. It was used widely in testimony before the Congress in 1965 in opposition to a similar threat to close out the PHS general hospital system during that year. I recall that, at that time, it was my distinct privilege to follow the distinguished Chairman of this Committee in testimony before the Honorable Lister Hill and his Committee on the same subject. We hold that our position in support of the PHS hospitals then is equally valid today.

We have heard that competent medical staff has left the PHS hospital program due, in a very real sense, to the permitted deterioration and overall disregard for improvement in the hospital facilities. Surely, the constant uncertainty as to the future status of these hospitals has not only caused many professional staff members to leave but also mitigated against prospective staff

members aligning themselves with the program. This is an unhealthy condition and should be stopped.

It is time for the Congress to insist that its will be carried out; that the PHS program be increased to help provide for the unmet needs of the nation; that the PHS hospital facilities be modernized and the services themselves expanded. We urge this Committee and the Congress as a whole to adopt an appropriate Concurrent Resolution to save the Public Health Service Hospital program and the fine institutions which already serve some one-half million people annually in the field of health care.

We respectfully request that this statement be made a part of the record of the hearings.

Earl W. Clark
Hoyt S. Haddock
Co-Directors
Labor-Management Maritime
Committee

March 8, 1971

Senator KENNEDY. Our final witness today is Mr. William Moody, administrator of the AFL-CIO Maritime Trades Department, Seafarers International Union.

We welcome you here. You have been extremely patient, and we appreciate it.

STATEMENT OF O. WILLIAM MOODY, ADMINISTRATOR, MARITIME TRADES DEPARTMENT, SEAFARERS INTERNATIONAL UNION; ACCOMPANIED BY PETER M. MCGAVIN, EXECUTIVE SECRETARY-TREASURER, MARITIME TRADES DEPARTMENT

Mr. MOODY. Thank you very much, Mr. Chairman.

I am accompanied by Mr. Peter M. McGavin, executive Secretary-Treasurer of our department.

Senator KENNEDY. You are more than welcome.

Mr. MOODY. In recognition of your great patience, I am going to file my testimony, and we certainly appreciate, Mr. Chairman, the interest you have taken in this problem of ours.

Senator KENNEDY. It will be printed in the record.

Mr. MOODY. I also represent the Seafarers International Union, whose membership includes seamen, fishermen, and tugboat men who are the primary beneficiaries we have heard so much about here today.

I would like to make it perfectly clear—

Senator KENNEDY. Mr. Moody, do you have some good citizens from Massachusetts who are members of that?

Mr. MOODY. Yes, we do.

Senator KENNEDY. Are they members in good standing?

Mr. MOODY. Yes, sir, they are. They use the Boston hospital too, and we hope they continue to use it.

For those very reasons, I want to make it clear that I represent a special interest group. Dr. Walsh, I think, correctly stated the special needs of seamen and fishermen with respect to the hospitals.

These needs were recognized in the establishment of the hospitals in 1798, and I think it was considered necessary to establish these hospitals at that time as a matter of national interest and that no one considered these hospitals in the nature of a welfare project.

Mr. Chairman, I would respectfully caution the committee against being lulled into a false sense of security by the qualified assurances which were given here this morning by the witnesses from HEW.

As a matter of fact, as I sat here this morning, I had the eerie feeling that I had come into the middle of a very bad movie that I had seen before, because sitting in this same room in 1969, hearing testimony on the decision of HEW to close the hospitals at Detroit and Savannah, I heard many of these same assurances, always qualified, given at those hearings.

Despite the best efforts of Senator Yarborough and Senator Hart and others, and Senator Talmadge, who were greatly interested in this matter, we know what happened to those hospitals.

They are closed. There is no longer a public health service hospital to serve the seamen on the Great Lakes. We have heard in the testimony this morning about these primary beneficiary patients having to go elsewhere for their treatment. I might suggest in the case of southern California HEW might consider establishing a hospital there so those

patients, many of whom are also fishermen, would not have to look to San Francisco or Seattle for care.

The effect of closing the hospitals in Detroit and Savannah has been in many instances that the Federal Government at great expense flew patients to Baltimore or New Orleans or to Staten Island.

In the light of the track record of HEW in connection with these hospitals, we have no sense of security from the kind of assurances we heard this morning.

Senator KENNEDY. Let me ask you this, Mr. Moody.

When the administration was drafting their program regarding possible termination of these hospitals, were you ever called in to visit and consult with them and were your interests ever represented in this decision?

Mr. MOODY. No, sir. We elbowed our way in after the fact, when we heard the reports and rumors.

Senator KENNEDY. Were you consulted again as the representatives of the people who are most directly affected by these public health hospitals by HEW, or have you ever been asked, to the best of your information and knowledge, to come in and help to work out these programs?

Mr. MOODY. Senator, we have not. As I said, we have from time to time elbowed our way in and forced meetings, usually at the secondary level of management in the department.

Senator KENNEDY. Would you welcome that opportunity?

Mr. MOODY. Absolutely.

Senator KENNEDY. Don't you think you, as well as other groups, ought to have the chance to be heard in terms of decisions that are being made by the administration in this area?

Mr. MOODY. Absolutely, and on the basis of what was said by HEW this morning on where most of their caseload comes from we think we are the first people who should be consulted.

I mentioned before the flying of patients from areas there where they have been closed to other hospitals, cases such as the case of a man in Michigan, who was referred by his contract doctor to the VA. He was a cancer case. Three weeks later, the VA Administration had not even answered the letter, and they were trying then to refer him to Staten Island and/or Baltimore.

So we would welcome the opportunity to consult with the department on this, and we would subscribe to the broader uses of these hospitals that were referred to this morning by Dr. Walsh and later by Dr. Kimmey.

We again congratulate you and thank the committee for its leadership in trying to prevent the closing of these hospitals and we would hope that out of these hearings would come some effort not only to guarantee that these remaining hospitals and clinics are kept open, but that a great deal of attention be given to expanding the system for the broader requirements of the community and of the total population that we think they would readily lend themselves to.

Senator KENNEDY. Do I gather that you won't look with favor on the development of contractual arrangements for providing services?

Mr. MOODY. Senator, we would not be satisfied with that for the reason that really the contractual arrangements results with the

exception, I guess, of some outpatient care, generally results in referral of the patient to a VA hospital that he can't get into, or a far distant public health service hospital.

Senator KENNEDY. I could not agree with you more. I shall write the Secretary this afternoon and ask him if he will include you and the representatives of your union, and other groups as well that have a similar kind of interest.

I think it is terribly important that we get these facts out on the table.

Mr. MOODY. We would quite agree with you, and we would welcome such an opportunity, because we are convinced, Mr. Chairman, that the intent of Congress is being subverted by a hostile bureaucracy in this case, because this is not a matter of just this administration.

It has been going on under the administrations elected by both political parties.

We think that we have a real problem within the bureaucracy itself. As a matter of fact, we challenge the statement of the witnesses this morning that the primary beneficiary is getting better care where these hospitals have been closed. We think in the absence of any study as to just what has happened to the beneficiaries as the result of the closing of these hospitals that it ill behooves anybody to make that kind of a statement.

We can, however, document hardship cases that have resulted from the closing.

Senator KENNEDY. I think any information in the way of individual letters, or comments of people who have written to you would be very helpful.

Mr. MOODY. We can supply such documentation, and will.

Senator KENNEDY. I think it would be very valuable.

We understand, also, the enormous expense of these contractual arrangements. I don't know whether you have any information on that.

I asked Mr. Clark earlier to come up with whatever he could on that.

Mr. MOODY. We will research that, also.

Senator KENNEDY. And also comments from the members of your union in areas which have had facilities closed and who write to you and say, "Where do we go, what do we do?"

It probably won't show up on statistics, but they are getting poorer service now than they obviously are entitled to. We would like anything you can show on this as well.

Mr. MOODY. There is one point that Mr. Clark alluded to, and that is the point that if we close these hospitals and force many of the primary beneficiaries into the open market for the services of private institutions and private doctors, we are then going to have these patients making a demand upon their union health and welfare funds.

The unions in return will have to make greater demands upon the steamship management which supports these health and welfare funds. This will put an already shaky industry in a most unwholesome

competitive situation, one which the Congress is trying to bail it out of through the Merchant Marine Act of 1970, and we don't need any more of these kinds of obstacles to the success of implementation of that act.

(The information referred to and subsequently supplied may be found on p. 276.)

Senator KENNEDY. Thank you very much, Mr. Moody.

I think this has been a terribly helpful statement. We will review your written statement with great interest. If you could provide this information we discussed as well, I think it would be of great value to us.

(The prepared statement of Mr. Moody follows:)

TESTIMONY OF O. WILLIAM MOODY, ADMINISTRATOR
AFL-CIO MARITIME TRADES DEPARTMENT
ON SENATE CONCURRENT RESOLUTION 6
BEFORE THE
SUBCOMMITTEE ON HEALTH OF THE
SENATE COMMITTEE ON LABOR AND PUBLIC WELFARE
MONDAY, MARCH 8, 1971

Mr. Chairman, and members of the Subcommittee. My name is O. William Moody, and I am the Administrator of the AFL-CIO Maritime Trades Department. This Department is a constitutional arm of the AFL-CIO, created by the national trade union center to represent organized labor's interests in maritime and related fields. There are 42 national and international unions which are affiliated with the Maritime Trades Department. Together, these unions have a membership of more than 7.5 million American workers. These unions are affiliated with the Department because they represent workers in all phases of the maritime industry -- seagoing and shoreside; shipping, shipbuilding, cargo handling and supporting trades and services.

In addition to appearing here today as the spokesman for the Maritime Trades Department, Mr. Chairman, I am also appearing on behalf of my own union -- the Seafarers International Union of North America -- which represents men who man our merchant ships sailing from the Atlantic, Gulf and Pacific Coasts, and from the Great Lakes, which now constitute this nation's "fourth seacoast."

Let me acknowledge at the outset that in the fullest sense of the words, I am here as the representative of a special interest group.

Although the Public Health Service hospitals have taken on additional responsibilities over the years, their primary role is still

the care of America's seamen. In 1969 -- the last year for which figures are available -- seamen represented 52 percent of the patient load. And seamen accounted for 31 percent of the outpatient visits -- more than any other single group.

As you can see, Mr. Chairman, American seamen have a very special interest in these hospitals.

However, this is not a one-way proposition. The United States also has a very special interest in adequate health care for her seamen. This special interest dates back to 1798, when the first marine hospitals -- the direct predecessors of those we are discussing here -- were established.

I hardly need to point out that 1798 fell within the Federalist administration of John Adams. It can be safely assumed that the establishment of marine hospitals was dictated solely by the national interest, not undertaken as a welfare project.

That assumption is fully supported by the facts. The American seaman has always had unique health problems. He is at sea for long periods of time, during which -- with few exceptions -- the only medical care available to him is first aid. Comprehensive treatment of illnesses and injuries must often be deferred until the return to home port. Virtually every returning ship carries a sizeable complement of seamen who need the prompt medical care which only a Public Health Service hospital can provide.

This care must be immediately available, even for ailments which for the rest of the population are less demanding. To avoid loss of employment -- and income -- a seaman needs to get into the hospital

promptly so he can be out in time for the earliest possible sailing. The time pressure increases as U. S. merchant vessels reduce the time they spend in port.

The availability of top-quality medical care on a priority basis in Public Health Service hospitals has made the American merchant sailor the healthiest and most productive in the world -- qualities whose preservation is vital to the success of the nation's expanding maritime program.

By adopting the Merchant Marine Act of 1970, Congress committed the country to maritime expansion. Many new vessels will be built -- ultimately, as many as 30 a year. But the success of this program depends upon the ability of American-flag ships to compete for cargoes. Every unnecessary cost makes this indispensable goal harder to reach.

Suppose the Public Health Service hospitals were allowed to close. Presumably, merchant seamen would first have recourse to the alternatives proposed by the Department of Health, Education and Welfare. But not for long. We have said time and again, and we repeat it today: In a practical sense, these alternatives do not exist. It is a simple, provable fact that the United States does not have enough hospital beds to meet present demands. To pretend that existing facilities cited by HEW could absorb the load now carried by the Public Health Service hospitals is an insult to the intelligence of American seamen and of the Congress itself.

Inevitably, the seamen would be forced to turn to private medicine. They would naturally expect their union health and welfare systems to pay the bills. The impact of these added costs would be more than the

present programs can bear. The unions would have no choice but to negotiate higher contributions from the shipowners.

In an industry where the competitive balance is so close, this might make the difference between success and failure for the merchant marine program. Thus the national interest in these hospital facilities is as clearly evident today as it was to John Adams in 1798.

We believe, Mr. Chairman, that the Public Health Service hospitals are well worth preserving for these reasons alone; that the \$179 million, which the Administration tells us is needed for renovation, would be a small price to pay even if merchant seamen were the only patients.

However, as I indicated at the beginning of this statement, these hospitals now play a far broader role. Coast Guardsmen, injured government workers and a variety of other groups use their facilities. And because of their unsurpassed professional excellence, they have served as teachers, exemplars and training-grounds for others.

The most illuminating evidence of this was provided by hearings in the various hospital communities conducted by "fact-finding commissions" dispatched by the Department of Health, Education and Welfare. The purpose of these commissions was to gauge public reaction to the hospital closings. If, as might be presumed, HEW hoped to find widespread indifference, the results must have come as a shock.

Members of port councils of the Maritime Trades Department attended all these hearings and gave us first-hand accounts. They were remarkably alike in substance.

Most of the hearings drew overflow audiences of two or three hundred; often it was necessary for some to leave so others could be heard.

In attendance were academicians, hospital administrators, surgeons, community leaders, school teachers, servicemen's wives, retirees -- a full cross-section of the residents. All testified that the Public Health Service hospital in their community provided the best possible care, with facilities and personnel of the top rank. They explained why the hospital was irreplaceable, and expressed the deepest dismay at the prospective closing.

If HEW and the rest of the Administration listened to the reports of these commission hearings, the whole matter would be settled by now. But apparently there is as great a need as ever for the persuasive powers of Congress.

Thus we most warmly support Senate Concurrent Resolution 6 as -- if we may say so -- a minimum position. We are confident that the investigation it contemplates will completely vindicate the case for continuing and even expanding the Public Health Service hospitals. However, we also believe a warning is in order.

Three times in the last five years these hospitals have been under attack by the Executive Department, a period involving Administrations of both parties. Since 1965 four hospitals have been closed, leaving only eight.

Over these and previous years, Congress has consistently appropriated funds for the upkeep and modernization of the Public Health Service hospitals, surely indicating that Congress wanted them maintained. But much of this money was never spent.

The danger, as we see it, is that an apparent victory in the present, highly-publicized contest may be subverted in the semi-secrecy of bureaucratic maneuver. A determined opposition in HEW may abandon any further

attempt to close all or many hospitals at once, and instead, pick them off one at a time -- just as was done in the previous five years. We hope the concurrent resolution will not only be enacted but implemented. and that Congress will join us in maintaining constant vigilance against the possibility of piecemeal attacks.

In conclusion, we can do no better than to cite three very similar statements that pose the question clearly.

Paul Hall, president of the Seafarers International Union, wrote to each of you:

"To even consider closing any hospital at a time when so many persons have need for greater medical care than the U. S. health care system can provide is a paradox the nation can ill afford."

AFL-CIO President George Meany told Secretary Richardson:

"To allow the first health-care action of the new year to be the closing of eight hospitals would be a severe blow to the hopes of millions of Americans for adequate and affordable health care."

And the distinguished chairman of this subcommittee, Senator Kennedy, said:

"It would be a tragic mistake to close these facilities . . . at a time when the nation is already facing a severe shortage of health resources."

We believe these reasons, too, are enough in themselves to justify the preservation of these hospitals. We hope the Congress will overwhelmingly agree.

Senator KENNEDY. I hope you will feel that you can communicate as you gather information in terms of what is happening in the local communities.

As I mentionel, we will write the Secretary and ask that HEW people meet with your representatives in these areas. They ought to meet with a wide variety of people; doctors, and others. I hope that you, as well as the other witnesses who appeared here this morning, will give us the reaction you are getting out in the field, the kind of testimony that has been gathered, and the procedures which are being followed so that we can really ventilate this issue. We want to insure that the Federal responsibility is lived up to, and that we are not going to be making a decision at the executive level which frustrates congressional intent in this area, disadvantaging hundreds of thousands of people who otherwise ought to be receiving sufficient health care.

We would welcome this information, and it would be of great service to this committee.

At this point I order printed all statements of those who could not attend today, and other pertinent material submitted for the record.

(The material referred to follows:)

AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

EXECUTIVE COUNCIL
GEORGE MEANY **LANE KIRKLAND**
 PRESIDENT SECRETARY-TREASURER

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815 SIXTEENTH STREET, N.W.
 WASHINGTON, D.C. 20006
 (202) 293-5000

March 9, 1971

Honorable Edward M. Kennedy, Chairman
 Subcommittee on Health
 Senate Committee on Labor and Public Welfare
 4230 New Senate Office Building
 United States Senate
 Washington, D. C.

Dear Mr. Chairman:

Keeping open the eight remaining Public Health Service hospitals is definitely in the public good. The health of the people of our nation must always remain high in our national priorities.

Therefore, we are pleased you are holding hearings on this vital subject.

In lieu of appearing, we ask that the enclosed statement by the AFL-CIO Executive Council on "Public Health Service Hospitals" be included in the Committee report.

Sincerely yours,

Andrew J. Biemiller
 Andrew J. Biemiller, Director
 DEPARTMENT OF LEGISLATION

Statement by the AFL-CIO Executive Council

on

Public Health Service Hospitals

Bal Harbour, Florida
February 18, 1971

The AFL-CIO strongly opposes the Nixon Administration's proposal to dispose of the remaining eight Public Health Service Hospitals. These hospitals are located in major port cities and provide comprehensive health services for the merchant seamen of the United States. But this is not their sole function.

The PHS Hospitals also treat government and military personnel and their dependents. In addition, they provide medical care to the citizens who live in the communities near the hospital, often acute and emergency care that otherwise would not be available.

The cost per patient day in these hospitals averages \$55-\$60 per day, only a little more than half of what private voluntary hospitals are charging in the same cities. Moreover, the per diem cost of PHS hospitals includes medical staff salaries for medical services which are not included under private voluntary community hospitals.

The alternative proposed for the care of PHS Hospitals' patients is to transfer them to the Veterans Administration hospitals. This alternative can hardly be considered seriously. The VA hospitals are understaffed, undermaintained and underfunded. As any veteran knows, the VA hospital system does not have the capacity to meet the medical care needs of veterans, let alone the needs of more patients.

The PHS hospitals must be kept open so that they can continue to provide a wide range of medical services to seamen and private citizens alike. The AFL-CIO calls upon Congress not to allow the closing of the Public Health Service hospitals.



AMERICAN
NURSES'
ASSOCIATION,
INC.

10 COLUMBUS CIRCLE, NEW YORK, N.Y. 10019
TELEPHONE (212) 582-7230

Hildegard E. Peplau, R.N. Ed.D.
President

Eileen M. Jacobi, R.N. Ed.D.
Executive Director

March 25, 1971

The Honorable Edward M. Kennedy
Chairman, Senate Subcommittee on Health
Senate Committee on Labor and Public Welfare
U. S. Senate
4226 New Senate Office Building
Washington, D.C. 20510

Dear Senator Kennedy:

Enclosed is the American Nurses' Association Statement on Proposed
Closing of U.S. Public Health Service Hospitals.

We request that this be made a part of the record of the hearings.

Sincerely,

Constance Holleran
Director, Government Relations

(Washington, D.C. Office)

American Nurses' Association
Statement On
Proposed Closing of U.S. Public Health Service Hospitals
to
Senate Subcommittee on Health
Senate Committee on Labor and Public Welfare
March 25, 1971

The American Nurses' Association is the professional organization of registered nurses in the United States. Its purposes are to foster high standards of nursing practice, promote the professional and educational advancement of nurses and promote the welfare of nurses to the end that all people may have better nursing care.

At this time, when there is an acknowledged health crisis because of the lack of qualified health personnel and adequate facilities for the care of people, the Association believes the proposed closing of the United States Public Health Service Hospitals and clinics may be short-sighted.

These facilities presently serve specifically defined groups such as merchant seamen, members of the Coast Guard and their dependents, dependents of members of the Armed Services, Public Health Service employees and Bureau of Employment Compensation patients. If this clientele seems too limited for the resources available, consideration should be given to extending the services to the people of the communities not now receiving adequate care in which the facilities are located. Expecting these communities, and other Federal installations, to assume the responsibility of providing care to those now cared for in the P.H.S. hospitals is unrealistic, given the shortage of health personnel and local public and private hospital beds and the understaffing and underfunding of other Federal health care facilities, especially in the health care system conducted by the Veterans Administration.

Further, the P.H.S. Hospitals and clinics are now contributing to the education of several types of health personnel. Many provide clinical experience for students of nursing, internes and residents, technicians and others. It would be difficult in some cases for the educational institution to find comparable clinical laboratories.

The hospitals have the reputation of being generous and responsive to community needs. Individuals, otherwise not eligible for care, have been admitted when the special research being conducted by the hospital staff would be of benefit. When an emergency arises which the local hospital cannot meet, admission is possible to the Public Health Service Hospital.

The American Nurses' Association is concerned that quality care be available to all who need it. Before the closing of facilities, public or private, in any community, careful planning should be undertaken to assure that comparable services will be available.

We would like to point out one example of community service. The Public Health Service Hospital is providing comprehensive medical services to the people of San Francisco and Northern California. While the major thrust of this hospital is directed towards the maritime industry, its facilities are used by the total community. A few examples follow:

1) The San Francisco Community Hemo-Dialysis Unit provides treatment for acute and chronic renal disease. This unit as of January 20, 1971 was treating 12 patients, 3 Public Health Service beneficiaries, 3 V. A. beneficiaries and other patients from San Francisco and Northern California.

2) The Leprosy Service and Leprosy Research Unit has at the present time 314 ambulatory patients and averages 5 in-patients; lectures are given at the University of California, Letterman General Hospital, Presbyterian Hospital and a large number of other Northern California hospitals; nearly 1,000 contacts of active leprosy patients are under surveillance by the Clinic.

3) The Richmond Psychiatric Clinic and In-Patient Service provides mental health services for the residents of the Richmond District of San Francisco and in the six month period, July 1970 through December 1970, 144 out-patients evaluations and 398 treatment visits were performed for the Richmond District residents. The above three examples are but a few of the services that would be lost to the people of San Francisco and Northern California.

Another problem created by this proposed action would be the shortage of alternate facilities in the area. San Francisco's community facilities are now overburdened by the Medi-Cal cutbacks, and the additional demand of having to absorb the Public Health Service patients would be traumatic for both patients and staff.

Crews and passengers from passenger vessels, also, use this hospital.

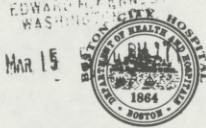
As you can see, the American Nurses' Association has a vital interest in the continuing provision of these patient care services.

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DEPARTMENT OF HEALTH AND HOSPITALS

TRUSTEES

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818 HARRISON AVENUE
 BOSTON, MASSACHUSETTS 02118

Commissioner
 ANDREW P. SACKETT, M.D.

Tel. 424-5365

1971

March

Tenth

Hon. Edward M. Kennedy
 United States Senate
 Washington, D.C. 20510

Dear Senator Kennedy:

I regret very much that I was unable to attend the hearing on March 8, 1971, on the future of the Public Health Service Hospitals. I do have views on the subject which I would like to communicate to you by this letter.

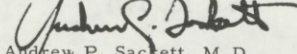
The Public Health Service Hospital has an on-going place in the medical care system of Boston which cannot be filled by any other institution. According to the State Health Department, there is a deficiency of 700 short-term acute care beds in the Greater Boston area. As a result most of the hospitals have a two to six week waiting period for elective admissions. Clearly, no one of them could undertake to provide care to the statutory beneficiaries of the Public Health Service. Even were this possible it would be uneconomic because the per diem cost in the voluntary hospitals is almost double that of the present Brighton Public Health Service Hospital in most instances.

It is important not only this hospital be retained but that its role be expanded. I would propose that this be done by converting it into a community hospital that could provide first rate but low cost care to patients of selected neighborhood health centers who require hospitalization for the "garden variety" of medical conditions as well as continuing to provide care for statutory beneficiaries. The savings to the economy would be substantial. In Boston, an innovative arrangement would be entirely feasible and one which would provide for a demonstration of low cost ways of providing high quality care through a different organizational arrangement.

I would urge that with the permission of Congress, the Administration be encouraged to embark on a feasibility study to explore the several interesting possibilities that come to mind for the future of this institution. There is an opportunity here to do something positive and unique. It is imperative that it not be lost.

I have been in touch with the three medical schools and with a number of substantial and skilled providers of care. All are very interested in the future of the hospital and are willing to collaborate fully with any feasibility determining and planning activity that is set up. Their expertise and resources will be made fully available in order that an optimal arrangement can be worked out. My office will be available also to assist in any way possible.

Sincerely yours,



Andrew P. Sackett, M.D.

Commissioner

Department of Health and Hospitals



 REGIONAL PLANNING COUNCIL

101 WEST FAUL STREET BALTIMORE, MARYLAND 21202 TEL. AREA 6-0100

March 16, 1971

The Honorable Edward M. Kennedy
 Chairman, Subcommittee on Health
 U.S. Senate Committee on Labor and Public Welfare
 431 Old Senate Office Building
 Washington, D. C. 20510

Dear Senator Kennedy:

On your committee's investigation into the nation's health care crisis, I am writing, as Chairman of the Regional Planning Council, to share with you some views of the Public Health Service Hospitals situation in the context of areawide planning for metropolitan Baltimore.

The Regional Planning Council was established by the Maryland General Assembly in 1963 as a cooperative planning body for metropolitan Baltimore, an area of about 2200 square miles, in which two million persons reside. The majority of our governing body are local elected officials from the area's six major jurisdictions -- Baltimore City, and Anne Arundel, Baltimore, Carroll, Harford and Howard Counties.

The Regional Planning Council has been designated by the local community, the State of Maryland, and the United States Department of Health, Education and Welfare as the region's areawide health planning agency. This responsibility is carried out in joint effort with a broadly representative Citizens Health Council, which involves the general public and the many individuals, and private and public organizations providing health service in the area. Our planning strategy and style is to involve those affected and those who can affect health planning decisions. We view federal resources, including the Public Health Service Hospital in Wyman Park, as regional resources. The PHS Hospital and the neighboring community have been planning together to meet people's needs nearby, and have related their planning to community health planning. Thus, we were very much concerned when the precipitous closing of PHS hospitals and clinics was first rumored last December.

We are aware of the complex issues which the Congress and Administration must face in considering the Public Health Service Hospital's role and future course at this time of transition and accelerating health care crisis. Our basic position is to support the continuation, indeed, the strengthening of the Public Health Service Hospital as a community resource; with that, we strongly feel that the role and function of such technical resources should be determined in good part in the context of the health needs and strategies of the communities in which they are located. We also suggest that the role and function, and needs and strategies for the Public Health Service Hospitals will be different from one community to another.

We have found that the Public Health Service Hospital in our community has, with a relatively small federal investment, demonstrated itself, already to be a critical catalyst for innovative manpower development. The hospital serves individuals involved in manpower programs ranging from high school and Job Corps through post-graduate university training. Of perhaps greater importance, the hospital and its staff have demonstrated the potential to be a creative nucleus for developing more effective community health service systems.

In January, we assisted in a "fact-finding" visit by an HEW team; and our Health Planning Director, William McC. Hiscock, chaired an evening discussion session of leaders from our community's varied parts. The evening session demonstrated an unique coalescence of state and local legislators and executives, neighborhood citizens groups, adjacent hospitals, medical societies and hospital associations. The coalescence was around the point I made above: the demonstrated and potential ability of the PHS hospital to assist in solving health care problems in our community.

As in most metropolitan areas, primary ambulatory care is a principal deficit. Should the hospital be closed, this deficit would be magnified for the federal beneficiaries for whom the hospital provides health maintenance and care continuity. On the other hand, we have an unique opportunity: a programmed extension of the facility as a community resource could assist in meeting that deficit for a significant portion of the people in our region. In short, we urge an alternative in which the federal partners join with us in areawide health planning, on the ground in Baltimore, focused on the twin problems of care for beneficiaries and the function of the PHS hospital.

If such a positive course is to be followed, several steps are important now, including:

1. A clear and loud declaration of intent from HEW that this course will be followed to prevent the loss of staff by attrition.

2. A commitment, supported by the Congress, to work through the inherent issues.
3. Encouragement of the facility and its staff to continue and extend its community service functions.
4. Recognition by the Administration and the Congress of the capital and operating costs involved.

The members of the Regional Planning Council and Citizens Health Council, and our staff are pleased to present our thoughts to you. We are encouraged by the interest shown by the Congress in this issue, and we stand ready to assist in any way in developing a positive resolution in our area.

Sincerely,

Carville M. Akehurst
Chairman
Regional Planning Council

djf

cc: The Honorable J. Glenn Beal, Jr.
The Honorable Charles McC. Mathias

bcc: Mr. Stanley B. Jones

Staten Island Chamber Of Commerce

Adam P. Antenucci
President

Richard B. Irwin, CCE
Executive Vice President



130 Bay St., Staten Island, N. Y. 10301

212-727-1900

March 5, 1971

Senator Jacob J. Javits
Subcommittee on Health,
Committee on Labor and Public Welfare
Senate Office Building
Washington D. C.

COMAR 8 1971

Dear Senator Javits:

We learned today that you will preside at a hearing concerning the United States Public Health Service on Monday, March 8, 1971. We would have liked to have had a Chamber representative present, but the short notice of the session makes it impossible. Therefore, I would appreciate your including the following statement:

The largest Public Health Hospital is on Staten Island, and The Staten Island Chamber of Commerce believes it is absolutely essential that this hospital be retained.

Staten Island is a community of 300,000 people - is growing rapidly - and it presently needs about 700 additional hospital beds. The closing of Public Health Hospital would be a medical disaster to this community.

All Island hospitals rely on the medical expertise and advanced equipment and research at the Public Health Hospital, as well as bed space it makes available to patients needing emergency care. The Island's other hospitals are operating at or over capacity; this community needs increased medical facilities, not less.

Many services are provided by the United States Public Health Service Hospital on Staten Island. Some facts about it are:

It serves 420 patients per day.

It serves 140,000 out patients annually.

It provides emergency medical service to the public.

It provides physical examinations and laboratory tests for a number of local agencies.

It provides desperately needed nurses training in cooperation with local colleges.

It provides desperately needed laboratory technician training.

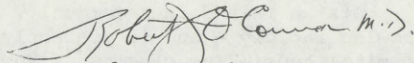
It provides desperately needed dental laboratory technician training.

It provides unique medical assistance for our other hospitals and their staffs.

If this hospital is closed who is going to fill the huge gap created by its absence? Certainly no other facility on our 60 square mile Island can provide the medical services, and other nearby New York City hospitals are already crowded.

Staten Island needs the Public Health Hospital. The Staten Island Chamber of Commerce urges - as strongly as possible - that it be retained.

Very truly yours,

A handwritten signature in dark ink, appearing to read "Robert J. O'Connor M.D.", with a stylized flourish at the end.

Robert J. O'Connor, M.D.
Chairman, Subcommittee on
Health Facilities
Community Development Committee



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

DIRECTOR
U.S. PUBLIC HEALTH SERVICE HOSPITAL
NORFOLK, VIRGINIA 23506

March 4, 1971

The Honorable William B. Spong, Jr.
U.S. Senator (Virginia)
5327 New Senate Office Building
Washington, D. C. 20510

Dear Senator Spong:

Thank you for your telegram of March 3rd. I am pleased to have the opportunity of filing a statement for you to insert in the hearing record on reasons why the U.S. Public Health Service Hospital in Norfolk should remain open.

As a resident of the City of Norfolk, a former employee with the Virginia Department of Welfare and Institutions during which time I supervised a number of Welfare Agencies in the Hampton Roads Area, and currently the Chief of the Social Service Department at the U.S. Public Health Service Hospital in Norfolk, I feel that I can speak with knowledge of the excellent medical and para-medical services offered at this hospital and its value to the area communities.

The U.S. Public Health Service Hospital in Norfolk was the first to be established for the care and treatment of Merchant Seamen. It not only has a reputation of giving excellent medical care to patients but it is a landmark of historical significance and it has a great deal of meaning to the citizens of Norfolk and the adjoining communities.

This facility has 210 operating beds. It is a general medical and surgical hospital with all the supporting para-medical services. Last year the hospital had an average daily patient work load of 142 or 67.6% occupancy. It also had 92,983 outpatient visits. These figures are misleading as to the needs in the community. In my opinion any underutilization of this hospital is due to the lack of financial support and proper staffing.

The beneficiaries include in addition to American Seamen, other related Seamen, Coastguardsmen, retired service personnel, their dependents, dependents of active duty service personnel and certain Federal Civil Service personnel, etc.

The area served by the hospital includes Virginia, North Carolina, South Carolina, Georgia and Foreign Seamen. It is particularly valuable to areas such as the outier banks of North Carolina, Mathews and Gloucester Counties, Virginia, etc. where hospital facilities do not exist.

Hospital facilities in the Tidewater area are overcrowded and long waiting periods are necessary. Many service dependents and retired personnel live in the Norfolk area. Transportation to the Naval Hospital in Portsmouth, including the tunnel fares, is more expensive than most of the beneficiaries can afford. In addition many prefer coming to this hospital.

Private medical care under the Champus program is inadequate. Most dependents and retired people cannot afford the initial payment of \$50.00 or \$100.00, nor can they afford to pay the 20% or 25% required for continuing treatment. Cost for patient care in private hospitals continues to increase. Should this hospital close many eligible persons in need of medical care will go lacking and the impact on the Health and Welfare agencies in the communities will be greatly increased.

In my opinion the Veterans Administration Hospital in Hampton will not be able to adequately absorb the extra work load imposed by closing this hospital. We are currently experiencing difficulty in transferring inpatient Veterans to the Veterans Hospitals. It takes one or two months sometimes to complete a transfer due to the lack of beds. Outpatient Veterans who apply are often put on long waiting lists.

This hospital offers some services that are not available in the community. Examples are the MIRA MF - 1000 Xenon AVC Photo Coagulator in our Ophthalmology Department. This Coagulator is the only one available in Eastern Virginia area and it is available for non-beneficiaries on a reimbursable basis as well as beneficiaries. In addition to all the normal radiology and nuclear medicine procedures, the Radiology Department makes diagnostic ultrasound studies. This is the only hospital in the Greater Norfolk, Virginia Beach and Portsmouth area which offers these ultrasound studies. This hospital is the only one in South Hampton Roads with a professionally trained Social Service staff. They are often asked to give services to the nearby Naval Dispensary.

The U.S. Public Health Service Hospital in Norfolk serves as a teaching facility for doctors, nurses, physical therapists, social workers and other para-medical personnel. The hospital has academic affiliations with several educational institutions including Norfolk State College and Old Dominion University School of Nursing; Virginia Commonwealth University School of Social Work and School of Physical Therapy; Medical College of Virginia, University of Pennsylvania and Marquette University School of Physical Therapy. The hospital will no doubt expand its teaching facilities with the forthcoming medical school.

The hospital employs 332 people including 42 Commissioned Officers and 290 Civil Service workers. All of these employees are devoted to giving personalized attention to each patient. The Staff services are supplemented by the employment of special consultants such as psychiatrists as needed.

We cannot overlook the fact that closing the hospital would not only be a disservice to patients but that many of the employees would have difficulty locating other jobs in the community. Many would lose retirement benefits and some would probably find themselves on the Welfare rolls.

I had the opportunity of sitting in on all five of the hearings conducted recently by a team from the Federal Health Programs Service. I heard repeated statements from community leaders, politicians, members from training institutions, beneficiaries and employees affirming to the need for continued operation and expansion of this facilities services.

Most assuredly, the Norfolk hospital is busy and its activities is evidence that it is needed. It would appear that with the unmet medical and dental needs and with the rising cost of private medical care that this hospital should not close. There is a great need for treatment of drug addicts in the area as well as for alcoholics.

It would appear to be a sounder plan to modernize the hospital with a new structure or remodel the present structures to afford more adequate facilities, and to expand services in all areas of medical care.

Your help and concern is greatly appreciated.

Sincerely,

Beulah D. Wheeler
(Mrs.) Beulah D. Wheeler, ACSW
Chief, Social Service Department

BDW:mf

cc:
Dr. Garfield



City of Norfolk

Virginia

Office of the Mayor

STATEMENT OF ROY B. MARTIN, JR., MAYOR, CITY OF NORFOLK, VIRGINIA IN
REGARD TO THE UNITED STATES PUBLIC HEALTH SERVICE HOSPITAL, HAMPTON
BOULEVARD, NORFOLK, VIRGINIA

Hampton Roads, being one of the maritime centers of the world, can ill afford to lose the United States Public Health Service Hospital which serves the merchantmen who visit this port.

Beyond this, the United States Public Health Service Hospital also serves the dependents of military families in the area due to its close location to much Navy housing. It would be a tremendous inconvenience to these dependents if this hospital were closed.

It has been the feeling of many of us that the use of this facility by the various branches of the military should be expanded. The closing of the United States Public Health Service Hospital would be very detrimental to the overall health needs of these citizens. The City of Norfolk, like other communities throughout the nation, needs additional hospital beds, not fewer. I think the records will show that the other hospitals in the area will not be able to take the case load that is now being handled by the United States Public Health Service Hospital.

We sincerely urge that every consideration be given to maintaining this facility and, if anything, to expand its operation and certainly not to close it down or lessen the services to the community that are now offered by the United States Public Health Service Hospital located in the City of Norfolk, Virginia.



SEAMEN'S CHURCH INSTITUTE of NEW YORK

15 STATE STREET, NEW YORK, N. Y. 10004

(212) 269-2710

THE REV. JOHN M. MULLIGAN, DIRECTOR

FOUNDED 1834

February 23, 1971

The Hon. William B. Spong
Member of Senate Committee on Commerce
United States Senate
Washington, D. C.

Dear Senator Spong:

As Director of the Seamen's Church Institute of New York, an agency which since 1834 has been dealing with the welfare and health of merchant seamen of all races and nationalities coming into the Port of New York, we wish to let you know of our firm support of Representative Long's concurrent resolution pertaining to the continuance of the United States Public Health Service Hospitals. We urge that hearings on the matter be held and that all interested parties be notified so that they can submit testimony, if invited.

The closing of these facilities would result in the termination of extremely important research programs and the dispersal of highly effective professional personnel who over the years have gained great expertise in coping with maladies and injuries peculiar to seamen. Since no budgetary saving can result, it would seem unwise of the Government to close these valuable institutions. The move would also put in further jeopardy the historic status of the American seaman as a "Ward of the Government".

We therefore urge that every effort be made to persuade the Congress not only to continue but to improve these facilities.

Faithfully yours,

John M. Mulligan
The Rev. John M. Mulligan, D.D.
Director

JMM:c

BUSINESS AND PROFESSIONAL WOMEN'S CLUB
Portsmouth, Virginia

March 6, 1971

The Honorable William B. Spong, Jr.
United States Senate
Washington, D.C. 20510

Dear Senator Spong:

The members of the Business and Professional Women's Club of Portsmouth are opposed to the closing of the Public Health Service Hospital of Norfolk, and as you will recall, we notified you of our position on January 30, 1971.

Since our organization will not be represented at the public hearing on Monday, March 8th, we wish the record to show our opposition to this proposal, and our support of Senate Concurrent Resolution 6. We ask that you please file the enclosed copy of this letter to you with the Senate Labor and Public Welfare Subcommittee.

We strongly believe that the Public Health Service Hospitals and out-patients should be adequately funded through 1972, pending a thorough Congressional investigation.

We would remind the gentlemen of the Subcommittee that President Nixon is firmly committed to an improved national health care program, and any reduction of such services by HEW, without Congressional approval, would, of necessity, have to be interpreted as a violation of his pledge to the people of this country.

Thank you for your cooperation and interest in this important matter.

Sincerely yours,

Inez D. Baker
(Mrs.) Inez D. Baker, Chairman
Civic Participation Committee
81 Kansas Avenue
Portsmouth, Virginia 23701

cc: (2)
Senate Labor and Public Welfare Subcommittee
Representative G. William Whitehurst

TELEGRAMS

NORFOLK, VA., March 6, 1971.

Senator WILLIAM B. SPONG, Jr.,
New Senate Office Building,
Washington, D.C.

Hospital beds in Norfolk, Va., are presently at a premium, there being a continuous waiting list. I urge upon the Congress to look favorably in keeping of the U.S. Public Health Hospital open. Its closing would create an undue hardship on this maritime oriented community.

Mrs. ROSE MURDOCK,
President, LAFRA Unit 60.

RICHMOND, VA., March 22, 1971.

Hon. WILLIAM A. SPONG,
U.S. Senate,
Washington, D.C.

I am sending you this telegram to express my concern about the proposed closing of the Public Health Service Hospital at Norfolk, Va. I would hope that the facility would be retained until a detailed analysis of the issues at stake can be completed. Present evidence indicates that if this facility is closed, the people that it now serves would not receive adequate care from any other existing facility. Knowledgeable medical personnel in the Norfolk area have presented these facts to my office, and I feel that these citizens are sincere in their expressed concern of the health of those served by the hospital.

I am aware of those who may consider the closing of this hospital as in the best interest of the U.S. Government. But I am aware of the people it serves and consider its retention in the best interests of their health and welfare. Until facilities are available to serve the people that the Public Health Service Hospital now serves, I strongly support its retention.

I would appreciate it if you would have this statement included in the record of the hearing on the closing of the hospital held March 6, 1971, by Senator Edward Kennedy.

LINWOOD HOLTON,
Governor of Virginia.

STATEMENT BY REPRESENTATIVE JOHN M. MURPHY
BEFORE THE SUBCOMMITTEE ON HEALTH OF THE
SENATE COMMITTEE ON LABOR AND PUBLIC WELFARE

MARCH 1, 1971

Mr. Chairman, late last year rumors began to circulate about the future of the Public Health Service. Some had it that the eight PHS hospitals and thirty clinics would close almost immediately; others talked of a staged closing of some facilities over a period of a year or so.

The origins of these rumors were in the Department of Health, Education and Welfare (HEW). A decision was being formulated - without the advice or consent of the Congress - to proceed to closing of the Public Health Service system. This decision was being made in direct response to an edict by the Office of Management and Budget (OMB) to close the hospitals, and to seek coverage for beneficiaries on a contract basis.

This decision was made in secret, in direct disregard for the Congress, and in heartless ignorance of the impact of this decision on the hundreds of thousands of Americans dependent on the Public Health Service.

I commend the distinguished Chairman of this Subcommittee for bringing the full glare of Congressional and public awareness to bear on the plans of the bureaucrats who are toying with the future of the Public Health Service. We now have full public discussion of the Public Health Service, and any decision that ensues will be based on the best information available. I also commend Chairman Edward Garmatz of the Committee on Merchant Marine and Fisheries for his early and forthright exposure of HEW and OMB plans for clandestine elimination of the Public Health Service System. And finally I wish to commend Chairman Paul Rogers of the House Public Health and Welfare Subcommittee for his diligent efforts to prevent this travesty from being foisted on the American people.

The largest Public Health Service Hospital is located in my district (Staten Island, New York), and serves the entire New York metropolitan area and beyond.

The hospital began as a 34-bed facility in 1831, and has been treating American seamen and other beneficiaries ever since. The Federal government formally purchased the facility in 1903, and has had direct responsibility for its operation since that time.

The Staten Island hospital has responsibility for Public Health Service medical care activities within the States of New York, New Jersey, part of Connecticut, part of Pennsylvania, Ohio, Michigan, Illinois, the Virgin Islands, and Puerto Rico. It also operates as a central medical center with

direct responsibility for 9 satellite Outpatient Clinics located in Buffalo, Charlotte Amalie, Chicago, Cincinnati, Cleveland, Detroit, New York, Philadelphia, and San Juan.

Additional responsibilities include supervision of contract physicians in Albany, Cape May, Oswego, and Point Pleasant; provision of consultant service and relief to the Merchant Marine Academy at Kings Point; operation of a central dental laboratory servicing Public Health Service Hospitals, ten Outpatient Clinics, and 11 Coast Guard Bases; regional recruitment and processing of commissioned personnel; maintenance of isolation facilities for quarantinable diseases for the Quarantine Division; medical evaluations for the U.S. Immigration and Naturalization Service; hospitalization of complex medical care cases for the Bureau of Prisons; training of paramedical personnel for the Federal Health Programs Service, Division of Indian Health, and for the community, including laboratory technologists, X-Ray technicians, nurse anesthetists, and practical nurses; provision of immunization service for foreign travelers, including yellow fever, smallpox, plague, and cholera vaccinations; medical treatment and evaluation for Department of Labor, Bureau of Employees Compensation referrals; operation of the East Coast Leprosy Center; operation of the Pharmacist Mate School for ships' pursers; and medical evaluations for Cuban Refugees seeking citizenship.

It should be obvious from the foregoing that the Public Health Hospital on Staten Island is a principal medical facility on the East Coast, serving a wide range of public health functions. Any intelligent consideration of change in the operation of this system must be the product of careful and detailed study by the Department of Health, Education, and Welfare, and the appropriate Committees of the Congress. It must not be the result of hasty and arbitrary decisions by dollar-conscious accountants in the Office of Management and Budget.

When Doctor Egeberg testified late last week he described three principal alternatives currently under study in HEW. They include maintenance of the present system with expansion into the community, and two variations of a scheme for conversion to local use.

However, judging from the history of OMB and HEW handling of the question of the future of the PHS, it is clear to me that the first alternative

is not seriously under consideration. Rather, HEW appears tightly bound to the OMB edict to get out of the public health business. This was abundantly reflected in the President's budget, which included no funds for continuation of the Public Health Service.

It is unfortunate that serious consideration of the first alternative - maintenance and expansion of the existing system - is not really taking place. Yet it is this alternative that offers the best course for the future, and it is the course which I heartily recommend to this committee. I support adoption of the many resolutions expressing the sense of Congress that the Public Health Service be maintained as a vital source of primary health care for beneficiaries entitled to care under the law - the law as enacted by Congress, and not the law as interpreted by bureaucrats.

In this connection, I note that two legal opinions rendered by the Comptroller General of the United States flatly affirm the illegality of HEW administratively terminating the Public Health Service. This service was created by the Congress, and its future should be determined by the Congress. I understand that HEW will submit a legal opinion to the contrary, and I noted with some dismay the assertion by the Comptroller of the Health Services and Mental Health Administration, before this Subcommittee, that the ruling by the Comptroller General of the United States merely constituted "one man's opinion." We shall see.

The Public Health Service is a first-class source of medical care for its primary beneficiaries. It must continue to treat those beneficiaries entitled under the law, and the facilities for such care should be maintained in an up-to-date condition.

The system should also be expanded to make full use of its facilities in the community-at-large (on this we are all agreed). To the extent that PHS beds are available, they should be used for emergency care for any person requiring care not available elsewhere. They should also be used on a reimbursable basis for care for patients on an elective basis, particularly when the beds would otherwise be idle. In this regard, both Medicare and Medicaid patients should be covered for treatment in a Public Health Service hospital when other sources of care are not available. Acceptance of patients on a reimbursable basis would be the smoothest and least costly method whereby

PHS could extend itself into the community at large.

Incidentally, this idea is not new - it was receiving active consideration within HEW and elsewhere when the first dark rumors of closing began to seep out.

Further, the hospitals and clinics can and must assume a greater role in the treatment of narcotics addiction. Clearly, it would be absurd to back-out of the primary health care business when there is a crying national need for effective treatment centers for narcotics addicts. The federal government is currently expanding its funding and involvement in treatment centers; how absurd to close one ready-to-use system of facilities only to provide greater funding elsewhere in the bureaucratic maze for new facilities.

In this connection, I plan to introduce an omnibus bill for federal commitment of certain classes of addicts - particularly recent veterans who return to civilian life as drug addicts. The PHS is ^{eminently} ~~eminently~~ suited and capable of treating these addicts. If we proceed with dismantling the PHS, then we will only have to go elsewhere - at greater expense - to treat these addicts. They are not going to disappear, and society will have to treat them one way or another.

Since the first rumblings of closing began, the thousands of dedicated personnel in PHS have lived with doubt and uncertainty as to the future of their jobs. This doubt has inflicted harm throughout the system, and has affected recruitment of new interns, doctors, nurses, and other professional, para-professional, and non-professional personnel. This doubt and uncertainty can potentially destroy the high-spirited dedication of these men and women, and it could deal a fatal blow to PHS by attrition. I remind you that most of these people work for PHS at salaries far below those available in private medicine. Doubt and uncertainty will ultimately drive them away.

When Dr. Egeberg appeared, he frankly admitted that any alternative under consideration would involve a vast increase in the funding of PHS or service to its primary beneficiaries under contract arrangements. This is a far cry from the early OMB interest in reducing costs, and thoroughly negates any argument emitting from that corner of the government.

Meeting our legal and moral responsibility to PHS primary beneficiaries,

and intelligent expansion into a greater community role, will certainly cost money. However, the greatest savings - in dollars and ^{lives} - will ultimately be achieved by improving and expanding our existing system, rather than inventing new bureaucratic schemes for conversion and contract care.

Mr. Chairman, I urge prompt consideration and passage of H.Con.Res. 98 and similar measures, and early consideration of the best future role of the Public Health Service. Thank you.

#####

United States Senate
Hearings
Room 4232
New Senate Office Building
Washington, D. C.

Ref: The closing of eight
Public Health Service
Hospitals.

Dear Sirs:

It is with great and sincere appreciation that we have been invited by the Honorable William B. Spong, Jr., Senator of the State of Virginia, to voice our opposition to the closing of eight Public Health Service hospitals.

It is indeed a personal honor to be called upon, by the President of the 'TIDEWATER VETERANS ASSOCIATION', Mr. Warren E. Waters, to present to you our facts and opinions, as we believe them to be, honest, trustworthy and sincere.

We of the 'Tidewater Veterans Association' (Inc. of VA.), consist of forty two thousand members, representing thirty five different veterans groups, all being located in this, the most stratic military area of our nation.

Through the portals of our local seaports, pass many great ships of our nations Navy, many of whom are berthed in this area. As well as other ships that pass through these portals, some privately owned, and those of other nations..., all being served by our local Public Health Service facilities.

Many men and their families, who have served our great nation, in verious military uniforms, have retired in this area, due to the availability of medical care and treatment... Some having picked up the gauntlet to further serve our nation... Many have passed away leaving loved ones to more or less shift for themselves and in the apathy of our society, these loved ones have no income after the passing of the military retired....

In the 'retired', many Comrades families are advised of 'Champus', but champus requires a forty precent payment for medical expenses, and of course the depending on what medical facility and/or doctor willing to accept this program.

The Public Health Service hospitals are indeed the 'lighthouse' in the storm of the destitue, and especially those who have served our great nation.

In our local newspapers and on radio and television, it was suggested that the Public Health Service hospital patients be transfered to the local Veterans Administration Hospital facility.... This was not confirmed or denied by the local V. A. Administrator, however it was stated that such decisions would have to come from the central office.

Upon checking with the Veterans Administration, it was learned that there were only eighteen beds available and these were reserved for emergency patients only.

I, as a member of this association, as a Life Member of the Disabled American Veterans, as Past Department Commander for the Disabled American Veterans of Virginia and as current Commander of a local Chapter of the Disabled American Veterans, make special note of opposing any encroachment upon the hospital care and treatment of our nations wartime service connected disabled veterans.

The proposed closing of these Public Health Service hospitals, remind me greatly of the closing of various Veterans Administration hospital facilities in 1965... In my opinion, this shows complete and utter disconcern and even contempt to those who have and who are now serving our great nation.

In the begining of the Public Health Service facilities was for deep sea sailors, this was later expanded to include certain units of the military, the Coast Guard and Navy and some lay citizens in cases of emergency.... Through the war years this service was expanded still more to include the military retired and some local welfare cases..

These eight Public Health Service facilities services have been extended to some fourteen thousand ships and have a record of some ninty thousand out patients, in 1970 alone.

While unknown to the general public, the Public Health Services have controled and prevented the spreading of many dreaded diseases: Cholera, Small Pox and yellow feaver, to name a few...., Then further extended their services whenever there is a disaster....

These Public Health Service facilities are needed in our area, due the hurricane 'alley' that exist along our Atlantic sea coast.

On report, there are some fifty cases handled at sea and over forty that was handled within these facilities...

As some clinics of the Navy have been closed and are being closed, the patients have no recourse but to seek medical assistance from the local Public Health facilities.

It has been reported that some Navy wivies have had to wait as long as three hours at the Naval Dispensary, and on an average of three to four ~~days~~ weeks for treatment.!!

For the Naval personal living in Norfolk area, they have to travel to Portsmouth for treatment, which is some distance away and which requires a combination of 'road' and 'tunnel' fares, to say nothing of the public transportation... In cases of emergency, it would cost fifteen dollars or more to reach the Naval Hospital in Portsmouth..! (Which for the lower graded Naval personnel, makes it nearly impossible.)

Currently, the hospital at Fort Monroe, Va., is closed, only limited clinical work is done there, If hospital care is required, the patient is 'shifted' to Langley Air Force Base, Va., or to Portsmouth Naval Hospital... It is nothing unusual for a patient to start out from Fort Monroe, then to the Langley Air Force Base, then to the Portsmouth Naval hospital, then be brought back to the local Veterans Administration, especially if the patient is military retired....

It is felt that this Committee should understand the complex problem of this area, Fort Monroe is located at the end of the peninsula, Langley Air Force Base is located a bit higher up on the peninsula, about ten miles from Fort Monroe, the local V. A. Center is more or less in between, facing Hampton Roads and is located in the community of Hampton. Norfolk is less than twenty minutes or so away, but requires the passing over a bridge and through a tunnel, in which a 'toll' is required, To pass from Norfolk to Portsmouth, another tunnel and thus another 'toll', to go from 'Hampton' to the Portsmouth Naval hospital one has to choose one of two ways, either of which require a 'toll', the second choice would be to go over the James River Bridge to reach Portsmouth, a distance slightly over twenty miles, Thus the whole area is connected by a system of 'toll' roads and bridges.

Therefore, in view that many of the Naval personnel, live within reasonable distance of this Public Health Service hospital, it makes care and treatment within fare means of the Naval personnel, as well as many of the retired military personnel....

In reference to 'CHAMPUS', and the statement made, It was explained that the 'retiree makes all payments to the hospital or doctor and then they must submit a statement for the return of forty percent of the medical care.... It is understood that this program is being changed.....

Regretfully, many physicians prefer to see the color of ones money, before knowing the ailment of the patients.....

Many civilian employees, working for the Navy in the Norfolk area are treated at the Public Health Service center, for injuries accuring on their jobs, to say nothing of those employees who may come in contact with a disease that could be transported to other employees and/or members of their families.

The Honorable Representative J. M. Murphy, is reported to have said, "To close these Public Health Service facilities, is a joke, with nothing to laugh at....!"

Medical care and treatment for all our citizens must be upper most in our minds and deeds, There is nothing that our citizens should have to make a choice of, in so far as medical aide in required. We have those citizens who were injured in a time of war, we have those citizens who have escaped injury and who fulfilled their obligations to our nation and who are retired, then last and surely not the least, are those citizens who suffer physicial ailments,

social and economical problems, must be cured so that they will become productive citizens of our communities, Therefore the medical aide, cure and treatment are related in three stages, each equal to the other, each in their own right requiring a division headed by qualified medical assistance, care and treatment.

The three stages being qually divided, in so far as medical aide and assistance are refered to:

- (1) The wartime disabled and their families.
- (2) The 'in' service and retired and their families.
- (3) The deprived citizen and that family.

Not included are the 'special' services to our national deepsea seamen and other deepsea seamen of other nations, When any of the four herein mentioned are combined without full and just understanding of the consequence, then dissatification will result, regardless of what may be suggested or imposed as a replacement.

The initial problem here is a notable proposed discontinuance of services, That have long been established as a result of wars and unavailable hospital care and treatment elsewhere within the communities now associated with the Public Health Service hospital, without any policy to re-establish equal care and treatment within a reasonable distance of those effected.

While an agency of government has proposed the closing of these Public Health Service facilities, it must be noted that the hardships imposed would be unworthy of our nation in response to the need and care of those being effected.....

Of what net gain it would be to close these facilities, can only be determined by the loss of the benefits of those who have profited from the medical skills in this great Public Health Service....

Then there is the question of these facilities being 'turned' over to some other federal agency..., Then this body should be made aware of this, Based upon the cost of 'transfer', if additional federal funding would be required, via another federal agency or agencies. What agency would assume control and to what extent would their services be?

In the meantime while awaiting whatever is to be determined, it must be noted the civilian employees are not going to wait for the doors to be closed before they seek other federal jobs or jobs in private institutions... These employees will began to leave this facility, thus in part, this would greatly effect the well being of this facility and the patients therein.....

We, of the Tidewater Veterans Association are greatly concerned for all those directly effected by the proposed closing of these Public Health Service facilities, we lack comprehensive knowledge of what federal agency, if any, that would assume this awesome task of fulfilling the 'medical care and treatment' gap that will exist....

Unrelated prehaps to the problem at hand, but of late there are two hospitals in the sister city of Hampton, Newport News that are considering closing their doors because they do not have the funds to maintain their hospitals, one is the Mary Immaculate Hospital, operated by a Catholic organization and the other is the Whittaker Memorial Hospital operated by negros in their community, Both hospitals reported the lack of funds and patients.... It must be noted here, that the lack of 'patients' can only mean those that could afford treatment in either hospital. Both hospitals have a fine medical staff, I have had the pleasure of visiting them, their medical equipment is modern and some of the best... The 'relationship' here can only be the mere fact that 'patients' can not afford the high cost of medical care now being demanded throughout the whole nation.

This further suggest that private interprise can not prevale where cost exceed income, nor can those citizens who are and who have served their country, pay for services that exceed their income....

Our nations military is expending their advertising program, to seek and enlist young men into our armed forces, they are seeking to renew the roots of a complete volunteer army and navy, as well as in other branches of the military... It is nearly impossible to establishe the military on the bases of volunteers, without first establishing the benefits to be obtained from the same, and medical care and treatment, must be the backbone of these benefits, during and after our citizens have faithfully fulfilled their obligations, this applies equally to the families of the proposed volunteers. To further guarantee the 'rights' to these proposed 'volunteers', they should be 'excluded' from having to submit, for medical treatment and care, to any educational instution; Meaning any and all Medical Colleges, without the expressed written consent of that veteran and/or members of his family....

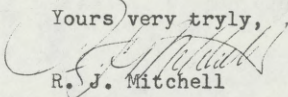
We may have leaped from one subject matter to another, however each subject is related to the closing (or proposed closing) of eight Public Health Service facilities. Where such facility is combined with other federal agencies or military units, such as in the Norfolk facility, which are:

- The Coast Guard and families
- The Navy and families
- The retired and their families
- The merchant marine of our nation and others.
- and the Welfare caes....

Each group in their own right depend greatly upon this facility, The Public Health Services, without which great and grave hardship would be imposed upon all.

I wish to thank this Committee for allowing the TIDEWATER VETERANS ASSOCIATION, to express our concerns, our opinions and viewpoints, Respectfully submitted in behalf of Mr. Warren E. Waters, President Tidewaters Association, Inc., of Norfolk, Va.

Yours very tryly,


R. J. Mitchell

CC: MR. WARREN E. WATERS
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THE HONORABLE WILLIAM B. SPONG
SENATOR OF VIRGINIA
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WASHINGTON, D. C. 20510

File:

STATEMENT
of the
AFL-CIO MARITIME COMMITTEE
Before the
SUBCOMMITTEE ON HEALTH
of the
SENATE LABOR AND PUBLIC WELFARE COMMITTEE
on
SENATE CONCURRENT RESOLUTION #6

Presented by:

Joseph Curran
Chairman

March 8, 1971

March 8, 1971

My name is Joseph Curran. I am President of the National Maritime Union of America, AFL-CIO and Chairman of the AFL-CIO Maritime Committee.

The AFL-CIO Maritime Committee consists of the following unions:

National Maritime Union

National Marine Engineers' Beneficial Association

International Longshoremen's Association

International Organization of Masters, Mates and Pilots

American Radio Association

United Steelworkers of America

Mr. Chairman, in our support of your position aimed at keeping open the Public Health Service Hospitals, we shall be as brief as possible. Despite this, for clarification purposes, we will be compelled to repeat some of the arguments presented to you in the past and today.

We thank and commend Senator Kennedy and his co-sponsors of Senate Concurrent Resolution #6. We urge one basic modification which is to strengthen the "resolve" language starting on line 5 of page 3 of the resolution which states, "During this interval, the Secretary and the Congress should explore the resources and capabilities of these facilities in their communities, to determine which facilities should continue to be operated

by the Public Health Service, which facilities should be converted to community operation, and which facilities, if any, should be closed." We understand the importance of this intent but we prefer the more direct wording of House Concurrent Resolution #149 introduced by Congressman Edward Garmatz and co-sponsored by 194 Representatives in the House. The stronger language of the House Concurrent Resolution is as follows:

" . . . the Public Health Service hospitals and outpatient clinics not only remain open and funds be made available for the continued operation of such hospitals and clinics, but that additional funds be made available for the modernizing, upgrading, and expanding of all existing facilities in order to properly carry out the responsibilities of the Public Health Service to provide the best medical care and treatment to beneficiaries entitled thereto under the law."

As a brief background we observe that the Public Health Service Hospitals came under attack during the opening days of each new Administration. Despite the program's origin back to 1798, the Bureau of the Budget in the past and the Office of Management and Budget today seem to find some strange reasons to keep up their attacks on this great program.

The Public Health Service hospital system has provided medical care for merchant seamen, Coast Guardsmen, and other beneficiaries for many years. This system has been tested for 173 years and passed the tests with adequate testimonials to its great work in helping to protect our nation against imported disease catastrophes. Furthermore, it has established and main-

tained a public service concept that has benefitted the medical profession by providing good training to young medical and dental professionals.

The highest number of PHS hospitals was thirty (30) which were scattered throughout our nation's seaports and inland waterways. These hospitals were decreased in number until today we have eight as follows:

<u>Hospitals</u>	<u>Number of Beds</u>
Staten Island	636
New Orleans	403
San Francisco	366
Seattle	281
Baltimore	238
Norfolk	210
Boston	190
Galveston	160

Also, there are 30 PHS Clinics located in Mobile, Alabama; San Diego and San Pedro, California; Jacksonville, Miami and Tampa, Florida; Atlanta and Savannah, Georgia; Honolulu, Hawaii; Chicago, Illinois; Portland, Maine; Detroit, Michigan; St. Louis, Missouri; Buffalo and New York, New York State; Cincinnati and Cleveland, Ohio; Portland, Oregon; Philadelphia and Pittsburgh, Pennsylvania; Charleston, South Carolina; Memphis, Tennessee; Houston and Port Arthur, Texas; Washington, D. C.; and San Juan, Puerto Rico.

As we stated, the Public Health Service hospitals and clinics provide care not only to merchant seamen but to Coast Guardsmen and their dependents as well as to active and retired military personnel and their families.

Congressman Paul G. Rogers (D-Fla.) has observed that the total inpatient and outpatient care of the 8 hospitals and all of the above outpatient clinics was over 1.7 million cases last year.

The AFL-CIO Maritime Committee listened intently to President Nixon's December 10, 1970 press conference. We heard the President emphasize that he was preparing the start of his Administration's attempt to solve the twin problems of health care in America which are:

1. The escalating costs for doctors, drugs, and hospital care that now cost Americans some \$70 billion a year. This staggering cost, last year, increased 16 percent which is far sharper than our general inflationary trend in the United States.
2. The poor state of the nation's health which exists despite our heavy and sharp cost increases. Thus, among industrialized nations, America today ranks 13th in infant mortality, 18th in life expectancy for men and 11th for women. It was emphasized that Americans today are less healthy than they were 20 years ago.

The Administration has now presented its health proposals to the Congress of the United States. At this time we would prefer not to discuss the many facets of the program on which your Subcommittee is holding hearings. However, we cannot separate the Public Health Service Hospital system from the overall health programming for our nation. We know that this must be the very reason you have woven in this hearing on Senate Concurrent Resolution #6 with your current hearings on the total health proposals.

In solving the current shortage of hospital beds in our nation, the Public Health Service hospital system provides some 2,500 beds. The system is staffed by 5,300 people with an annual budget of approximately \$70 million. In addition to the nearly 300 physicians, dentists and interns in training, the system provides employment opportunities and training to nurses, dieticians, specialized medical librarians, X-ray technicians, and pharmacists. Also, approximately \$6 million a year is invested in research programs.

Those who call for closing the PHS Hospital system state that there is an under-utilization of the current facilities and that merchant seamen, Coast Guardsmen, and other PHS beneficiaries would receive greater benefits at other community facilities or at the Veterans Administration facilities. These are not facts.

Congressman John Murphy, who has the Staten Island hospital in his Congressional District, made a pertinent and telling observation during the recent hearings before the House Merchant Marine and Fisheries Committee. He picked up Secretary Richardson's remark that:

" . . . taking the eight hospitals as a whole, the average rate of occupancy is 70 percent, which is comparatively low as hospitals go today . . . "

Congressman Murphy countered this charge with the following:

"Mr. Secretary, your largest facility is the Public Health Service Hospital at Clifton, Staten Island. It is true that its occupancy based on its old

rated bed capacity is a low rate, lower than 70 percent you just mentioned; but your Department has only staffed this hospital for about a 410 bed usage, which is 65 percent. Now the hospital would be utilized at a hundred percent of bed capacity had the Department staffed it for a hundred percent bed capacity. It is staffed for 65 percent so it is operating at 100 percent of its staff capacity." (underlining ours)

We have been claiming for years that the Public Health Service Hospital system, as any institutional system, will provide the quantity and quality of services for which it is budgeted. This is especially true where there is a need for a service such as health care.

Another misstatement is that the merchant seamen who use approximately fifty percent of the PHS system and the other beneficiaries using the other 50 percent could be adequately cared for in other community hospitals and Veterans Administration hospitals.

There is little necessity to repeat the many observations of the nationwide shortage of hospital beds in American communities both in cities and in rural areas. Also, it is well-known that the Veterans Administration hospitals have long wartime lists and are now appearing to feel budgetary pinches which are resulting in inadequate care in too many cases.

The veterans organizations strongly support the Public Health Service Hospital system. They acknowledge the need for this system which should continue to be supported and not curtailed.

Our nation and, in fact, all nations bounded by oceans, are facing a great future in the oceans and on the ocean bottoms.

Oceanography and aquaculture will provide great resources needed by all mankind. These observations are not ours alone. They have been stated and restated by those agencies of the Executive Branch of our Government and the pertinent Congressional Committees. In fact Congressman Jack Brooks of Texas recently pointed out to the House Merchant Marine and Fisheries Committee:

"Now the Marine Biomedical Program, one of the leading edges of this facet of human knowledge, is being installed in Galveston now, a fifty to sixty thousand dollar decompression chamber, in connection with the auspices of the University of Texas Medical Branch there in Galveston. The Public Health Service has assumed the responsibility for underwater casualties. We have considerably more underwater activity in the Gulf than we do elsewhere on the other coasts of this country. This will be a facility that will lead the way in how to take care of underwater casualties.

"There are now 25 beds already set up for such care that is now proposed. They have a training program in conjunction with the University trained doctors and personnel who work with the Public Health Service in an effort to save these people."

Congressman Brooks then made the important conclusion as follows:

"That hospital (at Galveston) was built about 35 years ago to house 79 patients. It now has 160 patients. It has a steady use and need for 200 beds at all times. I would say that rather than closing Galveston, the hospital needs replacement . . . The need for this new hospital has been demonstrated. The wisdom of this investment in health services to our area is plainly evident. The dividends that will be paid by its association with the University of Texas Medical Branch will be astronomical and continued delay can only result in losses of medical training and services on the same order."

There is no doubt that the need for marine hospital specialization will grow greater when aquaculture, in the form of three-dimensional farming in the oceans, takes people deep into the ocean waters. The health needs of the pioneers who will venture into the ocean depths must be met by an organized medical program. This program is already in existence and must be expanded to meet these current and future requirements.

We cannot conclude our statement without the observation that Congress, in its wisdom, has provided a Public Health Service hospital system. This wisdom is again and again pressed on by budget personnel who seem to ignore the needs of our nation which are clearly spelled out.

In 1965 the Comptroller of the United States had ruled that the Public Health Service Hospital system could not all be closed by administrative actions. Recently this was confirmed firmly and conclusively by Comptroller General Elmer B. Staats in an 8-page letter to Congressman Edward Garmatz which rules that the Administration does not have the authority to close all the hospitals in the PHS system. The key word is all, but he makes it plain that Congress passed a law in 1798, amended this law several times favorably, and that the Executive Branch has no authority to operate contrary to this law. He also states in his letter that PHS patients may be referred to facilities other than PHS only when there is an overflow of patients in the PHS system or if the nearest facility is remote in distance to the beneficiary needing care.

We shall not attempt to present all of our arguments in favor of not only retaining but expanding and improving our Public Health Service hospitals and outpatient clinics. We know that this great Congressional Subcommittee is quite aware of the medical and health needs of our nation. We have faith in your knowledge and wisdom that created this important system in 1798 and kept it in existence to date.

We thank you for the opportunity of presenting to you the views of the great majority of our nation's maritime workers.

BENEFICIARIES OF PHS HOSPITALSAmerican Seamen/Other Seamen and Related CategoriesAmerican Seamen

Owners, operators of documented commercial fishing vessels
 Trainees
 MSTs Personnel
 Alaska Native Service
 Army Corps of Engineers
 Army Signal Corps
 Fish and Wildlife Service
 Other Federal Seamen
 Cadets, Maritime
 Motorboat operators
 Applicants for positions as food handlers aboard vessels

Uniformed Service Personnel

National Oceanic and Atmospheric Adm. (NOAA)

Commissioned officers, crew members, active and retired, and dependents
 Coast Guard

Officers and enlisted men, active and retired, and dependents,
 applicants for enlistment

USPHS officers, active and retired, or candidates, and dependents

U. S. ARMY, NAVY, AIR FORCE, MARINE CORPS, officers and enlisted men,
 active and retired, and dependents

Armed Forces applicants for enlistment

National Guard Officers (dependents not eligible)

Foreign NATO personnel attached to Army, Navy or Air Force, and
 dependents

Dependents of deceased commissioned officers

Federal Civilian Employees

Discontinued Federal Programs

Other beneficiaries of Federal Government Agencies

Special Study (cancer, heart, by referral of private physician)

Miscellaneous

Foreign Seamen
 Immunization and Inoculation
 Emergencies

RECAPITULATION

<u>American Seamen</u>	<u>1969</u>	<u>1970</u>
ADPL (hospitals)	1004	912
OUT-PATIENT Visits	274,289	273,927
 <u>Seaman and Non-Seamen</u>		
ADPL (hospitals)	1820	1722
 <u>Seamen and Non-Seamen</u>		
OUT-PATIENT VISITS TO ALL HOSPITALS	763,809	812,180
 TOTAL FOR ALL 30 OUT-PATIENT CLINICS	799,483	820,635
Seamen 235,777		Seamen-229,274
Non-Seamen 563,706		Non-Seamen-591,361

AMERICAN SEAMEN

	<u>ADPL</u>			<u>OUT-PATIENT VISITS</u>	
<u>Hospitals</u>	<u>1969</u>	<u>1970</u>		<u>1969</u>	<u>1970</u>
Baltimore	63	52	)	17,507	18,162
Boston	46	44	)	12,639	13,335
Galveston	96	96	)	18,818	19,285
New Orleans	200	195	)	45,559	45,410
Norfolk	57	65	)	15,419	15,800
San Francisco	188	177	)	68,189	68,812
Seattle	77	64	)	29,323	29,346
Staten Island	<u>277</u>	<u>219</u>	)	<u>66,835</u>	<u>63,777</u>
TOTAL -	<u>1004</u>	<u>912</u>	)	<u>274,289</u>	<u>273,927</u>
All Hospitals			)		

AVERAGE DAILY PATIENT LOAD - Hospitals
(ADPL)

	1	9	6	9	Comparison
	<u>Seamen</u>	<u>Non-Seamen</u>	<u>1969</u>	<u>1970</u>	
			<u>Total</u>	<u>Total</u>	
Baltimore	63	134	197		172
Boston	46	69	115		126
Galveston	96	26	122		125
New Orleans	200	112	312		307
Norfolk	57	70	127		142
San Francisco	188	81	269		250
Seattle	77	121	198		180
Staten Island	<u>277</u>	<u>203</u>	<u>480</u>		<u>420</u>
TOTALS-	1004	816	1820		1722
All Hospitals					

OUT-PATIENT VISITS TO ALL HOSPITALS IN 1970

<u>Hospitals</u>	<u>Seamen</u>	<u>Non-Seamen</u>	<u>Total</u>	)	1969 Comparison <u>Total</u>
				)	
Baltimore	18,162	78,447	96,609	)	87,793
				)	
Boston	13,335	45,027	58,362	)	56,175
				)	
Galveston	19,285	25,992	45,277	)	43,632
				)	
New Orleans	45,410	100,037	145,447	)	138,447
				)	
Norfolk	15,800	77,185	92,985	)	85,704
				)	
San Francisco	68,812	49,762	118,574	)	110,957
				)	
Seattle	29,346	82,774	112,120	)	103,128
				)	
Staten Island	<u>63,777</u>	<u>79,029</u>	<u>142,806</u>	)	<u>137,973</u>
				)	
TOTAL -	<u>273,927</u>	<u>538,253</u>	<u>812,180</u>	)	<u>763,809</u>
All Hospitals				)	
				)	



**VIRGINIA COUNCIL ON ALCOHOLISM
& DRUG DEPENDENCE, INC.**

— TIDEWATER AREA —

SUITE 520 PROFESSIONAL ARTS BUILDING
NORFOLK, VIRGINIA 23510
625-5838

GORMAN G. BRINKLEY
Director

MRS. HENRIETTA D. WEST
Associate Director



March 8, 1971

Statement of Gorman G. Brinkley, Director, Virginia Council on Alcoholism and Drug Dependence, Inc. - Tidewater Area, which was prepared for insertion in record of Hearing of Senate Health Subcommittee on S. CON. RES. 6, which provides for study of U.S. Public Health Service Hospital facilities.

Mr. Chairman: Dr. Bernard Lidman, President, Norfolk County Medical Society, will make a verbal presentation before this Committee today on behalf of the entire Tidewater Virginia Region. My comments will hopefully be on some subject matter that Dr. Lidman will not be able to cover in the limited time allotted to him today. On four occasions - December 23, 1970; January 15th and 21st, and February 8, 1971 - I sent letters to President Nixon (with copies to all members of Congress) concerning the PHS facilities. Rather than repeat what was said in those letters, I am attaching copies of each to this Statement, with the request that they also be made a part of this Hearing record.

It might not be common knowledge to Congress that representatives from the Department of Defense, Army, Navy, Air Force, Veterans Administration, and HEW are holding meetings concerning the recognition by DoD of Alcoholism as an illness, which recognition is long overdue. I have assurances from someone in Navy BUMED that such recognition will be official "before this summer", which means June to me. When such recognition is made official I predict that within three years the Military, USPHS, and VA Hospitals will have a 25% - or more - increase in their patient load, if they treat the illness properly. The increase of which I am speaking will be from Alcoholism alone, and is not related to the increase in hospital patients which will occur, at the same time, as a result of Acts which Congress is now discussing to give Hospitalization coverage to those who are not able to afford such coverage. Where will we put these patients?

At our local level (Metropolitan area embracing about one million or more people), and using liquid measures for illustrative purposes, we need hospital beds equivalent to eight pints. We have enough beds to care for approximately six pints of patients. Removing the PHS Hospital would be removing another pint. THIS is HEW's plan to alleviate our hospital bed shortage? I've tried every kind of math that I know, and still cannot equate their plans with reality. President Nixon talks of sharing federal revenues with local governments. HEW speaks of PHS Hospitals as "lemons", i.e., financial liabilities, and they are trying to turn over the "lemons" to the communities in which they are located. THIS is revenue sharing? (Fortunately, we know that they are not "lemons").

We keep talking of 21 States, Washington, D.C., and Puerto Rico as the only States to be affected IF the PHS facilities were to be closed. This

is not so, as evidenced by the statements Senator Mansfield made when he asked to be included as a cosponsor of the Resolution now being studied. He spoke of Montanans going all the way to the PHS Hospital in Baltimore for help, and he praised the way in which they were treated there. Many patients from North Carolina come on a regular basis to our Hospital, and some come from other States. So we are talking about many more than 21 States being affected if the PHS Hospitals are closed.

Let's take the suggestion that the VA Hospitals would absorb some of the patient load of the PHS Hospitals and explore it a little deeper. If this could be done the VA Hospitals would no longer be Veterans Hospitals, so the name would have to be changed. Since the hospitals would be now dealing more with the general public, the word "Public" should be in the name. As the hospital would be supplying health services, that should also be reflected in the name. Since these health services would extend to every corner of our country, the name should indicate this. Put it all together and what do we have? U.S. Public Health Service Hospitals. What do you know. We have reassembled something we wanted to get away from. Why? Why do we want to get away from it? We don't.

HEW talks of contracting for medical services for PHS patients. This is nothing new, as all governmental hospitals have contractual arrangements with other hospitals, and some with individual physicians in remote areas. Congress would do well to take a hard look at the cost of some of these contractual arrangements, including CHAMPUS. I respectfully suggest that you not ask for these figures from any headquarters, but rather find out from a factual investigation in the field. You will find that the cost of many contract physicians is two or three times greater than the cost for comparable treatment at a PHS Hospital. You will also find that this same disparity exists in hospital costs when you compare public vs. PHS Hospital costs on comparable cases.

In providing enabling legislation to create area-wide Comprehensive Health Planning Agencies, the intent of Congress was clearly stated in the "Findings and Declaration of Purpose" stipulated by Public Law 89-749. Section 2 emphasizes dependence "on an effective partnership, involving close intergovernmental collaboration, official and voluntary efforts, and participation of individuals and organizations". Eleven communities have collectively designated the Tidewater Regional Health Planning Council, Inc., as the Comprehensive Health Planning Agency to serve its area, which is Southeast Virginia. By doing this, an areawide consensus was achieved, so that the spirit and intent of Public Law 89-749 could be fulfilled by a coordinating body, representative of the whole, for Tidewater Virginia. I respectfully suggest that the possible closure of the PHS Hospital be a matter of joint concern of the Federal Government in concert with the designated areawide Comprehensive Health Planning Agency for this area, in fulfillment of its partnership role. I further suggest that the Federal Government accept its responsibility for adherence to sound planning principles and community participation; it is therefore urged that Congress defer any decision relative to the closing of the Norfolk Public Health Service Hospital until this aforementioned Council can conclude appropriate studies currently in process under planning procedures which are essential to decisions of this magnitude. Only after appropriate study, review, evaluation, and comment should a decision, based on fact, be made relative to the future role of the Norfolk Public Health Service Hospital.



**VIRGINIA COUNCIL ON ALCOHOLISM
& DRUG DEPENDENCE, INC.**

— TIDEWATER AREA —
SUITE 520 PROFESSIONAL ARTS BUILDING
NORFOLK, VIRGINIA 23510
625-5838

GORMAN G. BRINKLEY
Director

MRS. HENRIETTA D. WEST
Associate Director

December 23, 1970



Richard M. Nixon
President
The White House
Washington, D. C. 20500

COPY

Dear President Nixon:

The season is now here for the annual rumors concerning the closing of our U. S. Public Health Service Hospitals.

Even children know of the dearth of competent hospital facilities in this country. Consider the chaos which would result if the following persons, now treated at U. S. Public Health Service Hospitals, were dumped on our inadequate (numerically) community hospitals: all members of the Uniformed Services, Active or Retired (Army, Navy, Air Force, Marine Corps, Coast Guard); the Commissioned Corps, Active or Retired, of the Public Health Service and the National Oceanic and Atmospheric Administration; Dependents of the aforementioned, and Dependents of deceased Active Duty and deceased Retired Members; American Seamen, Employees on vessels of the Mississippi River Commission and of the Fish and Wildlife Service; Owners of commercial fishing vessels performing seamen duties; Civil Service Employees injured on job; and Foreign Seamen - if a bed is available. It would be misleading to state that these people could be sent to an Army, Navy, or Veterans Hospital, as most of these hospitals are presently filled to capacity - to state the situation mildly.

Last fall a study was made of the U. S. Public Health Service Hospitals, and one of the questions asked was how these Hospitals could better serve the community. Our answer: "Restructure and also make more comprehensive the treatment and the treatment facilities for those for whom they are responsible. By so doing, more beds would be made available in the community for persons not eligible for treatment in a U. S. Public Health Service Hospital."

Expandable? Yes. Expendable? Emphatically No.

Sincerely yours, *

Gorman G. Brinkley
Gorman G. Brinkley
Director

GGB/hw
Copy to:
Members of Congress
et al



**VIRGINIA COUNCIL ON ALCOHOLISM
& DRUG DEPENDENCE, INC.**

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GORMAN G. BRINKLEY
Director

MRS. HENRIETTA D. WEST
Associate Director



January 15, 1971

Richard M. Nixon
President
The White House
Washington, D. C. 20500

COPY

Dear President Nixon:

This is a follow-up to my letter of December 23, 1970, concerning the rumored closing of our Public Health Service Hospitals, receipt of which has not yet been acknowledged by your office.

Copies of the first letter were sent to all members of Congress, as indicated. Since the mailing was done at an inopportune time - last few days of 91st Congress, Christmas holidays, etc. - not much response was anticipated. However, the response has been excellent, and all strongly for retention and expansion of the Public Health Service Hospitals. The tenor of Congress, as gleaned from the response, is best exemplified by a quote from one of the letters: "On December 21, 1970, Congress passed and sent to the President an act that would expand the role of the Public Health Service in providing adequate medical care to this nation. This act reflects the overwhelming, bi-partisan sentiment of Congress that the Public Health Service should not only continue its present functions, but should be utilized in bold new programs as well. Any decision to close the existing facilities of the Public Health Service would, therefore, not only have tragic consequences in terms of health care in the United States, but would be contrary to the expressed intent of Congress."

Because the Public Health Service was created by an Act of Congress in 1798, and because Congress broadened the activities of this Service by Acts passed in 1956 and 1970, it will be my suggestion to Members of the 92nd Congress that they pass another Act posthaste which would prohibit any person or any agency from closing or substantially curtailing the functions of any U.S.P.H.S. Hospital unless permission for such action is granted by Congress. Only such strong action will stop the whittling away of these Hospitals by this, and subsequent, administrations.

Sincerely yours,

Gorman Brinkley
Gorman G. Brinkley
Director

GGB/hw
Copy to:
Members of Congress
et al
enc.

12-31-76 Hospital Need Stressed

U.S. May Shut Norfolk Unit

By TIM MORTON
Virginian-Pilot Staff Writer

NORFOLK—Closing the U.S. Public Health Service Hospital on Hampton Boulevard could seriously impair the services provided by already burdened civilian hospitals in Tidewater.

That was the reaction Wednesday from medical leaders in Norfolk of the announcement that the Department of Health, Education, and Welfare is considering closing the PHS hospital along with seven others across the country.

Harry Mansbach, chairman of the Norfolk Area Medical Center Authority, pointed out that the 51-year-old hospital, in recent years, has become the largest in the area in amount of services provided to outpatients.

Within the last decade, the hospital's outpatient population has grown from 40,000 to an expected 100,000 people this year. Hospital spokesmen attribute the increase to the fact that dependents and retired military personnel have been added to the hospital's beneficiaries.

The PHS hospital historically has served merchant seaman, Coast Guardsmen, and some other federal employees.

"Norfolk General Hospital, for example, reached its capacity in the amount of services it can give to outpatients some time ago," Mansbach said.

"If this additional load were put on it or any of the other civilian hospitals, for that matter, I don't know what we could do."

In terms of inpatients, Norfolk General is operating at more than 90 per cent capacity and General Hospital of Virginia Beach at more than 100 per cent, Dr. Mason C. Andrews, a former chairman of NAMCA, said.

"The problem boils down to the number of doctors and facilities available. There are not enough of either to take care of an additional 100,000 people," Andrews added.

The Virginian-Pilot

M

Saturday, January 2, 1971

Section B

Administration Answered

PHS Hospital's Chief Defends Care Quality

By TIM MORTON
Virginian-Pilot Staff Writer

NORFOLK — The administrator of Norfolk's Public Health Service Hospital Thursday took exception to a statement made by a high-ranking Nixon administration official that PHS hospitals across the country are not providing high-quality medical care. "There is nothing wrong with the quality of health care provided by this hospital," Roy Driscoll said.

"What is wrong is that this administration like others in the recent past has not released money — money appropriated by Congress — which would have gone to improve outmoded PHS hospital facilities."

The secretary of health, education, and welfare, Elliot L. Richardson, Wednesday told a con-

gressional committee that HEW has under review a plan to close all eight general hospitals and 30 outpatient clinics operated by the Public Health Service. PHS is a division of HEW.

Richardson gave as the primary reason behind the possible closing the Public Health Service's inability to provide high-quality medical care through an increasingly inefficient and outmoded system.

Driscoll Thursday charged that the secretary's statement, in effect, is self-serving. Neither Richardson nor his predecessors in recent administrations have released money appropriated by Congress to modernize the PHS hospital system, Driscoll said.

Congress appropriated money as long as five years ago for studies aimed at modernization and expansion of PHS research

and hospital facilities, Driscoll explained.

"This hospital has been the subject of almost constant study since then, but nobody has ever seen fit to do the funding."

The record would appear to support Driscoll's contention. In 1965, James F. Kelly, then deputy assistant secretary of HEW, announced that the Norfolk hospital would undergo "over-all modernization and expansion of its research and training facilities." According to projections, the cost of modernizing the hospital at that time would have been about \$1.5 million.

Two years later, another HEW study determined that the Norfolk hospital was becoming obsolete and proposed the construction of an entirely new hospital in the Norfolk medical center com-

(See Hospital, Page B3)

Continued

plex. A price tag of \$9.1 million was put on the project.

The proposed new hospital was linked by the committee to the plans for building a medical school at the center. It was thought then that the school and the hospital would be set up under a joint program.

Planning for the medical school has proceeded apace. The proposal for a new PHS hospital apparently was dropped only to be revived again last year when another HEW-backed study, at least in the form it was in before it

reached Washington, recommended a new hospital.

This most recent study was done by consultants with the Life Sciences Division of North American-Rockwell Inc. The results of the study as they relate to Norfolk have not been released by HEW.

Earlier forms of the study, however, were read by PHS officials here. "The draft we saw recommended a new hospital as part of the medical center," Driscoll said.

The North American-Rockwell study, in addition to Norfolk's, involved six other PHS hospitals. A new hospital was recommended for Galveston, Tex., and money was appropriated by Congress to build it. The money has not been released.

GORMAN G. BRINKLEY
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THINK

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ORMAN G. BRINKLEY
Director

MRS. HENRIETTA D. WEST
Associate Director

Number 4

1/21/71

This is a copy of the Presentation of my opinions given at a Meeting of local Health Care Officials, Staff Members of our U.S.P.H.S. Hospital, and the following persons: Dr. Clifford Cole, Region 3 Medical Director, HEW; Dr. Jack Butler, Director, Federal Health Programs Service; and Mr. Ralph C. Reeder, Director, Personnel Office, Health Services and Mental Health Administration. This meeting was held at 7:30 P.M., January 21, 1971, at the U.S.P.H.S. Hospital, Norfolk. Purpose of the Meeting - - "In announcing the possibility that the 8 general hospitals and 30 outpatient clinics might be closed, the Secretary (of HEW) stated that before a decision is reached, discussions will be held with the communities involved." (Quote from HEW Notice)



+++++

Ladies and Gentlemen, the guides furnished to use in our discussion tonight are worded in a very negative manner, so I intend to ignore them. My simple mind cannot even cope with the thought of closing any hospital or clinic at this time. Congress is appropriating money for new hospitals, and HEW is talking about closing theirs. This doesn't make sense, and it is my strong conviction that Congress won't stand idly by and let this happen. In the words of Senator Ervin's mythical Josh Billings, "It is better to be ignorant than to know what ain't so." Congress was evidently kept ignorant of the proposed closing of these facilities, but they know of it now, and our Congressmen also know "what ain't so" about the closing of same. With such positive thinking I came tonight not to bury nor praise the PHS Hospitals, but to offer constructive suggestions on how they can better serve their beneficiaries.

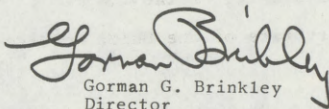
When a survey team questioned us in September of 1969 as to how the PHS Hospital here could best help the community, our answer was for them to give comprehensive treatment to their own (beneficiaries), and in particular to those who abuse alcohol and other drugs. Dr. Roger O. Egeberg, the top medical man in HEW, stated over a year ago that Alcoholism is the "biggest" illness in this country, and "is a disease that demands a broad approach, and I would like to get something started on it." If anything has been started, notice of it hasn't reached my desk. The Civil Service Commission has been urging all governmental departments to implement Alcoholism Rehabilitation Programs, and some have already done so. But not HEW. The Veterans Administration and the Navy Department have established some Alcoholic Wards, but not HEW. My point is that HEW should set the example in the federal health field, and they have not done so. Failure to exercise leadership brings forth criticism, and HEW wants to make scapegoats of the PHS Hospitals, claiming that they are outmoded and inefficient. HEW controls the efficiency of these Hospitals through inadequate budgets. Our local Hospital has no more doctors on the staff than it had ten years ago, yet the prime beneficiary list has been increased tremendously. Speaking of a limited budget, our little agency contacted a large pharmaceutical company last year and asked them to donate a certain medicine to our local Hospital, as they didn't have the funds to purchase it. The failure to properly administer our PHS Hospitals is not solely the fault of our

present administration. The blame must be shared by past administrations, too. For many years the attitude at HEW seemed to be "I would rather switch than fight", i.e., they would rather do the easier job of closing these hospitals than exert the effort to achieve the maximum good for the country from them.

There are 210 beds at our local Hospital. If HEW will properly fund this facility our Agency alone could keep those beds filled with our clients - clients who would qualify as prime beneficiaries of PHS care, too. These persons would not be those for whom the community is responsible, but would be those who are entitled - by law - to treatment at PHS facilities, but who are not receiving it. Those few who are treated receive treatment for the symptom - drinking - and not for the illness - Alcoholism. They are dried out, patched up, pronounced fit for duty, and sent out to continue their illness. This Hospital is not properly staffed to treat Alcoholics, but it should be, and could be.

Public Law 89-749 states, in part: "the Congress finds that comprehensive planning for health services, health manpower, and health facilities is essential at every level of government;; and that support of health services provided people in their communities should be broadened and made more flexible." Not abolished, Ladies and Gentlemen, but broadened and made more flexible.

Copies of this statement, and other pertinent information, will be sent to all members of Congress.


Gorman G. Brinkley
Director

The reprint below is part of the first page of material furnished for the above-mentioned Meeting.

U. S. PUBLIC HEALTH SERVICE HOSPITAL
NORFOLK, VIRGINIA 23508

January 13, 1971

GUIDE FOR DISCUSSIONS WITH COMMUNITY

Purpose of Meeting

In announcing the possibility that the 8 general hospitals and 30 outpatient clinics might be closed, the Secretary stated that before a decision is reached, discussions will be held with the communities involved. These discussions should include the following considerations:

1. Ability of community to absorb Federal beneficiary workloads.
2. Impact of withdrawing PHS medical services to community groups.
3. Effect on community health educational and training programs and ability to provide alternatives.
4. Ability of the community to employ personnel affected by closure.
5. General effect on local economy.
6. Potential use of facilities should they be closed.

I. Medical Care

1. Ability to absorb PHS workloads (Provide group with projected workloads and alternatives to PHS direct care)



**VIRGINIA COUNCIL ON ALCOHOLISM
& DRUG DEPENDENCE, INC.**

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GORMAN G. BRINKLEY
Director

MRS. HENRIETTA D. WEST
Associate Director



February 8, 1971

Richard M. Nixon
President
The White House
Washington, D. C. 20500

COPY

Dear President Nixon:

One of your Staff Assistants - Mr. Dana C. Mead - acknowledged, in a letter dated January 20, 1971, receipt of my two letters concerning the rumored closing of the U.S.P.H.S. Hospitals and Clinics.

In your State of the Union Message you stated: "I have faith in people, I trust the judgment of people. Let us give the people a chance, a bigger voice in deciding for themselves those questions that so greatly affect their lives." The sincerity of your delivery was most impressive. The thought occurred to me at the time that our Board is a group of those people to whom you were referring. Why should our Voluntary Health Agency be concerned with the closing of hospitals? One of our primary concerns is the development of adequate medical treatment services. Conversely, we are opposed to the closing of any such services until our community, and our nation, has an ample supply of same, sufficient to meet the demand.

There is no question that both you and Secretary Elliot Richardson are dedicated, humane, and highly intelligent men. However, both of you are in a situation now which is very similar to that of football players who have moved up to coaching; you are now Head Coach, and Mr. Richardson is one of your Assistants. As you know, Coaches rely on "spotters" to keep them informed of the action which is taking place on the field. In the matter of hospital facilities it is my opinion that your spotters are not seeing some of the action. What is printed about HEW's plans disagrees with what I see by direct involvement in the muck and mire of daily contact with the needs of sick persons. I invite you both down to where the contest is being waged, for a ground level view of the situation (inadequate hospital facilities) as it now exists.

Attached is one of my Newsletters containing pertinent information on this matter, which is deserving of study.

Sincerely yours,

Gorman Brinkley
Gorman G. Brinkley
Director

Copy to: Members of Congress
et al

"A VOLUNTARY HEALTH AGENCY"

THINK**WITH****BRINK**

VIRGINIA COUNCIL ON ALCOHOLISM
AND DRUG DEPENDENCE, INC.
520 PROFESSIONAL ARTS BUILDING
NORFOLK, VIRGINIA 23510

GORMAN G. BRINKLEY
Director

MRS. HENRIETTA D. WEST
Associate Director

Number 5

2/8/71

Listed below are some facts, figures, statements, thoughts, and questions concerning the rumored closing of the USPHS Health Facilities, and some of the ramifications of such an act - if it occurred - to related health facilities.



Did HEW commit itself in 1965 to the modernization of the PHS Hospital in Norfolk?

"Former Representative Porter Hardy, Jr. today said that the federal government reneged on plans to modernize the Public Health Service Hospital here. 'I thought this was understood five years ago', Hardy said when asked to summarize his presentation Thursday night to a federal fact-finding committee. 'We had a commitment for modern facilities out there and I believe the funds were appropriated to improve the hospital. But HEW never spent them', Hardy said. Hardy was in Congress (retiring in 1968) when the federal government last suggested closing the hospital. A strong public protest was raised then, as it is now, and the hospital remained open." (Ledger-Star, 1/22/71).

"In 1965, James F. Kelly, then deputy assistant secretary of HEW, announced that the Norfolk hospital would undergo 'over-all modernization and expansion of its research and training facilities.'" (Pilot, 1/2/71).

(The appropriated funds which Mr. Hardy mentions were for studies aimed at modernization and expansion of PHS research and hospital facilities, as we understand it. Ed.)

Three of more studies in recent years have been made of PHS facilities - in 1965, 1967, and 1969. (A career employee of PHS told me: "They're studying us to death.") Why was it necessary for HEW to hastily arrange for four fact-finding (?) teams to visit the PHS Hospitals after Secretary Richardson appeared before the House Merchant Marine and Fisheries Committee on December 30, 1970? What could these teams find out in two days that a team of trained consultants from the Life Sciences Division of North American-Rockwell, Inc., did not uncover in late 1969? Secretary Richardson had the North American-Rockwell report available when he appeared before the House Committee. Why didn't he use that report to support the argument for closing these hospitals and clinics? In fact, why hasn't that Report from North American-Rockwell been released to the general public for study? Could it be detrimental to the proponents of closure? Either way, it is public property, and should be released.

All queries to the President, or to HEW, concerning HEW's plans have met a standard answer - a copy of Secretary Richardson's prepared statement

to the House Merchant Marine and Fisheries Committee. However, the Associated Press, on February 4, carried some new statements, one of them saying:

"It's not a wrecking ball and never was meant to be one," said a HEW official close to the (PHS) dispute over facilities."

No, the tactics which are apparently being used by HEW to "finish off" PHS hospitals aren't as clean, quick, and efficient as the use of a wrecking ball. Death by starvation (continuing budget cuts) is a slow, painful, and inhumane method - but at the conclusion just as effective. No Secretary of HEW could stand up and say that PHS Hospitals were outmoded if the Staff at HEW headquarters had done their jobs properly by seeing that funds were secured for modernization or replacement of these facilities. This modernization can - and should - be started immediately. HEW estimates that to do the job it "would require at least \$140 million at Fiscal year 1971 prices." They should have further stated that all of this money would NOT be used in this fiscal year, but would be spread over many years. (For that kind of money we should be able to build 8 new hospitals).

The Secretary stated that "The majority of the PHS facilities have difficulty in attracting and retaining career professional staff." Correct?

All of our services - Air Force, Army, Navy, and USPHS - rely heavily on the draft (or Berry Plan, which is influenced by the draft) to fill their medical billets. In the January 15, 1971 issue of U.S. Medicine Dr. Louis M. Rousselot, top medical man in DoD, states, as part of a paper:

"Because of the relative national shortage of physicians, they have been subject to special draft calls for the past twenty years under various provisions of law. National shortages are now greater than ever before." "Should the current Selective Service law be changed to exclude physicians and allied health professions or not be re-enacted, the Department of Defense will be faced with a grave crisis of insufficient health manpower."

So all of the Services are having "difficulty in attracting and retaining" medical people, and not just PHS. When you have to draft a person, or even threaten to do so, to get him to perform a task, this indicates that a program of attraction isn't working. What doctor, if he knew of the "yo-yo game" being played by HEW with PHS Hospitals, would volunteer to serve at one of these facilities? His tour of duty would stand the constant threat of being aborted before it had a chance to get going.

Are the VA Hospitals in a position to "provide care for additional primary beneficiaries of HEW on a space available basis with no modification in present VA beneficiary priorities?"

Below are some quotes from a letter written on January 27, 1971 by Francis W. Stover, Director, National Legislative Service, Veterans of Foreign Wars, which letter was made a part of the record of the hearing of the House Merchant Marine and Fisheries Committee:

"Despite the extra \$105 million the Congress so wisely approved for VA Hospitals, this will not begin to be sufficient to reduce the critical problems and shortages the VA hospital Directors are faced with throughout the Nation.

All indications are that the VA hospitals problems will be further compounded next fiscal year. Instead of additional funds, the V.F.W. is expecting a further reduction in some of the programs unless VA programs are given higher priority by the Administration.

With this background, the V.F.W. is deeply disturbed that the proposed closing of Public Health hospitals may further aggravate a serious situation in VA hospitals which will be affected by the proposed closings. It is noted that all of these hospitals that are proposed to be closed are in larger cities. VA hospitals in these cities are operating at full capacity with waiting lists for admission."

The last paragraph touches on one of the most sensitive spots in this entire situation. All of the PHS Hospitals are located in large Metropolitan areas, where existing health services are now stretched close to the breaking point. Enough is enough.

Gorman Binkley

Government Employees Council Of The AFL-CIO

100 Indiana Ave., N.W. • Washington, D. C. 20001 • 393-2820-393-2821

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J. STANLY LEWIS, Vice-Chairman

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John A. McCart, Operations Director

STATEMENT OF THE GOVERNMENT EMPLOYEES COUNCIL, AFL-CIO, TO THE SENATE COMMITTEE ON LABOR AND PUBLIC WELFARE ON S. CON. RES. 6 (Operation of Public Health Service Facilities).

Mr. Chairman and members of the Subcommittee:

As a coordinating organization for 34 AFL-CIO unions representing in excess of 1 million Federal employees, we appreciate your arranging hearings on the future of Public Health Service facilities and the opportunity afforded the Council to offer its views.

Our unions are deeply concerned about the announced plan of the Executive Branch to close eight remaining Public Health Service hospitals and outpatient clinics throughout the country.

This keen apprehension centers around four points.

First, as an organization representing the interests of Federal workers as citizens, we are troubled by any attempt to terminate or transfer from Federal jurisdiction these vital functions performed by PHS for almost a hundred and seventy-five years.

Second, some of the unions associated with the Council represent merchant seamen, the primary beneficiaries of PHS care.

Third, as a Council representing Federal workers, we must express concern over the loss of service supplied by PHS to these employees who incur job related injuries.

Fourth, among the unions affiliated with the Council are those who have civilian employees of PHS activities as members.

Whether the present plan of the Executive Branch is to discontinue operation of all PHS hospitals and clinics simultaneously or to accomplish that goal piecemeal, the central issue is the same.

It is an accepted fact that our nation is confronted with a crisis in meeting the health care needs of its people. Congress has and continues to address itself to this problem. Even now, committees of the House and Senate are concentrating attention on the inadequacy of present health facilities, treatment, and spiraling costs of medical care. To even contemplate closing existing PHS institutions under these conditions is a disservice to millions of Americans, who must wait weeks to secure needed hospital and surgical assistance.

Marine hospitals were first established in 1798 to extend health services to American seamen using American ports. While tradition alone should not be the sole justification for continuing the existing PHS system for these workers, it is unthinkable that merchant mariners would be tossed into the maelstrom of confused and inadequate health services existing in other spheres of our society at the present time. And this is exactly what would happen if one or more of the present PHS facilities is discontinued.

This Subcommittee is aware of the steady erosion of PHS facilities which has occurred over the past twenty-five years. Even with the continuing expansion of health problems throughout the nation, PHS hospitals have been closed.

Yet, in 1970, Congress approved a new Merchant Marine Act designed to move the United States again into the mainstream of maritime nations by expanding our merchant fleet. Presumably, construction of additional vessels will result in employment of larger numbers of merchant seamen. It is foolhardy to plan reductions in health services for maritime workers at a time when the demand for these functions will increase.

Other witnesses have acquainted you with the cost of patient care in PHS hospitals compared with similar service in private facilities and the folly of shifting the PHS patient load to non-Federal communities already overburdened with health and financial problems.

We have not dealt with the legal question of the right of the Department of Health, Education and Welfare to proceed with its plan, because the record is clear on this point through a decision by the Comptroller General. The basic question is whether the Executive Branch can in good conscience proceed with its plan for terminating PHS facilities in the face of the health crisis in our country.

Members of this Subcommittee are aware that Federal employees injured on the job are able to receive diagnostic services and treatment at PHS facilities under authority of the Federal Employees' Compensation Act, when available. In general, the quality of this assistance has been superior.

In a normal year, more than 100,000 Federal civilian employees experience job related disabilities. We do not know how many of these persons require PHS care. But reduction or termination of PHS operations would deprive injured Federal workers of this inexpensive, high quality medical care.

It has been suggested that these activities of PHS could be transferred to Veterans Administration or private institution. This proposal ignores the facts. VA hospitals have a primary mission of assisting veterans. They are overcrowded and understaffed. The same is true of private facilities. To insist that Federal employees be referred to these other institutions will mean simply that they will not receive the timely, expert medical service to which they are entitled.

Finally, the Subcommittee should consider the equity of more than 6,000 civilian employees of PHS. None of the public pronouncements of the Department of Health, Education and Welfare have alluded to the future of these Federal workers.

Most have devoted their careers to the humanitarian goals of PHS. Many are in age categories that would make it difficult for them to find suitable employment elsewhere, despite the shortage of paramedical and professional skills in the labor market. This is certainly no time for the Federal Government to think of adding to the serious unemployment level in our country.

The anxiety stimulated by the uncertainty of job security is causing a serious morale problem among the employees. Nothing has been said to reassure them about plans for utilizing their skills elsewhere in Federal Service.

We urge, Mr. Chairman, that the Subcommittee move expeditiously to approve the pending resolution, and hope sincerely that the Executive Branch will heed any expression by Congress on the matter.

The Council is grateful for this occasion to acquaint you with the seriousness of the action proposed by the Administration.

**Material Submitted by Col. D. George Paston,
AUS-Ret., Legislative Chairman, Disabled
Officers Association.**

STATEMENT OF COL. D. GEORGE PASTON, AUS-Ret.,

before the

Subcommittee on Public Health & Welfare of the Committee
on Interstate & Foreign Commerce, U.S. House of Represen-
tatives,

March 10, 1971,

on THE CONTINUATION OF THE U.S. PUBLIC HEALTH
SERVICE HOSPITALS AND OUT-PATIENT CLINICS.

(House Concurrent Resolutions 98, 99, 108, 119, 128, 149-156, 177, and 191).

My name is D. George Paston, Colonel, AUS-Ret. I am the National Legislative Chairman of the Disabled Officers Association, a non-profit organization, organized 52 years ago in Walter Reed Hospital by severely wounded and maimed officers of WW I. Our membership is limited to officers of the armed services who were retired for or with permanent disabilities sustained in line-of-duty officially determined to prevent continued performance of active-duty. Our National Headquarters is at 1612 K St., NW., Washington, D.C. 20006.

Our National Commander, Captain Robert W. Smith, wounded several times and decorated with the Distinguished Service Cross among other awards for gallantry in action, is now in Ohio. He asked me to convey to you his thanks for giving us this opportunity to present to you the results of our investigation of the USPHS facilities.

I am accompanied by Major Walter J. Reilly, U.S. Marine Corps., Ret., our Chief of Staff, who had been a prisoner of war in the hands of the Japanese in WW 2.

I find it unusual to argue in favor of the Resolutions to continue the operation of the USPHS facilities because I am unaware of any meritorious opposing reasons.

Our factual and documented research and investigation resulted in conclusive reasons for the continuation of the USPHS Hospitals and Clinics and their ability to care for additional beneficiaries in their communities.

These facts and recommendations were reported by us to the President in letters dated January 28, February 1, 11, and 22.

Copies of these letters were submitted to your committee in view of which I believe it is unnecessary for me to burden you with my reading their contents to you at this time.

I ask that they be entered in the record here, with the same force and effect as if I read their contents to you.

When word leaked out that the Administration had decided ex-parte to close these facilities, Congressmen, military retirees and other beneficiaries, became alarmed. Many Senators and Representatives came to our rescue by overtures to the Administration and Concurrent Resolutions. Then, for the first time, the Administration decided to conduct reviews and to consult with appropriate committees of Congress and with representatives of beneficiary groups, employee organizations, and community agencies before a final decision is made on the future of the PHS Hospitals and Clinics.

I hand you herewith, marked Exhibit A, a letter to that effect I received from the White House, signed by Noble M. Melencamp, Staff Assistant to the President.

In 1801, Thomas Jefferson said:

"The will of the people is the only legitimate foundation of any government, and to protect its free expression should be our first object."

In addition to Congress, we may expect to receive Resolutions by State legislatures calling upon the President and the Congress to continue the operation of the USPHS Hospitals and Clinics in their respective States.

I hand you herewith, marked Exhibit 2, Resolution No. 55, introduced in the New York Senate by Hon. Paul P. E. Bookson. It implores the President and the Congress to continue the USPHS Hospital in Staten Island, and the USPHS Clinics in New York City and in Buffalo, all in the State of New York.

The Staten Island Hospital, in one year, had 142,805 outpatient visitors. Except for open-heart surgery, it provides complete medical and surgical care. It was modernized at a cost of \$26.9 million. It has 17 buildings and 24.1 land acres. It supervises the following USPHS Clinics with the annual number of outpatient visitors indicated:

New York City (122,216),	Cincinnati (15,973),	San Juan (21,532)
Buffalo (9,337),	Cleveland (23,812),	
Charlotte Amalie (377),	Detroit, (35,328),	
Chicago (53,650),	Philadelphia (32,586),	
TOTAL 457,616.		

Our letters to the President, which you have, contain the details concerning the USPHS facilities in other States.

I overlooked pointing out to you that the cost to the government of operating the USPHS facilities is far less than it would cost the government to contract for the care of its beneficiaries in non-Federal institutions most of which are so overloaded with patients that admission of a patient is delayed more than three weeks after application for admission. In the USPHS hospitals admission is practically immediate. As one example, at the Staten Island Hospital, the inpatient per diem cost to the government is \$60.46. According to a recently released study by the Army Surgeon General's Office in Washington, costs averaged \$76.35 per patient day in 1969 for the 211 large civilian community hospitals studied. Most of us know that civilian hospitals charge much more than that amount to-day. And, as President Nixon pointed out in his State of the Union Message:

"America has been the wealthiest nation in the world. Now it is the time we became the healthiest nation in the world. "

One of the best things the President and the Congress can do for our people and our nation is to continue the operation of the USPHS Hospitals and Clinics.

Many Congressmen have come to the rescue by overtures to the Administration and by Resolutions. Every Congressman who introduced, cosponsored, and will support these Resolutions will have earned the gratitude of his constituents and the nation who will benefit by prevention and cure of disease which the USPHS facilities are organized to do and are doing.

I shall be glad to try to answer any questions.

EXHIBIT A

THE WHITE HOUSE,
Washington, D.C., February 27, 1971.

COLONEL D. GEORGE PASTON,
Brooklyn, N.Y.

DEAR COLONEL PASTON: The President has asked me to thank you for your letters of January 28, February 1, and February 11 concerning the study of the hospital and clinic system of the Public Health Service. The information you have sent is much appreciated. I can well understand your special concern for disabled officers and their dependents who are served by Public Health Service facilities.

The Administration, too, is concerned that the best possible resolution of this situation should be reached. The Department of Health, Education, and Welfare is conducting reviews in each of the communities where there are Public Health Service hospitals in order to determine what provisions can be made for the care of PHS beneficiaries and the possible use of these facilities by communities. The Administration has every intention of consulting fully with the appropriate committees of the Congress and with representatives of beneficiary groups, employee organizations, and community agencies before a final decision is made on the future of the Public Health Service Hospitals and clinics.

You may be sure that your views have been brought to the attention of the appropriate authorities who are studying the situation.

With best wishes,

Sincerely,

NOBLE M. MELENCAMP,
Staff Assistant to the President.

EXHIBIT B

CONCURRENT RESOLUTION EXPRESSING THE SENSE OF THE LEGISLATURE OF THE STATE OF NEW YORK WITH RESPECT TO THE CONTINUED OPERATION AND EXPANSION OF THE UNITED STATES PUBLIC HEALTH SERVICE HOSPITAL AT STATEN ISLAND, AND THE U.S. PUBLIC HEALTH SERVICE CLINICS IN NEW YORK CITY AND IN BUFFALO, N.Y.

Whereas, The United States Public Health Service Hospital at Staten Island provides medical and surgical treatment, medical care and outpatient medical treatment, pursuant to federal law, to thousands of American seamen, federal employees, retired military personnel, their dependents, and many others; and

Whereas, The United States Public Health Service Clinics in New York City and Buffalo provide outpatient medical treatment pursuant to federal law, to thousands of beneficiaries; and

Whereas, These facilities have earned the well-earned appreciation and approbation of their patients, some of whose lives have been saved by their surgical and medical care and the health of thousands of others have been improved; and

Whereas, Said hospital is affiliated with the Columbia-Presbyterian Hospital, College of Physicians and Surgeons, the Albert Einstein Medical College, and other top notch medical institutions, for medical training and research; and

Whereas, The cost to the government of inpatient averages less than sixty dollars per patient per day, and the outpatients less than fourteen dollars per patient per day; and

Whereas, The Secretary of Health, Education, and Welfare is considering the closing of said hospital and clinics allegedly to save the cost of their operation and to contract with the Veterans Administration or non-federal institutions for the care of United States Public Health Service patients; and

Whereas, The Veterans Administration hospitals, in caring for their own statutory patients, are unable to accommodate United States Public Health Service patients except on a space available basis, if at all; and

Whereas, Non-federal contract resources accessible to United States Public Health Service patients, due to their own patient load, are unavailable to accommodate and provide the United States Public Health Service patients with the immediate care they require and, even if they were available, such contract expenses would far exceed the cost of continuing the operation of the United States Public Health Service facilities since a study by the Army Surgeon General's Office revealed that costs averaged \$76.35 per patient per

day in 1969 for the two hundred eleven large civilian community hospitals studied, the cost is alarmingly increasing; now, therefore, be it

Resolved (if the Assembly concur), That it is the sense of the Legislature of the State of New York that the United States Public Health Service Hospital in Staten Island and the United States Public Health Service Outpatient Clinics in New York City and in Buffalo, New York, should remain open, continue to care for their statutory beneficiaries and expand, if possible and practicable, to also care for additional beneficiaries, as a foundation to effectuate the President's plan, announced in his State of the Union Message, to insure that no American family will be prevented from obtaining basic medical care by reason of inability to pay; slow the alarming rise in the costs of medical care; and to make America the healthiest nation in the world; and be it further

Resolved (if the Assembly concur), That a copy of this resolution be transmitted to the President of the United States, the Secretary of the Senate of the United States, the Clerk of the House of Representatives of the United States and to each member of Congress of the United States duly elected from the State of New York and that the latter be urged to devote themselves to the task of accomplishing the purpose of this resolution.

Over Fifty Years of Serving Disabled Officers

Disabled Officers Association

Organized in 1919

NATIONAL HEADQUARTERS
1612 K STREET, N. W.
WASHINGTON, D. C. 20006
202-347-3401

LT. N. S. STEVENSON, DSC
NATIONAL COMMANDER
EMERITUS
1906-1967

MAJOR WALTER J. REILLY
CHIEF OF STAFF

NATIONAL EXECUTIVE COMMITTEEMEN

EASTERN AREA
LIEUT. MARVIN H. NEW, PA.
COL. D. GEORGE PASTON, N.Y.

CENTRAL AREA
CAPT. DALE G. ACKERSON, MICH.
MAJ. JOSEPH H. LIEBERSTEIN, ILL.

SOUTHERN AREA
LT. COL. HOWARD CARLETON, JR., OKLA.
LT. COL. SYDNEY G. OSBORNE, FLA.

WESTERN AREA
MAJOR FRANK E. BACHELDER, CALIF.
CAPT. R. L. EVANS, ARIZ.

CHAIRMAN
NATL. LEGISLATIVE COMMITTEE
COL. D. GEORGE PASTON
178 ADAMS STREET
BROOKLYN, N.Y. 11201

January 28, 1971

CAPTAIN ROBERT W. SMITH, DSC
NATIONAL COMMANDER
MAJOR MORRIS B. BROWN
NATIONAL VICE-COMMANDER
LIEUT. JULIAN H. HOPKINS
NATIONAL VICE-COMMANDER
MAJOR JOSEPH A. CARR, JR.
PAST NATIONAL COMMANDER
CAPT. PAUL F. SHAUGHNESSY, PNC
NATIONAL JUDGE ADVOCATE
MAJOR ROBERT W. GARDNER
NATIONAL CHAPLAIN
CAPT. JOSEPH L. ROTHFEDER
NATIONAL SURGEON
MAJOR WALTER J. REILLY
NATIONAL HISTORIAN

President Richard M. Nixon,
The White House,
Washington, D. C.

Dear Mr President,

Opposition to the closing of USPHS Hospitals & Clinics.

We urge you to continue and expand their operation because:

- (a) they are rendering inpatient and outpatient medical services of great value to so many beneficiaries, seamen, government employees, military retirees, and other members of the public;
- (b) if closed, contractual care of these patients at other facilities will cost the government far more than the continued normal operation and expansion of the well-organized PHS facilities;
- (c) if closed, these patients will be exposed to less care, if any, at less convenient medical facilities where the average waiting time for patient admission is six weeks; and
- (d) their continued operation and expansion can be the foundation upon which the laudable medical program announced in your January 22, 1971 State of the Union Message may be based.

PRESIDENT NIXON'S STATE OF THE UNION MEDICAL PROGRAM.

- (a) Insure that no American family will be prevented from obtaining basic medical care by inability to pay;
- (b) Slow the alarming rise in the costs of medical care;
- (c) Appropriation of an extra \$100 million to launch an intensive campaign to find a cure for cancer; and
- (d) America has been the wealthiest nation in the world. Now it is time we became the healthiest nation in the world.

CLOSING THE PHS HOSPITALS & CLINICS WOULD DEFEAT PRESIDENT
NIXON'S MEDICAL PROGRAM AND WOULD BE A TOO EXPENSIVE FOLLY.

Since we need hospitals and clinics, it would be irrational and insane for anyone to propose burning or closing the PHS hospitals and clinics.

It would be difficult or even impossible to contract for and actually receive medical care comparable to the USPHS. It would cost the government billions of dollars to build new hospitals and clinics. This is unnecessary since we have the buildings, equipment, physicians, and employees, now operating the PHS facilities.

CANCER, THERAPY, RESEARCH.

At Baltimore, Maryland, the PHS hospital has 238 beds. 35 of these beds are National Cancer Institute beds, a considerable part of the Institute's 120 bed total.

At Seattle, Washington, the PHS hospital is affiliated with the Division of Oncology of the University of Washington. The Division uses one-half of the 7th and 10th floors of the hospital, employs 56 persons, including 14 physicians who work at the USPHS hospital. The Division has funds, provided by the National Cancer Institute, with which it carries on:

- Adult Leukemia Research Center;
- Separation of blood by continuous flow centrifuge;
- An oncology training program;
- Immunologic aspects of autochthonous tumor regression;
- Normal and abnormal bone marrow metabolism; and
- Investigation of the role of Isogenic and allogeneic marrow in the therapy of cancer.

The Division has funds, provided by the National Institute of Allergy and Infectious Diseases, for Evaluation of typing techniques in clinical hemotransplantation, and for Irradiation and marrow transplantation in large animals.

It has funds, provided by the National Heart & Lung Institute, for preparation of Platelet concentrates.

The USPHS pays one physician \$21,300. The American Cancer Society pays one Fellow a \$4,800 stipend. The Leukemia Society has a \$10,000 Special Fellowship. The State of Washington provides \$27,000. Patients donated \$5,000. Total expended in one year is about \$1 million.

At Miami, Florida, the USPHS Clinic also treats an increasingly large number of Dade County patients afflicted with Hanson's Disease (Leprosy).

The San Francisco PHS Hospital averages between 260 and 300 patients a day and receives approximately 116,000 outpatient visits a year. The leprosy service has at present 314 leprosy patients registered and under treatment on an ambulatory basis except for brief periods of hospitalization. The inpatient Leprosy Service averages 5 patients. Any patient in the Western United States suffering from this disease may be assisted at the Leprosy Clinic held Tuesdays and Thursdays. In addition, nearly 100 contacts of active leprosy patients are under the continued surveillance of the Clinic. Of 149 registered male patients between the ages of 14 and 65 with leprosy, 110 are actively engaged in their usual occupations or attending school. Of 97 female patients between those ages, 59 are useful homemakers, employed, or are students. The Laboratory is funded by a \$75,000 annual N.I.H. grant with a staff of 2 physicians, 2 technicians, 1 animal caretaker, and 1 secretary.

The hospital also operates a psychiatry clinic, a coronary care unit, an intensive care unit, an alcoholic and drug detoxification unit, a yellow fever immunization clinic, a metabolic unit, a cardiovascular project, a laboratory for performing sophisticated analyses of the lipid contents of blood in high volume and with rigid quality controls. During 1970, over 26,000 lipid analyses were performed in studies involving phenotyping project, the hyperlipidemia diet intervention program, the pediatric screening program. It also operates a hypertension clinic, a renal clinic, a virology laboratory unit, a department of nuclear medicine which handled 955 patients in the last six months of 1970.

Its Cancer Clinic and Tumor Registry, accredited by the American College of Surgeons, has been in operation over 15 years. More than 2000 patients are seen annually. The Clinic follows an average of 468 patients with major malignancies, exclusive of skin cancers, per year. Patients are not only Federal beneficiaries but also Special Study patients from the San Francisco community. To continue describing the work of this hospital would fill a book. We assume that you have been furnished a copy of the document entitled "Special Services Provided By The PHS Hospital, San Francisco, California," rendering it unnecessary to repeat its contents here.

THE ASCRIBED REASONS FOR THE CLOSINGS ARE THE BEST REASONS
FOR THE CONTINUANCE OF THE PHS HOSPITALS AND CLINICS.

HEW Secretary Elliot Richardson said that the PHS facilities are underutilized and outmoded. He recommends their closing and to arrange with the VA to care for the patients on a space available basis with no modification in present VA beneficiary priorities; that, in those locations or situations where the VA cannot serve the patients' needs, to utilize non-Federal contract resources more accessible to the beneficiaries.

"Space availability basis" means that if space is not available, as is usually the case, the patient cannot be accepted.

An adequate number of non-Federal contract resources to care for the present PHS beneficiaries are not available. Even if they were available, they would be too expensive in view of the alarming rise in the costs of medical care.

The assumption that PHS facilities are underutilized is THE BEST REASON for continuing and expanding their operation to include additional beneficiaries. Patients would thereby be more easily accommodated than in VA hospitals on a space available basis or in fully utilized and overcrowded non-Federal contractual resources.

If any PHS facilities are not modern, they can be modernized at little expense. Beekman-Downtown Hospital in New York City was not closed because it was outmoded. It was modernized and serves a most useful purpose. The same is true of many of the best non-Federal hospitals. And, it is not true that the PHS facilities are not modern. We cannot conceive of a more modern facility than the PHS Clinic at 245 West Houston St., New York City, the largest outpatient clinic of the PHS in size and patients. During the fiscal year, from July 1, 1969 to June 30, 1970, this clinic handled 115,000 outpatients. In addition to medical and dental treatment, its yellow fever center administered 7200 immunizations, and the clinic conducted 26,000 immigration examinations and 5,000 physical examinations. There are 10 physicians in the General Medical Clinic, 9 Dentists, 8 Physical Therapists, 2 Pharmacists, an X-ray Department, a Laboratory Department, a Nursing, and Medical Records Department. The 115,000 outpatient visits, at a cost to the government of \$1,226,829, amounts to \$10.66 per visit, which compares very favorably with the cost in non-Federal hospitals.

We also cite the very modern Tampa, Florida, PHS facility, as another example (see Exhibit 1, hereto attached).

Regarding accessibility of PHS facilities to beneficiaries, we cite the Portland, Maine, PHS hospital, as an example (see Exhibit 2, hereto attached).

It would be fair to summarize the reasons advanced for the closings, by referring to President Nixon's address to the United States Junior Chamber of Commerce in St. Louis, Missouri, June 25, 1970, in which he said:

"This is like a doctor telling you when you have
a sore finger that the cure is to cut off your arm."

PHS FACILITIES RENDER UNIQUE MEDICAL SERVICES,
UNAVAILABLE ELSEWHERE, AT A LOW COST TO THE
GOVERNMENT.

The USPHS Clinic in Honolulu is a modern new clinic, only five years old.

Its staff of 31 employees and two medical consultants on the capital island of Oahu and four clinics and physicians on the other Hawaiian Islands—two clinics in Hawaii, one in Maui and one in Kauai, serve:

- American seamen,
- * Nat'l Oceanic & Atmospheric Administrative officers,
- * Army, Navy, Air Force and Marine Corps uniformed service personnel,
- * Dependents of uniformed services personnel,
- * Coast Guardsmen,
- Bureau of Employees Compensation Recipients.

(* Active duty and retired personnel.)

Medical assistance is furnished thru the Coast Guard to all ships at sea, both American and foreign, at all times, DAY AND NIGHT and, occasionally, to isolated islands throughout the Pacific.

For the past several years, it had 33,000 patient visits. Its FY 1970 budget of \$455,300, averaged the cost per patient of \$14 or less. If it were closed, contractual costs per patient would be far more. This would also be true as to uniformed services' dependents who would be referred to the Champus Program.

An American Seaman is usually a transient docking about a day to three days. The cost of contracting out the treatment of such walk-in patients (no appointments) and filling the necessary medical and insurance forms would be prohibitively expensive. And we cannot contract medical assistance to all ships at sea or to isolated islands throughout the Pacific.

Retired personnel of the armed services and their dependents may avail themselves of the medical facilities at the U.S. Army Tripler General Hospital, Pearl Harbor Dispensary, Hickam Air Force Base Dispensary, and Kaneohe Marine Base Dispensary. This group, for reasons of accessibility or other causes, apparently prefers the USPHS facility, evidenced by 1,300 patient visits per year.

Information from a reliable source indicates that (a) it would be impossible for the other medical facilities and the VA to accommodate the PHS's average patient load of 33,000 visits, and (b) it would be much costlier than PHS facility operation.

The unique medical services required by seamen are ably described in the Buffalo, New York, PHS facility report (exhibit 3, hereto attached) and in the Cleveland, Ohio, PHS facility report (exhibit 4, hereto attached).

PHS HOSPITAL, STATEN ISLAND, N.Y.

This hospital was MODERNIZED at a cost of \$26.9 million.

Except for open heart surgery, it provides complete medical and surgical care.

ADPL: 420. 268 are PHS beneficiaries. 152 are others.

OUTPATIENT VISITS: 142,805, consisting of 72,360 PHS beneficiaries and 70,446 others.

There are 17 buildings on 24.1 acres. FY Budget: \$13,675,067. Per Diem cost: \$60.46. Outpatient visit cost: \$14.82.

Total Personnel: 1060. 162 physicians, 16 dentists, 14 pharmacists, and 43 others, amount to 235. 227 nursing, 126 dietary, 59 housekeeping, 53 laboratory, 38 radiology, 74 engineering and maintenance, 41 on medical records, 207 others, amount to 825 Civil Service personnel.

The above figures include 30 medical interns, 68 medical residents, 24 others, amounting to 122.

This hospital is also responsible for PHS medical care activities in New York, New Jersey, parts of Connecticut, Pennsylvania, Ohio, Michigan, Illinois, the Virgin Islands, and Puerto Rico.

It operates as a medical center with direct responsibility for these outpatient clinics:

Annual visits

Buffalo, N.Y.	9,337	
Charlotte Amalie, V.I.	377	
Chicago, Ill	53,650	
Cincinnati, Ohio	15,973	
Cleveland, Ohio	23,812	
Detroit, Mich	35,328	
New York, N.Y.	122,216	
Philadelphia, Pa.	32,586	
San Juan, P.R.	<u>21,532</u>	314,811

Adding these 314,811 visits to the Staten Island Hospital's 142,805 outpatient visits, totals 457,616 outpatient visits.

It provides isolation facilities for quarantinable disease for the Foreign Quarantine Division, medical evaluations for the U.S. Immigration & Naturalization Service, hospitalization of complex medical care cases for the Bureau of Prisons, medical evaluation and treatment for Department of Labor, Bureau of Employees Compensation referrals, operation of an East Coast Leprosy Center. In 1968, it performed 7,077 operations. It has training affiliation agreements with Columbia College of Physicians & Surgeons, the Albert Einstein Medical College, the New Jersey College of Medicine, Columbia Presbyterian hospital, the University of Pennsylvania Division of Physical Therapy, the New York Medical College, and many others. It has a cardiopulmonary laboratory, and a renal-electrotype laboratory, renal dialysis, artificial lung, cobalt therapy, diagnostic isotope screening.

According to a recently released study by the Army Surgeon General's Office in Washington, costs averaged \$76.35 per patient day in 1969 for the 211 large civilian community hospitals studied. That cost is alarmingly increasing.

To avoid duplicate reading of the details of the many medical services rendered by this hospital, reference is made to the attached document entitled "U.S. Public Health Service Hospital, Staten Island, Staten Island, New York. Briefing Information," marked Exhibit 12.

The undersigned, now 72 years of age, resided in the New York area all his life (except during World Wars I and II when he served in the Army). From time to time, he spoke to many individuals who were treated medically and surgically in the Staten Island PHS Hospital. Every one of them voluntarily and enthusiastically praised the service he received there.

THIS HOSPITAL IS A READY-MADE FOUNDATION UPON WHICH THE PRESIDENT'S LAUDABLE MEDICAL PROGRAM (January 22, 1971 State of the Union Message) MAY BE BASED.

More detailed statements are included in the following attached Exhibits:

- Exhibit 1 TAMPA, Florida,
- 2 PORTLAND, Maine,
- 3 BUFFALO, New York,
- 4 CLEVELAND, Ohio,
- 5 CHICAGO, Illinois,
- 6 SAVANNAH, Georgia,
- 7 ATLANTA, Georgia,
- 8 MIAMI, Florida,
- 9 PHILADELPHIA, Penna.,
- 10 MOBILE, Alabama,
- 11 NEW ORLEANS, Louisiana,
- 12 STATEN ISLAND, New York.

Because of their interest in this subject, copies of this communication are being sent to HEW Secretary Elliot Richardson and the Merchant Marine & Fisheries Committee of the House of Representatives.

Sincerely yours,

D. George Paston,
Col., AUS-Ret.,
Legislative Chairman, Disabled Officers Ass'n.

Inclosures: as listed.



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

January 22, 1971

MEDICAL OFFICER IN CHARGE
US PHS OUTPATIENT CLINIC
FEDERAL BUILDING
801 FLORIDA AVENUE
TAMPA, FLORIDA 33601

Colonel D. G. Paston - Chairman
National Legislative Committee
Disabled Officers Association
175 Adams Street
Brooklyn, New York 11201

Dear Sir:

It was a pleasure to hear from you. All the employees will be pleased that someone cares about the closure of our Hospitals and Clinics.

Far from outmoded, this Clinic in Tampa was completely renovated in 1967-1968 with the most modern and the very latest of medical, dental and scientific equipment. The cost of renovation was in the range of approximately \$312,059 which was the approximate cost to the U.S. Public Health Service; the over-all cost was probably in the range of \$450,000. Capitalized equipment cost \$153,164 which does not include medical books and journals. The Staff moved into this new facility on July 1, 1968. Our Clinic occupies 14,740 cubic feet of floor space on the first floor of the Federal Courthouse and Post Office Building in downtown Tampa.

The physical layout of this Clinic consists of the following facilities:

There are offices for 4 physicians, each physician has a suite of 2 interconnecting examining rooms with the latest Valtronic Units, as well as other modern equipment. All, except one unit, have toilets.

The Nursing Section consists of a Nurses Office, adjoining the Treatment and Procedures Room, Recovery Room, Observation Room and EKG Room, together with a completely equipped Minor Surgery Operating Room. Piped-in oxygen and vacuum systems are available in the Recovery, Surgery, and Treatment and Procedures Rooms. Piped-in compressed air is available in the Treatment and Procedures and Surgery Rooms. There are 2 EKG machines.

We also have a new rear elevator, and a few parking places for patients in the rear, especially for those patients who are not ambulatory. There is also a front elevator on the ground floor which many patients use.

The Dental Clinic has a very modern section which consists of 8 operatories: 4 operative rooms, 1 oral surgery room, 1 dental hygienist room, 1 x-ray room with associated developing room, and 1 prosthetics room; a laboratory, and supply room. The dental equipment which is the most modern including the dental x-ray unit cost a total of \$26,903. This does not include the vacuum system which cost approximately \$5,000. Piped-in oxygen is available in all operatories and the oral surgery room.

In addition, there is available a very complete and well equipped Physical Therapy Department with a hydrotherapy section and whirlpool baths. The physical therapy area is probably one of the most delightful areas in the Clinic.

The Pharmacy is a completely equipped, ultra modern unit. Equipment includes a Barnstead still, a new Triumph digital table counter, Monarch labeling machine, refrigerator, Al-Sop mixing tank (60 liters), typewriter, and weighing balances. Ample storage space is ideally located in an adjoining room with a special ventilated cabinet for the storage of flammables. Pharmacy cabinetry is more than ample and consists of natural-finish Swartz units. There is also a recently completed consultation booth at the dispensing window. The Pharmacy maintains a complete library of pharmacy literature and there is an adjoining office for literature review and administrative duties.

Clinical Laboratory with the latest automated equipment.

X-ray Department which is equipped with a Phillips Diagnex-50 Diagnostic X-ray Unit and an Eastman Kodak Instamatic Film Developer, X-OMAT, which develops films in 90 seconds.

The Receptionist Area is very spacious and modern consisting of 2 admitting booths and Lobby for the patients to wait. The Receptionist Area contains an Addressograph Machine for processing patient identification cards which identifies patient as to name and file number.

Additionally, there is a Medical Records Section with Diebold Power Files: Medical Records are filed by terminal digit utilizing the patient's Social Security Number. Index to patient's records are also filed in Diebold Power Files.

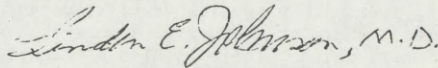
The Clinic's Administrative Section consists of Administrative Offices, Nyematic Dictating System with dictating stations located in each doctor's office and the radiology reading room; a Medical Library with very complete set of medical books, all quite recent, the cost of these books must be at least \$5,000 - additionally, we have had medical journals bound and on the shelves; the Conference Room, well equipped with ample seating capacity for all Clinic members, a slide projector and movie projector with a large screen for medical films; Employees Lounge; and, a Health Unit for Federal Agencies in the area is equipped and awaiting personnel to man it.

The Clinic is staffed by both Commissioned Corps and Civil Service Personnel. The Commissioned Officer complement consist of 4 Medical Officers, including myself, 2 Dental Officers, 2 Pharmacists, and a Physical Therapist. The civilian complement totals 16 Civil Service employees of which we have 2 Registered Nurses, 1 Licensed Practical Nurse, 2 Medical Laboratory Technicians, 1 X-ray Technician, 2 Dental Assistants, 1 Secretary, 3 Administrative Clerical Personnel, and 4 Medical Records Personnel.

The patient load for Fiscal Year 1970 was 32,046 patient visits compared to 33,553 patient visits for Fiscal Year 1969, or an average of 124 patient visits daily. Approximately 50% of the patient load are eligible to be seen in Department of Defense facilities.

Thank you for your interest.

Sincerely yours,

A handwritten signature in cursive script that reads "Linden E. Johnson, M.D.".

LINDEN E. JOHNSON, MD
Medical Director
Medical Officer in Charge



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

January 19, 1971

OUTPATIENT CLINIC
331 VERANDA STREET
PORTLAND, MAINE

Col. D. G. Paston
175 Adams Street
Brooklyn, New York

Dear Col. Paston:

The following information is supplied in response to your letter of January 15, 1971, regarding closure of Public Health Service facilities:

The Outpatient Clinic, Portland, Maine, served approximately 20,000 patients last year. The approximate breakdown according to beneficiary class was:

Coast Guard	- 20%
Dependents, Dept. of Defense	- 20%
Coast Guard Dependents	- 18%
American Seamen	- 8%
Department of Defense	- 12%
Other	- 22%
PHS	
Bureau of Employment Compensation	
Federal employees	
Innoculation & Vaccinations	

Stationed at Portland in the Coast Guard are approximately 850 active duty personnel assigned to 3 Coast Guard cutters, 4 smaller ships, Coast Guard Base, Portland, Maine, and outlying installations along the coast of Maine.

Portland, Maine, is also a very popular area for retirement of military personnel, one of the attracting features being the availability of medical care at the Public Health Service Clinic.

The average cost in medical supply per patient is \$1.56.

The nearest Veterans Administration Hospital is at Togus, Maine, approximately 130 miles from Portland, Maine. Personal experience has shown a wait of up to a month for elective admission at Togus.

The staff at the clinic consists of:

- 1 Director-pharmacist
- 2 Physicians
- 2 Dentists
- 2 Nurses
- 2 Dental technicians
- 1 laboratory technician
- 1 clerk-typist
- 1 clerk-stenographer
- 2 maintenance men

I hope this information will be useful. If you need more specific information, please contact Mr. Richard Gallant, Director, U. S. Public Health Service Outpatient Clinic, 331 Veranda Street, Portland, Maine. Mr. Gallant is presently on leave.

Sincerely yours,

Edward M. Solomon M.D.

Edward M. Solomon, M. D.
Chief Medical Officer



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

January 19, 1971

Col. D. G. Paston
175 Adams Street
Brooklyn, New York 11201

U.S. PUBLIC HEALTH SERVICE OUTPATIENT CLINIC
BUFFALO, NEW YORK 14203

The Merchant Marine and the Coast Guard travel from port to port, to all the seas, all the Great Lakes and all the rivers.

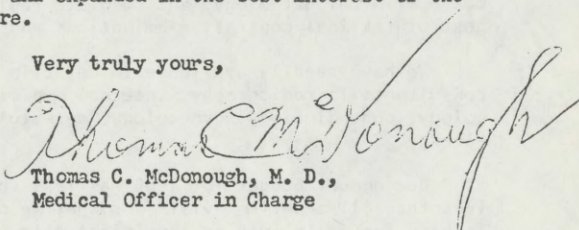
Medical care for transient members entitled to U. S. Government coverage is a special type of service. The medical care to American Seamen and Coast Guardsmen in the 173 years of the USPHS (1798 - 1971) has been and shall be excellent.

Diagnosis and treatment in other than USPHS facilities is not practical in that a long waiting period to see the doctor is involved.

Great Lakes ships are in port 4 to 8 hours. Waiting to be examined by a doctor in a non USPHS facility many times exceeds this period. USPHS doctors understand the special duties of seamen, Coast Guardsmen and Federal employees (beneficiaries of the U. S. Labor Department when injured on the job) and know how to communicate with them and how to determine duty status recommendations for further care.

It is, therefore, strongly recommended that USPHS Hospital-Clinic care be continued and expanded in the best interest of the nation and general welfare.

Very truly yours,


Thomas C. McDonough, M. D.,
Medical Officer in Charge



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

CHIEF MEDICAL OFFICER
U.S. PHS OUTPATIENT CLINIC
4094 U.S. POST OFFICE BUILDING
WEST THIRD AND PROSPECT AVENUE
CLEVELAND, OHIO 44113

20 January 1971

Colonel D. D. Paston
175 Adams Street
Brooklyn, New York 11201

Dear Colonel Paston:

In reply to your letter of January 15, 1971, which presented our clinic with the tentative schedule for the closing of the U. S. Public Health Service Hospitals and Clinics, I would like to make known some pertinent facts regarding the Cleveland Outpatient Clinic.

Our clinic here, as other Public Health Service Clinics, takes care of Coast Guard personnel, their dependents, and seamen in the Merchant Marine primarily. In addition, we regularly examine persons eligible for employment compensation and disability retirement for the Post Office and other Government agencies. Almost daily we examine FBI personnel, either for annual physical examinations, or for applications to the FBI Service. We examine retired military personnel in all services, care for the dental health of these patients as well, and recently have been providing regular care for Vista personnel stationed in Cleveland. We also do annual examinations for the Department of Defense in their executive department, and entrance examinations for candidates to the Peace Corps, State Department Foreign Service, Vista, and the Public Health Service itself. Our clinic here in Cleveland is the regional yellow fever center, and weekly we see from fifteen to fifty patients who obtain their yellow fever vaccine here.

Our total annual census, including the dental clinic, was approximately 18,000 visits for the fiscal year 1969. For these patients we provide full medical care, including medications, diagnostic studies, basic clinical pathology, and complete radiographic studies, including gastrointestinal contrast examinations and intravenous pyelograms.

We have readily available to our clinic, and make regular use of consultants in radiography, internal medicine, neurology, otolaryngology, ophthalmology, gynecology, dermatology, psychiatry, and allergy.

Our annual budget for 1969 was less than \$194,000, approximately less than \$11 a patient visit for what we consider complete care. It is hard for me to imagine physicians elsewhere in this community providing such complete diagnostic and therapeutic services for anywhere near that price. The most distressing fact related to the possible closing of this clinic is the criticism that we are outmoded, inefficient, and under utilized. Although the clinic walls could use a painting, we are NOT outmoded and not inefficient. Certainly we are not seeing

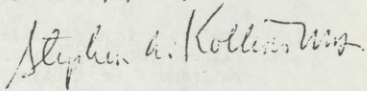
the number of patients we have seen in prior years, but it is my feeling this reflects, in part, the availability of other federally funded health care services i.e. Medicare. We are, however, running an active clinic which requires the presence of two full time physicians and one part time physician, ^{three} nurses, two dentists, and two dental assistants.

Equally as distressing is the recent publicity given to the Bill HR-19860, signed by President Nixon, which has granted \$60,000,000 to the Public Health Service to utilize commissioned officers such as myself in ghetto areas of cities such as Cleveland. Our clinic, although not located in a ghetto area, is located in the heart of metropolitan Cleveland. We are less than one hundred yards from the hub of all public transportation in Cleveland, making us more readily accessible to all segments of the population than any other clinic facility in this city, and certainly more accessible than the difficult-to-reach Veterans Administration Hospital and Outpatient Clinic, which is postulated to take over care of our patients.

I think Senators Magnuson and Jackson of Washington, D. C. have authored and sponsored a fine piece of legislation. However, replacement of this clinic with physicians sponsored by their bill would be a definite unnecessary expense to the Government. Transferring our patients to the Veterans Administration Hospital for their care and providing Public Health physicians and dentists for ghetto areas here in Cleveland would be an unnecessary duplication of services. We have at least 1,500 square feet of unused floor space immediately available for expansion into offices and examination or treatment rooms within the clinic as it exists today.

I have not practiced medicine at the Cleveland Veterans Administration Hospital, but I have had several opportunities to visit their already-crowded emergency room and outpatient clinic, and I don't believe they can conveniently see the 1,500 or more patients per month we see here in our clinic now. Expansion to handle the needs there could equally be matched by expansion here in our centrally-located clinic at equal, if not less, cost to the Government. It is my feeling that we should continue to care for the patients we are now seeing, and that a modest increase in our facility would most efficiently and most conveniently handle some of the needs of Cleveland's ghetto population. I believe our clinic is needed where it is, and if expanded to handle a larger patient (?ghetto) population, could provide the comprehensive continuing care which is needed in this city and country at this time.

Sincerely yours,



Stephen A. Kollins, M. D.
Surgeon - Acting Chief Medical Officer
CLEVELAND USPHS OUTPATIENT CLINIC

SAK:ml



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

PUBLIC HEALTH SERVICE

1/22/71

Medical Officer in Charge
U. S. Public Health Service Outpatient Clinic
4141 Clarendon Avenue
Chicago, Illinois 60611

Col. D.G. Paston
175 Adams Street
Brooklyn, N.Y. 11201

Dear Col. Paston:

Thank you for your invitation for us to relate facts and statistics relevant to the closings of PHS hospitals and clinics.

This clinic has full facilities of an outpatient clinic including medical and dental officers, nurses and dental assistants and services in pharmacy, x-ray, laboratory and physiotherapy. We have visiting consultants' services in orthopedics, ophthalmology, optometry, radiology, OB-GYN, dermatology and ENT. We have contract facilities for referral of all medical, surgical and psychiatric problems. In addition, we have a cross-service agreement with the Illinois Department of Mental Health for psychiatric and psychological outpatient care provided in our building. We use our own and also contract for ambulance service.

Our clinic provides medical and dental care for many beneficiary groups, the largest being U.S. Army active, retired personnel and their dependents (17,442 patient visits* for FY1970). The only other sources of care for these patients are the U.S. Army Fort Sheridan and Great Lakes Naval Hospital which are approximately 30 miles away. It has been discussed that Fort Sheridan might be closing in the near future. With a large number of Army patients, especially dependents, the closing of our clinic would cause a great hardship for these people.

We offer almost every kind of immunization. We are one of only two facilities in Chicago that give yellow fever immunizations which are provided, free of charge, to the general public; mainly, for those travelling to other countries. In FY1970, we administered 5,000 immunizations, 28% of these for yellow fever.

Federal employees from all Government agencies in Chicago and surrounding areas receive care. The following statistics are for FY1970:

-Employees injured while on duty-----	3,529 patient visits
-Fitness for duty, disability, retirement and routine physical examinations	----- 605 patient visits

*Patient visit - One or more medical or dental services rendered to a patient on any one day.

Aliens applying for permanent visas are determined medically admissible or inadmissible as citizens of this country. FY1970, 5,652 of these patients received physical examinations at this facility.

American seamen, who were the first beneficiaries of the U.S. Public Health Service hospital and clinic system, which began in 1798, made 2,713 visits to the clinic in FY1970.

The USPHS serves as the medical arm to the U.S. Coast Guard, as they have no medical or dental personnel among their ranks. In FY1970, 1,722 applicants, active and retired personnel, and dependents were served.

The Illinois Department of Mental Health, mentioned above, provided psychiatric and psychological outpatient care to 2,441 of our patients in FY1970.

We are involved in three programs for which we provide physical examinations and follow-up medical and dental care to socio-economically deprived persons seeking employment. These programs are the Neighborhood Youth Corps, Work Incentive Program, and the Concentrated Employment Program. In FY1970 we had 5,945 visits from these people.

May, 1970 we began the Model Cities Program which is unique to the USPHS. This program provides medical and dental care to residents in the neighborhood. Most of these patients have received in the past little or no care due to socio-economic reasons and the health crisis existing in Chicago. Please note that this program coincides with the Emergency Health Personnel Act recently signed into law by the President. From May, 1970 to the present, these patients have made 3,017 visits to our clinic.

We treat other beneficiary groups for which I will not burden you with details. The total patient visits to our clinic in FY1970 were 53,469. Projections for FY1971 indicate approximately 65,000 patient visits.

The clinic has tremendous potential for adding more programs and providing in-service training. In the future we plan to expand services for preventive medicine. Plans for starting a TB clinic are being discussed with the Chicago Board of Health. We provide on-the-job training for dental hygienists and medical students. We have requested that the city send us applicants who we are willing to train as nurses' aids, dental assistants, clerks, typists, etc.

As to administration's statements of underutilized, inefficient, and outmoded: Any witness could testify that our 70 well-trained, well-qualified personnel are constantly working to maintain that primary goal of good patient care. Underutilization does not apply to this clinic. Inefficiency would be accurately judged by the patient. No letters or voices of complaints have been received from patients. On the contrary, we have received many compliments from patients. Our medical records can offer further evidence of good patient care. Outmoded is a confusing term as in this period

of a declared, national health crisis, all resources that provide the primary objective of good patient care are essential. "Outmoded" facilities can be improved with additional funds. Certainly this expense would be less expensive and more practical than contracting our beneficiaries to other Government agencies already filled to capacity (i.e. VA hospitals).

We deeply appreciate your continued support of our cause. Good luck!

Sincerely yours,

George R. Adam, M.D.
George R. Adam, M.D.
Medical Director, USPHS
Medical Officer in Charge

GRA:jeb



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION
SAVANNAH, GEORGIA 31401

January 21, 1971

US PHS
OUTPATIENT CLINIC
SAVANNAH, GA.

Colonel D. George Paston
Disabled Officers Association
175 Adams Street
Brooklyn, New York 11201

Dear Colonel Paston:

The closing of the U. S. Public Health Service Hospitals and Clinics for inability to provide high quality medical care and also for economic reasons in my opinion is not justifiable.

First, to state that the hospitals and clinics are not providing high quality medical care is a direct insult to the fine, dedicated, highly skilled individuals staffing these facilities. I have been associated with the U. S. Public Health Service since 1961 and during this time I worked directly in the hospital located here in Savannah until it closed in July 1969. Since then I have been the Administrator of the present Outpatient Clinic which continued functioning after July 1969.

Prior to the closing of the hospital, the staff here worked directly with the outpatient clinics located in Charleston, South Carolina, Atlanta, Georgia, Jacksonville, Miami, and Tampa, Florida. Since the closing, we have worked with the PHS Hospital located in Norfolk, Virginia, and we are still completely supporting the clinic located in Charleston, South Carolina, and furnishing medicines and drugs to the clinics in Jacksonville, Florida, and Atlanta, Georgia.

My purpose in making these statements is in all this time and all the many patients that have been treated in these hospitals and clinics, there have never been any major complaints about the quality of care they have received. But more than that, I have seen for myself what has been done and I cannot conceive how this conclusion could be reached that medical care was anything but good. If it was anything else, some group or agency receiving the benefits would certainly have made it known. The Maritime

Union(American Seaman), or the U. S. Coast Guard are not advocating closing the facilities and they are both primary beneficiaries of the services rendered. Other beneficiaries such as retired military personnel, BEC(Bureau of Employees Compensation), Coast and Geodetic Survey, PHS Commissioned Corps, Immigration, etc., who are all receiving medical care at these facilities have never complained of the quality of care received, so I am at a loss in the reasoning of making this a factor for closing. I am not going to elaborate on the professional abilities of the staff members, all are required to meet the same standards established for each profession that is required in private hospitals and other medical facilities.

Secondly, in regards to the facilities available, prior to the closing of the hospital located here in Savannah, we could not have required more modern up-to-date equipment to enable us to provide the services we were staffed to give. This can be substantiated by the equipment records. As for the Outpatient Clinic as it now is functioning, it is well equipped with modern facilities to provide good, efficient treatment. This facility is definitely not under utilized. We were set up for an estimated 13,000 outpatient visits a year in July 1969 and as of this date we will average 24,000 visits this fiscal year, almost double.

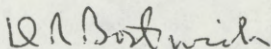
We have examining rooms, two (2) minor emergency rooms, oxygen therapy, a pharmacy(91,300 workload units), a well equipped laboratory(17,000 procedures), an x-ray department(2,500 procedures), dental clinic(4,500 procedures), physical therapy(3,300 procedures), and medical records. We also have an administrative staff to support these services.

If the hospitals and clinics are closed, the patients will have to be treated at private hospitals and doctors' offices. In this community they are already overcrowded. Even if it were more economical, the medical care will certainly be harder to obtain.

One other point I would like to bring to your attention. The two enclosed documents speak for themselves. The one by Secretary Richardson making the announcement on considering the closure of the hospitals and clinics dated December 30, 1970, and the other, an Act(S.4106 Manguson-Rogers

Emergency Health Personnel Act) signed by President Nixon to revitalize the Public Health Service and broaden its mission dated January 4, 1971. Both major proposals having opposite meaning, to close on one hand and broadening its mission on the other,

Sincerely yours,

A handwritten signature in dark ink, appearing to read "D. R. Bostwick". The signature is fluid and cursive, with the first letters of the first and last names being capitalized and prominent.

D. R. Bostwick
Administrative Officer



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

MEDICAL OFFICER IN CHARGE
USPHS OUTPATIENT CLINIC
NCDC BUILDING NO. 1, RM. 658
ATLANTA, GEORGIA 30333

January 21, 1971

Col. D. George Paston
175 Adams Street
Brooklyn, New York 11201

Dear Colonel Paston:

It has come to our attention that Washington is considering closing our Public Health Service Clinic. We feel this would be a grave error since this particular clinic sees many beneficiaries every year. In the fiscal year of 1970 the Atlanta Public Health Service Clinic saw 14,854 patients. Of these, only 166 were American Seamen, and 173 were Coast Guard Officers. The rest were active and retired military dependents, Federal employees, immigrants, Public Health Service Officers, and emergency cases. This clinic is closely affiliated with the Nation Center for Disease Control and should the clinic be closed all of its eligible dependents would have to go to the Veterans Administration Hospital or to Fort McPherson, a 45 minute drive from the Center. We have been in contact with the Fort and their facilities are, at present, completely overloaded and the usual wait, according to many who have been there, is greater than 2 or 3 hours. By treating the Federal Employees here at the Center for Disease Control we probably save the government many times the cost of the clinic for the employee is off the job for only a few minutes for minor problems as opposed to the entire day should they have to consult a private doctor. Needless to say the 14,854 people who were seen does not include the numerous phone calls and consult work which is provided by the clinic.

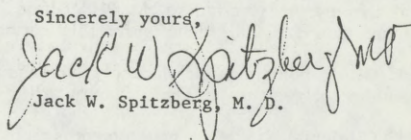
When problems arise and some specialty training is required we generally refer the patient to the nearest Public Health Service Facility or to a private doctor. However, the wait to see a private physician is usually quite long, except under the most emergent of conditions, therefore, to add an additional 15,000 patients to an already overloaded medical system seems to be rather illogical and also rather expensive. Here at the clinic we read our own X-rays and electrocardiograms, saving the government \$800 to \$900 per month.

In conjunction with the CDC Safety Officer we also monitor the Public Health Service Officers and Federal employees who deal with hazardous agents. We have an over-view for any epidemics or problems which could arise here at the Center. This perspective would be lost should everyone have to seek his own individual physician.

While there are many other services which this clinic provides, nevertheless, I am sure you will agree that closing it would be rather premature and, in my opinion, a mistake. While we agree that the system needs revision, one should not take such actions without considering each individual clinic. The "CDC Clinic" is more than merely a PHS Clinic since we serve the government by seeing Federal employees and saving many man-hours of work, in addition to performing our regular duties. Although the Veterans Administration System gives adequate hospital care, my experience is that the outpatient care is somewhat lacking and the system would need expensive changes. To attempt to farm these people out to the Veterans Administration would present numerous delays and burdens to those involved.

We would appreciate your support in our efforts to stay active, and should you need further information, please do not hesitate to call.

Sincerely yours,

A handwritten signature in dark ink, reading "Jack W. Spitzberg". The signature is fluid and cursive, with the first name "Jack" being the most prominent.

Jack W. Spitzberg, M. D.

MIAMI, FLORIDA, PHS CLINIC.

Approximately 57,000 patient visits annually, 1/3 American Seamen, 1/3 military retirees and dependents, and 1/3 active duty personnel and federal employees.

Due to their workload and lack of facilities, the VA hospital is unable to accommodate military retirees.

The Homestead Air Force Base is inaccessible. It is 35 miles south of Miami. Its pharmacy fills approximately 26,000 prescriptions per month and, under Air Force Regulations, needs 14 personnel. It has only 5 persons, one of whom is a registered pharmacist.

The Miami PHS Clinic administers 2,000 Yellow Fever immunizations annually.

The Medical Officer in Charge visits the Cuban Refugee Center once a week as a Hematology consultant.

The Physical Therapist also serves as the Center's consultant. Cuban refugees in need of physical therapy are referred to the PHS Clinic. Contractual therapists would charge the government over \$25,000 annually for this service.

The PHS Clinic holds regular Hanson's Disease (Leprosy) Clinics to treat an increasingly large number of patients in Dade County afflicted with this disease.

The PHS Clinic assists other government agencies, such as Immigration and Quarantine. This includes deportees in need of medical treatment while in custody of the Immigration Officials. Clinic physicians also accompany deportees to Europe, some behind the Iron Curtain, when medical supervision and sedation is required in the process.



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

U. S. PUBLIC HEALTH SERVICE OUTPATIENT CLINIC
225 CHESTNUT STREET
PHILADELPHIA, PENNSYLVANIA 19106

January 22, 1971

Col. D. G. Paston
175 Adams Street
Brooklyn, N. Y. 11201

Dear Colonel Paston:

This is in regard to the recent proposal of the Administration to close the U.S.P.H.S. Outpatient Clinic in Philadelphia.

The population of the Greater Philadelphia Area is approximately 8.5 million people. The several additional facilities available to military personnel are already overburdened.

In addition to the American Seamen and Coast Guard beneficiaries, we are also the authorized agent for Government employees injured on the job. Since there are over 87,000 Government employees in this area, furnishing care to these compensation cases is one of our largest functions.

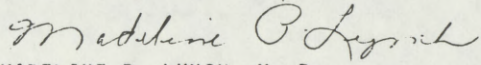
During the first quarter of this fiscal year we saw 13,697 patients. From July 1970 through September 1970, 16,946 laboratory tests were performed, including 1,050 electrocardiograms. During the same period 1,111 x-rays were taken. This work was done by two full time employees and one part time employee. Likewise, 2,325 prescriptions were filled and 2,354 physical therapy treatments were given.

If the U. S. Public Health Service Outpatient Clinic in Philadelphia is closed, the majority of these services will have to be performed by private institutions and the cost would be prohibitive; for instance, \$15.00 per physical therapy visit. The majority of our patients will also have to be seen by private consultants at the going rate of from \$15.00 to \$25.00 per visit.

As a taxpayer I cannot see the justification for the Government to spend a much larger sum of money to give fewer patients medical care.

In addition, this Clinic also operates an Occupational Health Unit for 25 Government agencies.

Sincerely yours,

A handwritten signature in cursive script, reading "Madeline P. Lynch".

MADELINE P. LYNCH, M. D.
Medical Director
Medical Officer in Charge

U. S. Public Health Service Outpatient Clinic
Mobile, Alabama

Background

The Public Health Service Outpatient Clinic was established in Mobile in September 1952 when the old U. S. Marine Hospital (as the PHS Hospital was then known) was closed for lack of funds. Continuous medical care has been given eligible beneficiaries since April 3, 1843, when the first patient was admitted to the hospital. Even during the Civil War when the hospital was used for military purposes, medical care was rendered to American seamen.

Statistics for 1970

During 1970 there were 24,026 visits to the Clinic, 14,730 of which were by American seamen. The majority of the remaining visits were by servicemen, their dependents, physical examinations for other Government agencies, and government employees injured on duty.

There are no other Federal medical facilities (with the exception of the U.S. Coast Guard dispensary) located within Mobile. The closest Federal medical facilities are located about 60 miles away in the following areas:

Naval Air Station Hospital, Pensacola, Fla.
Air Force Hospital, Keesler Field, Biloxi, Miss.
Veterans Hospital, Biloxi, Miss.
Veterans Hospital (Psychiatric), Gulfport, Miss.

The present Clinic is conveniently located in downtown Mobile, easily accessible from the waterfront, and from shipping agencies. Many of the American seamen who come here for treatment have no means of transportation, thus getting to the Veterans Administration Hospital would pose a problem. For lack of funds, many injured fisherman walk to the Clinic, and frequently do not have funds to pay street car or taxi fares to consultants. In many instances these fishermen do not have homes.

Jan. 22, 1971

STATEMENT BY REAR ADMIRAL R. A. MACPHERSON, USN, COMMANDANT
EIGHTH NAVAL DISTRICT, MADE BEFORE HEW COMMITTEE CONCERNING
PROPOSED CLOSURE OF PUBLIC HEALTH HOSPITAL, NEW ORLEANS.

19 January 1971

There are approximately 20,500 military personnel, retirees, and dependents within a 25-mile radius of New Orleans authorized to use the U.S. Public Health Hospital. Approximately 6,000 of these are Navy.

These military personnel and dependents utilize about 23% of the inpatient census and 50% of the outpatient load of the local Public Health Hospital.

If subject closure were effected, the only solution would be to use the CHAMPUS program since other medical facilities in the local area are either not authorized or are already overcrowded now. It is estimated that this would increase costs to the military by about \$1 million a year in the New Orleans area. In a telephone conversation I made this morning, a Navy official in Washington stated that of all Public Health hospitals in the United States, closure of the one in New Orleans would hurt the Navy most.

Every District Commandant in the United States and his supporting activities presently have a naval hospital available in the immediate vicinity. The one exception is here in New Orleans. The only military hospitals available in the Gulf area are:

Keesler Air Force Base, Biloxi, Mississippi (two
hours distance by vehicle),
Naval Hospital, Pensacola (six hours distance), and
Naval Hospital, Corpus Christi (twelve hours distance).

These are used infrequently because of distance.

Among the fringe benefits enjoyed by military personnel and their dependents is medical care. With the new pay raise just authorized, a Petty Officer Third Class with two dependents, with less than two years service, receives a total of \$413.50 per month. With CHAMPUS deductible costs of \$50 (for an individual) or \$100 (for a family), plus 20 to 25% of all medical costs borne by the individual, this would hurt enlisted personnel and retirees particularly. It is estimated that the average

retiree in the area is a twenty-year Chief Petty Officer drawing about \$250 per month retired pay. If the Public Health Hospital is closed, many of these low-income individuals and their families will find their medical costs increased considerably and will undoubtedly suffer financial hardship.

It is strongly recommended that the Public Health Hospital in New Orleans be retained.

R. A. MACPHERSON
Rear Admiral, U. S. Navy
Commandant, Eighth Naval District

United States Public Health Service Hospital, New Orleans, La.

Operating Beds: 403

Workload (FY 1970)

Average Daily Patient Load: 307

PHS Beneficiaries: 207

Others: 100

Outpatient Visits: 145,447

PHS Beneficiaries 48,056

Others: 97,391

Budget FY 1971: \$8,165,118

Per Diem Inpatient Cost (FY 1970): \$47.53 (All inclusive)

Outpatient Visit Cost (FY 1970): \$8.48 (All inclusive)

Personnel

Total: 629

Commissioned Officers: 140

Physicians: 92

Dentists: 10

Pharmacists: 15

Others: 23

Civil Service: 489

Nursing: 147

Dietary: 63

Housekeeping: 37

Laboratory: 37

Radiology: 13

Engineering and Maintenance: 38

Medical Records: 32

Other: 122

Commissioned Officer Trainees: 56

Medical Interns: 19

Medical Residents: 27

Dental Interns: 6

Others: 4

Facility

Date of Construction: 1932

Size of Property: 17.2 acres

Number of Buildings: 23

Cost of Modernization: \$21.9 million

Potential Community Use: with alterations -

General Hospital

Extended Care Facility

Community Health Center

AFFILIATIONS

AFFILIATIONS WITH UNIVERSITIES, HOSPITALS AND AGENCIES (Individuals trained under these affiliations are not USPHS employees). This involved at least 490 students and trainees during the past year.

1. ARCHDIOCESAN SOCIAL APOSTOLATE
Nurses Aides
2. DELGADO JUNIOR COLLEGE
Home Health Workers
Other Health Manpower
3. HOTEL DIEU HOSPITAL
Nursing Students
4. DILLARD UNIVERSITY
Nursing Students
LPN Students
5. JEFFERSON PARISH VOCATIONAL AND TECHNICAL SCHOOL
Dietary Food Service Supervisor
6. LOYOLA UNIVERSITY
Laboratory Technology
Dental Hygienist (planned)
7. LOUISIANA HOSPITAL ASSOCIATION AND LOUISIANA STATE
NURSES ASSOCIATION
Nurse Refresher Training
8. LOUISIANA STATE UNIVERSITY
Physical Therapy
9. NEW ORLEANS PUBLIC SCHOOLS
Practical Nurse Training
10. ST. MARY'S DOMINICAN COLLEGE
Diet Therapy
11. SOUTHEASTERN LOUISIANA UNIVERSITY
Medical Technology

12. TOURO INFIRMARY
Nursing
13. TULANE UNIVERSITY
 School of Medicine: Residency Training Programs
 Medical Students
 Medical Technology

 School of Social Service: Social Service

 School of Public Health and
 Tropical Medicine: Environmental Health
 Health Services Administration
 Hospital Administration

 Speech Therapy
14. UNIVERSITY OF ALABAMA
Physical Therapy
15. UNIVERSITY OF FLORIDA
Physical Therapy
16. UNIVERSITY OF SOUTHERN MISSISSIPPI
Medical Technology
17. UNIVERSITY OF SOUTHWEST LOUISIANA
Medical Technology
18. YALE UNIVERSITY
Ob-Gyn Clinical Clerkship
19. XAVIER UNIVERSITY
Pharmacy
Medical Technology

COMMUNITY TRAINING PROGRAMS

The Hospital participates in at least fifteen training programs which are sponsored or funded by the City of New Orleans, the State of Louisiana, the Archdiocese, and OEO (TCA, WIN, etc.)

In the past four years 1414 persons received training in the following categories:

1. CRAFTSMAN HELPERS
2. DENTAL ASSISTANTS
3. DIETARY AIDS
4. EKG TECHNICIAN AIDS
5. EKG TECHNICIANS
6. EMERGENCY ROOM TECHNICIANS
7. FILE CLERKS
8. FINANCE AIDS
9. FOOD SERVICE WORKERS
10. HOME HEALTH AIDS
11. INHALATION THERAPY TECHNICIANS
12. HOUSEKEEPING AIDS
13. KEYPUNCH OPERATORS
14. LABORATORY ASSISTANTS
15. LAUNDRY WORKERS
16. MAINTENANCE WORKERS
17. MEDICAL LABORATORY TECHNICIANS
18. MEDICAL LIBRARY TECHNOLOGISTS

19. MESSENGERS
20. NURSES AIDS
21. NURSING STUDENTS
22. PEDIATRIC PHYSICIAN ASSISTANTS
23. PERSONNEL AIDS
24. PHARMACY ASSISTANTS
25. PRACTICAL NURSING STUDENTS
26. RECEPTIONIST
27. SECURITY AIDS
28. TELEPHONE OPERATORS
29. X-RAY AIDS

The above Community Training Activities are sponsored by:

1. CATHOLIC ARCHDIOCESE
2. DESIRE COMMUNITY MEDICAL CENTER (OEO)
3. MODEL CITIES (Allied Health Program)
4. NEIGHBORHOOD YOUTH CORPS
5. OEO: Summer Aid Program
Student Work Study Program
Work Experience Program (New Career Program) - TCA
Work Incentive Program
YMCA Extension Residence Program
6. STEP (Supplemental Training and Employment)

INTRAMURAL TRAINING PROGRAMS
PHS HOSPITAL, NEW ORLEANS

1. RESIDENCIES: 39
 - Environmental Health
 - Internal Medicine
 - Obstetrics and Gynecology
 - Ophthalmology
 - Otolaryngology
 - Orthopedics
 - Pathology
 - Pharmacy
 - Radiology
 - Surgery
2. INTERNSHIPS;
 - Dental 6
 - Medical 19
3. OTHER:
 - USPHS Hospital School for Medical
 - Record Librarians, Baltimore - 4
4. TRAINING PROGRAMS FOR HOSPITAL EMPLOYEES
(other than medical)
More than 400 persons attended the following
courses and seminars:
 - Air-Sea Rescue
 - Clerical Training
 - Dietary Services Training
 - Equal Opportunity Seminars
 - Housekeeping Practices
 - Labor Relations
 - Medical Self-Help
 - Medical Terminology
 - Middle Management
 - Nursing Seminars
 - Supervision and Personnel Development

SPECIAL SERVICES AND RESEARCH

1. INHALATION THERAPY
2. MEDICAL-SURGICAL INTENSIVE CARE UNIT (including CORONARY CARE UNIT) - 15 beds
3. RADIOISOTOPE LABORATORY
4. RENAL DIALYSIS UNIT - 6 beds (4 patients)
5. TUBERCULOSIS UNIT - 24 beds (22 patients)

- A. COOPERATIVE STUDY OF HYPERTENSION - 59 patients
- B. COOPERATIVE CORONARY DRUG PROJECT - 103 patients
- C. COOPERATIVE STUDY OF RENAL DISEASE AND HYPERTENSION - 64 patients
- D. TULANE-USPHS MULTIPHASIC HEALTH TESTING PROJECT
about 150 patients per week
- E. COMPUTERIZED COLLECTION OF CLINICAL DATA UTILIZING
AUTOMATIC DATA PROCESSING TECHNIQUES
- F. THE EFFECT OF PROLONGED SEVERE CHRONIC EXERCISE ON
LONGEVITY AND MYOCARDIAL FUNCTION
- G. FLAME RETARDANT LINEN PROJECT, COOPERATIVE PROJECT
WITH USDA LABORATORY, NEW ORLEANS

The above are some of the 35 research projects currently in progress.

COMMUNITY HEALTH ACTIVITIES AND SERVICES
(incl. voluntary after hours services)

1. ARCHDIOCESE OF NEW ORLEANS - see Training Affiliation
2. CHILDREN'S BUREAU OF NEW ORLEANS
3. CONCENTRATED EMPLOYMENT PROGRAM OF NEW ORLEANS
4. LOUISIANA STATE HEALTH DEPARTMENT HANDICAPPED CHILDREN'S PROGRAM (includes Dentistry, Plastic Surgery)
5. DESIRE COMMUNITY HEALTH CLINIC (limited direct patient care)
6. COOPERATIVE LABORATORY PROGRAM - cooperative quality control program with six laboratories
7. DISASTER ASSISTANCE - natural; e.g., storms, floods, etc. other; e.g., fires, explosions
8. ENVIRONMENTAL HEALTH - microbiological sampling assistance to local health care institutions on request
9. FAMILY PLANNING SERVICE - screening of Pap smears
10. HEADSTART PROGRAM - NEW ORLEANS SCHOOL BOARD -- physical examinations
11. HOME FOR THE INCURABLES - physical therapy
12. JEFFERSON COMMUNITY ACTION (KemCo, ShrewCo) - limited direct patient care
13. LOUISIANA DEPARTMENT OF WELFARE
14. LOWER NINTH WARD HEALTH CLINIC - limited direct patient care
15. MEDICAL ADVICE TO SHIPS AT SEA - Coast Guard Search and Rescue Operation

16. MEDICAL SELF-HELP TRAINING - NEW ORLEANS SCHOOL BOARD NURSES
 17. MISCELLANEOUS - host to professional associations and Boards
 18. MULTIPHASIC HEALTH TESTING PROGRAM (Tulane-USPHS)
 19. POISON CONTROL CENTER
 20. PREVENTIVE MEDICINE - physical examinations for disadvantaged persons
 21. TOTAL COMMUNITY ACTION, INC. - OEO
 - Work Incentive Program (Volunteers of America)
 - Student Work Study Program
 - Summer Aid Program
 - Job Corps (YMCA)
 - Neighborhood Youth Corps
 - Work Experience Program (New Careers)
 22. TOURO INFIRMARY - provides administrative experience to dietetic interns
 23. TREATING OF NON-BENEFICIARY EMERGENCIES
-

WORKLOAD DATA BY BENEFICIARY

Beneficiary	FY 1970		Patient Days	Newborn
	Outpatient Visits	Inpatient Admissions		
American seamen	45,410	2,563	71,181	
Coast Guard:				
Active	1,703	229	4,266	
Retired	1,253	52	763	
Applicants	2	-	-	
Lighthouse Service (Retired)	64	4	66	
National Oceanic and Atmospheric Administration:				
Active	6	3	31	
Retired	1	-	-	
Public Health Service:				
Active	937	16	159	
Retired	171	10	258	
Applicants	109	-	-	
Bureau of Employees Compensation	1,219	51	889	
Patients with Leprosy	513	49	1,224	
Special Study (non-reimbursable)	10,503	570	6,004	110
Federal Employee Exam (")	608	-	-	
Emergency (non-collectible)	51	19	169	
Immunizations (non-pay)	577	-	-	
Aliens-Adjustment of Status, etc.	535	-	-	
Food handler & Motor boat operators	1,422	-	-	
Federal Employee Health	1,399	-	-	
Dependents:				
Coast Guard Active	4,940	172	860	249
Coast Guard Retired	1,596	44	549	-
Coast Guard Deceased	169	1	10	-

Beneficiary	Outpatient Visits	Inpatient Admissions	Newborn	Patient Days	Newborn
Dependents (Continued):					
NOAA Retired	1				
Public Health Service Active	1,822	41	18	516	113
Public Health Service Retired	145	3	-	105	-
Public Health Service Deceased	50	1	-	2	-
U.S. Army Active	15,907	557	232	3,665	1,091
U.S. Army Retired	7,443	209	16	2,428	72
U.S. Army Deceased	773	38	3	558	11
U.S. Navy Active	7,358	281	78	1,594	302
U.S. Navy Retired	6,858	172	9	1,527	47
U.S. Navy Deceased	342	12	-	285	-
U.S. Marine Corps Active	2,950	87	39	503	154
U.S. Marine Corps Retired	958	32	2	219	6
U.S. Marine Corps Deceased	89	1	-	21	-
U.S. Air Force Active	5,338	160	51	1,122	266
U.S. Air Force Retired	3,416	87	6	779	22
U.S. Air Force Deceased	163	9	-	101	-
Department of Defense:					
U.S. Army Active	1,614	93		1,200	
U.S. Army Retired	4,703	112		1,837	
U.S. Navy Active	1,398	90		1,251	
U.S. Navy Retired	4,242	128		2,250	
U.S. Marine Corps Active	444	27		321	
U.S. Marine Corps Retired	578	16		240	
U.S. Air Force Active	337	9		212	
U.S. Air Force Retired	2,046	52		1,126	
Foreign seamen	100	65		1,141	
Immigration (reimbursable)	1	-		-	
Indians	-	3		49	
Emergency (collectible)	122	43		581	
VISTA	4	-		1	
Job Corps	13	-		-	
Foreign Service - State Department	7	-		-	
Dependents - State Department	10	-		-	
Peace Corps	18	-		-	

<u>Beneficiary</u>	<u>Outpatient Visits</u>	<u>Inpatient Admissions</u>	<u>Newborn</u>	<u>Patient Days</u>	<u>Newborn</u>
Bureau of Prisons	58	13		198	
Federally Sponsored Community Projects	2,434	5		14	
Tort Claims Act	2	2		16	
National Guard	77	2		4	
Armed Forces Applicants	1	-		-	
Federal Employee Exam (reimbursable)	40	-		-	
Special Study (reimbursable)	370	39		1,915	
Immunizations (reimbursable)	7	-		-	
Newborn	-		215		1,143
TOTALS	145,447	6,172	722	112,210	3,586

Disabled Officers Association

Organized in 1919

NATIONAL HEADQUARTERS
1612 K STREET, N. W.
WASHINGTON, D. C. 20006

202-347-3401

LT. M. S. STEVENSON, DSC
NATIONAL COMMANDER
EMERITUS
1958-1967

MAJOR WALTER J. REILLY
CHIEF OF STAFF

NATIONAL EXECUTIVE COMMITTEEMEN

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CENTRAL AREA
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CAPT. JOSEPH L. ROTHFEDER
NATIONAL SURGEON
MAJOR WALTER J. REILLY
NATIONAL HISTORIAN

February 1, 1971

President Richard M. Nixon,
The White House,
Washington, D. C.

Opposition to the closing of USPHS Hospitals & Clinics.

Dear Mr President,

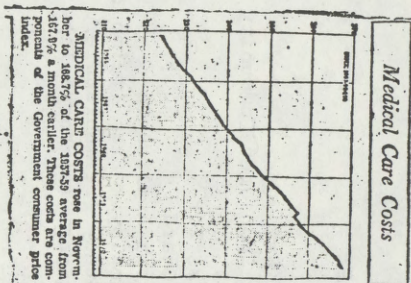
Supplementing my letter of January 28th, I am
pleased to enclose herewith the facts concerning the USPHS
Hospital at Boston, Massachusetts.

Sincerely yours,

D. George Paston,
Col., AUS-Ret.
Legislative Chairman, Disabled Officers Ass'n

Inclosure: as listed, 8 pages.

copies to:
HEW Secretary Elliot Richardson,
Merchant Marine & Fisheries Committee, H of R.



BRIEFING REPORTJANUARY - 1971U. S. PUBLIC HEALTH SERVICE HOSPITALBoston, Massachusetts

The Boston Public Health Service Hospital is a 190-bed general medical and surgical care institution located on 14 acres in the Brighton Section of Boston, approximately four miles from the business center of the city and conveniently situated with regard to medical centers, educational institutions and research facilities. It is well served by public transportation in addition to being readily accessible by road and convenient to Logan Airport.

Comprehensive care is given for acute medical and surgical illnesses. Obstetrical care is not given. Full-time physicians on duty at the hospital include two general surgeons, one urologist, one orthopedist, four internists (including one hematologist, one cardiologist and one endocrinologist), an ophthalmologist, a radiologist, a pathologist; all of whom are board-certified or board-eligible. Consultants affiliated with the three medical schools in Boston provide subspecialty care and consultations as well as participating in the teaching programs. In addition, strong dental, pharmacy, physical therapy, dietary, medical records, nursing and social services support the medical care programs.

Patients are drawn principally from American seamen (including fishermen who are actively engaged in care and preservation of the vessel), Coast Guard, active and retired members; active duty military; military dependents, active and retired; and Bureau of Employee Compensation referrals. Non-beneficiaries are treated in research and teaching capacities on a categorical basis. Medical emergencies are treated without reference to beneficiary groups.

Our hospital participates in two research programs funded by the *National Institute of Health*
~~Federal Health Programs Service~~ - the Cooperative Pyelonephritis Study and the Hypertension Group Study.

Our hospital is an affiliate of the Boston University School of Medicine. As such both medical and surgical services participate in the clinical training of 2nd, 3rd and 4th year students. Surgical residents are assigned to this hospital from University Hospital as senior residents. We also participate as an affiliate of University Hospital in the Eastern Cooperative Oncology Group as well as the Regional Medical Program for Cancer.

Another important affiliation is the Massachusetts College of Optometry. Several other affiliations are in effect (see appended listing).

Approved training programs provide training of nine rotating medical interns, four dental interns, a four-year program in general surgery, and three year training in internal medicine. Also, we have a hospital pharmacy residency program consisting of two residents for the current year.

Demonstrations and Projects recently initiated at the Boston PHS Hospital include:

- The Family Planning Clinic - recently expanded to three clinics per week. (This clinic provides family planning services to low-income citizens but principally to the Brighton-Allston community).
- College Mental Health Infirmary is located on the first floor of East Hall and is administered by College Mental Health Center of Boston. Provides inpatient care to participants in the plan.
- Coast Guard Rehabilitation Ward - an inpatient care facility to provide intensive care for active duty Coast Guardsmen.
- An innovative program of drug distribution and a modification of the unit-dose system was developed by the pharmacy and nursing services and will serve as a prototype to be installed in all PHS hospitals.

NAME: U. S. PUBLIC HEALTH SERVICE HOSPITAL - 4th oldest in United States(1799)

ADDRESS: 77 Warren Street, Brighton, Mass. 02135 TELEPHONE: (617) 782-3400

LINICAL SERVICES:

- | | | |
|---------------------|-------------------|---------------------|
| 1. <u>Medicine</u> | 2. <u>Surgery</u> | 3. <u>Dentistry</u> |
| Cardiology | General | General Dentistry |
| Endocrinology | Orthopedics | Oral Surgery |
| Gastroenterology | Urology | |
| Hematology | Anesthesiology | |
| Tumor | Otolaryngology | |
| 4. Ophthalmology | | |
| 5. Pathology | | |
| 6. Radiology | | |
| 7. Physical Therapy | | |

MAIN BENEFICIARIES:

- American Seamen (including eligible fisherman).
- Coast Guard Personnel - Active and Retired and Dependents
- Military Personnel - Active and Retired and Dependents
- Bureau of Employee Compensation Referrals.

WORK-LOAD FISCAL YEAR 1970

<u>ADMISSIONS:</u>	2377	<u>PATIENT DAYS</u>	46,167
<u>DISPOSITIONS:</u>	2361	<u>ADPI.</u>	126.48
<u>OUT-PATIENT VISITS:</u>	58,362		

<u>Beneficiary</u>	<u>ANALYSIS</u>	<u>Admissions</u>	<u>Patient Days</u>	<u>OPC Visits</u>
1. AMERICAN SEAMEN (including 11 categories including eligible fishermen)		682	16,055	13,332
2. COAST GUARD				
Active		495	11,870	5,295
Retired		137	2,404	2,496
Dependents		160	3,169	5,372
2A. PUBLIC HEALTH SERVICE				
Active		11	182	1,001
Retired		5	35	155
Dependents		33	222	1,701
3. MILITARY PERSONNEL				
Retired		150	2,841	4,120
Active		47	581	1,900
Dependents		397	4,432	12,490
4. BUREAU OF EMPLOYEES COMPENSATION Referrals		86	1,598	3,376
5. OTHER		174	2,778	7,124
	<u>TOTAL</u>	<u>2,377</u>	<u>46,167</u>	<u>58,362</u>

GENERAL INFORMATIONOperating Beds: 190Workload (FY 1970)

ADPL, Total: 126 (66.3% occupancy rate)
 PHS Beneficiaries: 77
 Others: 49

Outpatient Visits, Total: 58,362
 PHS Beneficiaries: 19,452
 Others: 38,910

Budget FY 1971: \$3,929,664Per Diem Cost (FY 1970): \$60.00 (Average Length of Stay: 19.6 days)Outpatient Visit Cost (FY 1970): \$14.40Personnel

Total: 304
Commissioned Officers, Total 60
 Physicians: 33
 Dentists: 9
 Pharmacists: 7
 Other: 11

Civil Service, Total 244
 Nursing: ~~52~~ 78
 Dietary: 35
 Housekeeping: 19
 Laboratory: 14
 Radiology: 7
 Engineering and Maintenance: 16
 Medical Records: 12
 Other: ~~22~~ 63

Commissioned Officer Trainees (included in personnel figures above):

Medical Interns: 9
 Medical Residents: 4
 Other: 6
Total 19

Facility:

Date of Construction: 1940
 Size of Property: 12.6 acres
 Number of Buildings: 11
 Cost of Modernization: \$8.7 million
 Potential community use: (with moderate alterations)

- Extended Care Facility
- Community Health Center

TRAINING PROGRAMS

<u>I. Training Category</u>	<u>Number of Trainees</u>	<u>Training Period</u>
Medical Interns	8	1 year
Medical Residents	3	3 years
Surgical Residents	4	4 years
Dental Interns	4	1 year
Pharmacy Residents	3	1 year

II. Affiliated Training Programs

<u>School</u>	<u>Affiliation</u>	<u>Number of Students</u>	<u>Length of Time</u>
Baltimore PHS Hospital (Record Librarian School)	Medical Record Librarian	3-4	1 month
Blue Hills Regional Technical School	Medical Laboratory Assistant	4	4 months
Boston Trade School for Girls	Dental Assistant	15	5 weeks
Boston University	Physical Therapist	5	2 weeks
Boston University School of Medicine	Medical Students		
	2nd Yr	16	4-5 weeks
	3rd Yr	4	4-5 weeks
	4th Yr	10	1-2 months
		(as elective)	
Northeastern University	Physical Therapist	6	3 weeks
Rindge Technical School	Medical Record Technician	2	2 months
(Proposed) Rosary Hill College (Buffalo, N.Y.)	Medical Records Management	1	1 month

III. Intra-Mural Training Programs

- A. Training of Nurses GS-4 (graduates of a 2-year Associate Degree Program - Six months of supplemental training in order to equip them with the necessary knowledge and practice to qualify as a fully functioning member of the nursing team.

III. Intra-Mural Training Programs (cont'd)**B. Day-to-Day**

On-the-job training as a regular recurring function or as needed in the following categories:

1. Radiology Technicians
2. Nursing Assistants
3. Operating Room Technicians
4. Food Service Workers
5. Medical Record Clerks
6. Medical Secretaries
7. Medical Transcribers
8. Medical Technicians and Technologists
9. Pharmacy Assistants
10. Physical Therapy Aids
11. Hospital Housekeeping Aids
12. Personnel Technicians
13. Hospital Supply Workers
14. Ward Clerks
15. Accounting Technicians
16. Laundry Workers
17. Hospital Building Maintenance Workers

C. Regular monthly supervisory management training sessions for all first-line supervisors.

D. Regular monthly orientation sessions for all new employees.

EMPLOYMENT OF YOUTHSinFURTHERANCE OF COMMUNITY PROGRAMS

<u>1970</u>	<u>*Neighborhood Youth</u>		<u>**College Work Study</u>		<u>Student and Summer Aids</u>	
	<u>Number</u>	<u>Hours</u>	<u>Number</u>	<u>Hours</u>	<u>Number</u>	<u>Hours</u>
January	1	48	21	1082	1	64
February	1	18	22	804	3	175
March			17	995	3	210
April			17	622	3	202
May			15	5558	3	224
June	5	130	16	2170	10	823
July	6	588	15	1918	11	1597
August	7	687	15	1348	9	1093
September			10	333	7	344
October			10	397	5	276
November			8	303	4	196
December			8	295	4	281
TOTAL HOURS WORKES	—	1471		10,825		5485

* In affiliation with Action for Boston Community Development.

** Current affiliations are with Boston University and Boston College. Past Year affiliations have also included Bentley College of Accounting, Boston State, Brandeis University, Framingham State, Harvard University, Northeastern University, Pembroke College, Simmons College, Smith College and Tufts University.

Over Fifty Years of Serving Disabled Officers

Disabled Officers Association

Organized in 1919

CAPTAIN ROBERT W. SMITH, DSC
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NATIONAL VICE-COMMANDER
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NATIONAL HEADQUARTERS
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WASHINGTON, D. C. 20006
202-347-3601

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CHAIRMAN
NATL. LEGISLATIVE COMMITTEE
COL. D. GEORGE PASTON
178 ADAMS STREET
BROOKLYN, N.Y. 11201

February 11, 1971

Resident Richard M. Nixon,
The White House, Washington, D.C.

Opposition to the closing of USPHS Hospitals & Clinics.

Dear Mr President,

Supplementing my letters of January 28th and February 1st, I am pleased to enclose the facts concerning the USPHS outpatient clinic at 4th & C Sts., SW., Washington, D.C. (Exhibit 13). You will note that in FY 1970, 84,223 outpatients cost the government \$1,477,318, averaging about \$17 per patient, including salaries, the cost of drugs and other supplies.

The attached Exhibit 14 are the facts concerning the USPHS Hospital at Galveston, Texas, which had 45,277 outpatient visitors at an average cost of \$11.82 and an average inpatient per diem cost of \$54.69, far, very far, below the cost in non-Federal hospitals. Another very important factor overlooked is that an applicant must wait 6 or more weeks before being admitted to a non-Federal hospital because of its own patient-load whereas the USPHS hospitals can accept inpatients immediately especially if they are underutilized as claimed, annually

The Houston and Port Arthur USPHS Clinics/serve 25,000 and 8,000 outpatients, respectively (page 1, Exhibit 14).

Contrary to the claim that the USPHS facilities are outmoded, the Memphis Clinic is "extremely modern and all new equipment is present in the facility" (Exhibit 15, attached).

We understand that the plan is to arrange with the Veterans Administration or non-Federal contract resources to care for USPHS beneficiaries if the latter's facilities should be closed.

The VA cannot handle USPHS beneficiaries in addition to the VA's own patients. Even now plans are afoot to construct a 1,400 VA bed hospital in Bronx County, New York City (HR 3604), a VA hospital in Queens County, New York (HR 3814), and a VA hospital in Vancouver, Washington (HR 3232). We assume a new VA hospital will be constructed in the San Fernando valley of California to replace the one destroyed by an earthquake the other day.

A proposal to close the available USPHS hospitals and clinics and to shift the patients to non-Federal sources makes no sense since the latter are overutilized and far more costly than the USPHS facilities which are claimed to be underutilized. In 1969, costs in civilian

hospitals averaged \$76.35 per patient per day (page 7, my January 28th letter) and, as you pointed out in your State of the Union Message, there is an alarming rise in the cost of medical care, whereas the government pays far less to operate the USPHS facilities.

Use of non-Federal contract resources would be under a program similar to CHAMPUS.

Initially, the CHAMPUS program paid doctors according to what was known as "negotiated fee schedules-fixed rates," periodically negotiated and agreed upon by CHAMPUS and the medical societies of the various States. From January 1967 through May 1968, CHAMPUS phased in "the reasonable fee concept" based on the usual and customary fee charged by a doctor as compared to the prevailing fee charged by physicians in his particular geographic area. In this system, the CHAMPUS program was following the lead of the social security program. Payments by CHAMPUS for surgical procedures rose from 5% in North Dakota to 53% in New Jersey. The median increase was 24% and the additional upward trend followed because the level of physicians' fees has been on the rise appreciably since then. You labelled such rise "alarming" in your State of the Union Message. One doctor in San Diego, California, received \$176,000 in one year-1968. As the result of an investigation, the doctor refunded \$11,121.75 of the amount paid. Of those physicians and clinics paid over \$20,000 by CHAMPUS during FY 1968, 34 physicians and 2 clinics were paid between \$20,000 and \$24,999, 45 physicians and 7 clinics were paid between \$25,000 and \$49,999, 6 physicians and 2 clinics were paid between \$50,000 and \$74,999, 1 physician and 1 clinic were paid between \$75,000 and \$99,999, and 1 physician, the one above mentioned, was paid \$176,000. The salaries paid to USPHS physicians are indeed far less.

Even worse than the much greater cost to the government in non-Federal contractual resources/^{plans} is more than a serious doubt, even under contract, whether they are prepared to and would provide USPHS beneficiaries with the same medical care, comparably adequate or as prompt as that provided by the USPHS facilities. Exhibit 16, page 1).

Bellevue, a very large non-Federal hospital, is an example of the treatment we may expect in non-Federal hospitals. (See attached Exhibit 16, page 2).

In the planned program to utilize non-Federal resources, we assume a system similar to CHAMPUS will be adopted. Some of the CHAMPUS shortcomings are demonstrated in the Report by the Subcommittee on Supplemental Service Benefits of the Committee on Armed Services, House of Representatives, 91st Congress, Second Session, July 3, 1970 (HASC No. 91-60). For example, in cooperation with the health insurance industry, the Department of Defense developed a program offered by Blue Cross-Blue Shield. Subsequent to its hearings, the subcommittee learned that Blue Cross-Blue Shield withdrew from the program thus ending all maternity care under the program (page 9286).

One of the difficulties experienced by patients under CHAMPUS is set forth in a letter of SFC William D. Stephens, Ret., to the Editor of Army Times (Feb 17, 1971, page 18) It reads as follows:

'Deductibles'

OMAHA, Neb.: I am SFC William D. Stephens, USA-Ret. This makes me, and my family, eligible for the Champus Program benefits. The supplemental benefits under Champus are \$50 per person or can be filed as a family for \$100. On the 8th of August 1970 I submitted forms DA 1863-2 for my wife and I under the Champus Family Plan. This was submitted to the Champus office in the Blue Cross-Blue Shield Building in Omaha, Neb. There, they separated the claims and returned them separately. Mine was returned dated Sept. 21, 1970 on a Blue Cross-Blue Shield Form stating, "An outpatient claim should not be filed unless eligible expenses exceed the required during a fiscal year". "The deductible amount(s) are \$50 per person, or collectively \$100 per family. The fiscal year extends from July 1 to June 30. You have \$31.05 for the fiscal year ending June 30, 1970." My wife's claim was returned dated Sept. 21, 1970 and noted, "Please file under your supplemental coverage before filing under Champus". My wife is employed by the U. S. Civil Service Commission and pays to be enrolled in the Federal Plan of Blue Cross-Blue Shield (High Option-Family).

I called the office of Blue Cross-Blue Shield about the first of October and got nowhere; so my wife went over a few days later and she was denied the right to see the Champus representative; and the Blue Cross representative said this is the way the claim must be handled. My wife's must be filed separately from mine as she had met the Blue Cross-Blue Shield deductible.

My total medical was \$31.05 and my wife's was \$155.15, a sum total of \$186.20. Under the Champus Family Plan (\$100 deductible) the refund would be based on \$86.20. Blue Cross-Blue Shield will not pay on me as mine is under \$50 and only pay

on \$55.15 of my wife's after \$100 is deducted.

I am aware that Champus states if you have other insurance coverage they must pay first; however, the supplemental benefits under the Blue Cross-Blue Shield and the Champus Program are not the same coverage.

I cannot see why we must adhere to the \$100 deductible per person when we are eligible for the \$50 deductible (\$100 family deductible).

I believe 20 years of my life for this country is enough, plus the low retirement pay, without being denied rights and benefits of retirement.

SFC WILLIAM D. STEPHENS, Ret.

25,391

The USPHS San Diego, California, ~~clincs~~ clincs 39,454 beneficiaries made / outpatient visits during the first half of FY 1971 (Exhibit 17). At the USPHS Hospital in Galveston, Texas, the inpatient per diem cost is \$54.69 and the outpatient cost is \$11.82 (Exhibit 14). I am also pleased to include the facts concerning the USPHS clinics at St Louis (Exhibit 18), at Jacksonville (Exhibit 19), and at San Pedro, California (Exhibit 20).

The facts in my two previous letters and in this communication compel the conclusion that closing the USPHS facilities and relegating the beneficiaries to other resources will

- (a) cost the government millions of dollars more than the continued operation of the USPHS facilities,
- (b) endanger the lives and health of the USPHS beneficiaries, and
- (c) defeat the government's commitment to provide medical care to the beneficiaries.

It is respectfully submitted that the USPHS Hospitals and clinics should remain open, continue to operate, and be expanded if found necessary and desirable and practical to do so.

Sincerely yours,

D. George Paston
D. George Paston
175 Adams St., Brooklyn, N.Y. 11201.

Inclosures: Exhibits 13 to 20 inclusive.

TOTAL VISITS TO WASHINGTON OPC BY SELECTED BENEFICIARY CATEGORIES, FISCAL YEARS
1968, 1969, 1970. ADAPTED FROM CUMULATIVE MONTHLY REPORT TO DIRECTOR.

BENEFICIARY CATEGORY	FY 1968	FY 1969	FY 1970
American Seamen & Related	581	595	552
Coast Guard Personnel	3,341	4,367	5,789
NOAA Personnel	597	488	357
PHS Officers (Includes NIH)	12,247	12,038	9,981
BEC	33,595	32,809	34,102
FEENP	5,520	2,628	1,756
Army Personnel	728	876	862
Navy Personnel	249	157	139
Air Force Personnel	1,976	2,597	2,585
<u>Dependents</u> - Coast Guard	3,634	3,392	3,385
NOAA	322	307	224
PHS	5,011	4,719	3,381
Army	1,620	1,509	1,558
Navy	774	578	529
Air Force	1,188	1,334	1,492
Immunization and Inoculation, Non-Pay	4,680	4,147	4,538
Aliens & Adjustment of Status	N/A	1,461	1,236
Applicants, Food Handlers	N/A	40	45
Federal Employee Health	PHSFE (179)	528	498
Other Non-Reimbursables	<u>2,594*</u>	<u>671*</u>	<u>843*</u>
TOTAL Non-Reimbursables	78,836	75,241	73,852

BENEFICIARY CATEGORY	FY 1968	FY 1969	FY 1970
Foreign Seamen	---	---	---
Immigration & Naturalization	---	- 1	---
Emergency, Collectible	---	4	15
Job Corps	---	43	112
Federally Sponsored Community Programs	---	---	---
Cooperative Community Programs	---	3,084	4,333
Federal Examination, Pay	N/A	5,646	5,403
Immunizations & Innocula- tions, Pay	N/A	216	133
Other Reimbursables	<u>5,365**</u>	<u>224**</u>	<u>375**</u>
TOTAL Reimbursables	<u>5,365</u>	<u>9,218</u>	<u>10,371</u>
TOTAL ALL CATEGORIES	84,201	84,459	84,223

*Includes Special Studies, Emergency Non-Pay, ADJS, IA, MBO.

**Includes Vista, Peace Corps, Bureau of Prisons.

TOTAL VISITS TO EACH SPECIALTY CLINIC AND ACTIVITY, WASHINGTON OPC, FISCAL YEARS
1968, 1969, 1970. ADAPTED FROM CUMULATIVE MONTHLY REPORT TO DIRECTOR.

SPECIALTY CLINIC	FY 1968	FY 1969	FY 1970
Internal Medicine	8,469	9,912	8,169
Inoculations	8,125	7,476	8,141
Medical Examinations	4,130	3,304	4,135
Pediatrics	1,910	1,708	1,553
Dermatology	3,105	2,686	2,298
Allergy	2,490	2,975	3,194
Gynecology	580	605	529
Dental Service, D.C.	6,460	5,754	5,671
Dental Service, NIH	3,975	2,975	3,107
Nutrition	71	106	184
Mental Health	3,319	2,601	1,695
EEENT	7,894	---	---
Ophthalmology	---	6,292	5,950
Otolaryngology	---	2,053	4,129
Surgery	21,985	21,465	23,625
Orthopaedics	N/A	453	615
Physical Therapy	13,211	13,261	13,259
Radiology, Total Visits	19,806	17,750	17,180
Exposures	33,594	30,768	30,941
Laboratory Visits	11,269	Not avail.	13,993
Social Service			
New & Reopened Cases	355	224	302
Casework Interviews	934	1,148	1,507
Visits	---	1,134	1,100
941 N. Capital St. Clinic	---	2,989 Oct. 1968	4,154

TOTAL PHARMACY ACTIVITY
AS ADAPTED FROM QUARTERLY REPORTS

	FY 1968	FY 1969	FY 1970
Total Cost Supplies (Drugs) Issued	\$62,642.00	\$73,315.00	\$72,621.75
Clinic	\$54,611.00	\$61,734.00	\$61,083.84
FEHU	\$8,031.00	\$11,581.00	\$11,537.91
Prescriptions & Requisitions, Clinic & NIH	50,004	46,358	44,580
Total Work Load Units	102,060	96,127	97,029
Value of Drugs Used at Clinic	\$54,611.00	\$61,734.00	\$61,083.84
Number of OPC Visits	84,201	83,350	82,554
Cost per OPC Visit	0.65	0.74	0.74
Number of OPC Prescriptions	50,004	46,358	44,580
Cost per OPC Prescription	\$1.09	\$1.33	\$1.38

PHS OUTPATIENT CLINIC
WASHINGTON, D. C.

	<u>FY 1969</u>	<u>FY 1970</u>	<u>FY 1971 (Projected)</u>
Salaries & Benefits	\$1,030,778	\$1,337,316	\$1,311,934
Drugs	65,075	71,278	71,280
Other Supplies	44,940	56,598	57,558
TOTAL ALLOWANCE	\$1,226,718	\$1,477,318	\$1,539,554

Average Employment - last 10 months - 106.3

Galveston, Texas*

Operating Beds: 160

Workload (FY 1970)

ADPL, Total: 125 (78.1% occupancy rate)

PHS Beneficiaries: 101

Others: 24

Outpatient Visits, Total: 45,277

PHS Beneficiaries: 22,707

Others: 22,570

Budget FY 1971: \$3,350,792

Per Diem Cost (FY 1970): \$54.69 (Average Length of Stay: 16.1 days)

Outpatient Visit Cost (FY 1970): \$11.82

Personnel

Total: 270

Commissioned Officers, Total: 39

Physicians: 24

Dentists: 5

Pharmacists: 4

Other: 6

Civil Service, Total: 231

Nursing: 78

Dietary: 33

Housekeeping: 17

Laboratory: 10

Radiology: 5

Engineering and Maintenance: 21

Medical Records: 12

Other: 55

Commissioned Officer Trainees (included in personnel figures above):

Medical Residents: 2

Other: 2

Total: 4

Facility

Date of Construction: 1931

Size of Property: 10.0 acres

Number of Buildings: 10

Cost of Modernization: \$14.7 million

Potential community use: with moderate alterations -
 Extended Care Facility
 Community Health Center
 Research Facility for UTMB

*Data received from Headquarters via facsimile transmitter 1-13-71

Houston Outpatient Clinic visits - 25,000/year

Port Arthur Outpatient Clinic visits - 8,000/year

OTHER HOSPITALS IN SERVICE AREA

Hospital	Total Beds	Occupancy (percent)
Danforth Memorial Hospital Texas City, Texas	82	73.0
Galveston County Memorial Hospital Texas City, Texas	315	74.9
St. Mary's Hospital Galveston, Texas	245	89.1
University of Texas Medical Branch Hospitals Galveston, Texas	1061	77.5
St. Joseph's Hospital Houston, Texas	613	95.0
Veterans Administration Hospital Houston, Texas	1332	95.0
St. Mary's Hospital Port Arthur, Texas	177	77.8

COMMUNITY ACTIVITIES

NEIGHBORHOOD YOUTH CORPS (NYC):

The program provides assistance to those who have already dropped out of high school and need job training and motivation. The Galveston PHS Hospital provides the NYC with two years training and experience plus the individual supervisors work closely with the NYC Program Director in providing counseling and job placement.

BOY SCOUTS OF AMERICA:

The Galveston PHS Hospital furnished staff and facilities to perform physical examinations on 180 "disadvantaged" boys, sponsored by the Island District so these boys could attend the special camp, "Invitation to Adventure".

PROPOSED PROJECTS

BOY SCOUTS OF AMERICA:

The Galveston PHS Hospital has been requested by the Island District to sponsor an Explorer Specialty Post (Medical) and also an Explorer Specialty Post (Radio).

GALVESTON COUNTY COORDINATED COMMUNITY CLINICS (4 C's)

The 4 C's will provide comprehensive family medical and dental clinics for all the indigents of Galveston County. The workload of the medical clinic would be 40,000 visits per year. The hospital is ideally located for this project.

MAN IN THE SEA:

The medical portion of the Man-in-the-Sea project could be located at the Galveston PHS Hospital. The facilities would contain compressors and hyperbaric chambers plus a 25 bed hospital unit.

NEIGHBORHOOD YOUTH CORPS: TRAINING CENTER:

The Galveston PHS Hospital facilities would be larger, more centrally located and would improve the coordinating, counseling and job-placement activities of the NYC Program.

PHYSICIANS IN GALVESTON COUNTY

Specialty	Private Practice	Group Practice or U.T.M.B.
Administrative Medicine	0	6
Anesthesiology	0	12
Dermatology	0	3
General Practice	16	31
Industrial Medicine	0	3
Internal Medicine	14	32
Family Medicine	0	1
Neurology and Psychiatry	7	14
Neurosurgery	0	3
Obstetrics - Gynecology	2	14
Ophthalmology	2	4
Orthopedics	2	7
Otolaryngology	1	4
Pathology	4	13
Pediatrics	4	10
Plastic Surgery	0	5
Preventive Medicine	0	1
Proctology	0	2
Radiology	3	14
Surgery	4	20
Urology	0	5
Not Classified	19	
Subtotal	78	204
Total: 282		

GALVESTON PHS HOSPITAL

TEACHING RELATIONSHIPS

PHS STAFF FACULTY APPOINTMENTS - UTMB

Surgeon, John E. Buck, M.D., Clinical Instructor, Department of Surgery

Medical Director, Leo J. Castiglioni M.D. Clinical Assistant Professor
Department of Internal Medicine

Dental Director, Biagio J. Cosentino, D.D.S., Clinical Assistant Professor,
Department of Surgery, Division of Oral and Dental Surgery

Medical Director, Stanley Graber M.D., Clinical Assistant Professor
Department of Pathology

Surgeon, Frank J. Grady, M.D., Clinical Assistant Professor, Department of
Ophthalmology

Senior Surgeon, Juan Leal, M.D., Clinical Instructor, Department of
Anesthesiology

Medical Director, John R. Mc Kenna, M.D., Clinical Assistant Professor,
Department of Surgery

PHS STAFF HOLDING OTHER THAN UTMB FACULTY APPOINTMENTS

Galveston College Associate Degree Nursing Program

Mrs. Anita Satterly

Nurse Officer, William J. Young

Senior Nurse Officer, Rudolph P. Zalesak

University of Texas Dental Branch - Houston, Texas

Dental Director, Biagio J. Cosentino, D.D.S., Clinical Assistant Professor,
Oral Surgery

PHS SUPPORTED RESIDENTS

General Surgery Resident (1 Affiliated Resident)

Ophthalmology Residents - 2

Orthopedics Resident - 1

PHS - UTMB AFFILIATED RESIDENCIES

Dermatology Resident - 1

Neurosurgery Resident - 1

Otolaryngology Residents - 2

Urology Resident - 1

COSTEPS (UTMB MEDICAL STUDENTS HOLDING TEMPORARY PHS COMMISSIONS)

Six 10-week appointments are normally available each fiscal year. The areas available are Anesthesiology, Medicine, Ophthalmology, Pathology, Radiology and Surgery.

UTMB MEDICAL STUDENTS ELECTIVE AT PHS HOSPITAL (23 STUDENTS FOR THE YEAR)

1 - Department of Medicine

1 - Department of Ophthalmology

(10-week periods - one student
on each service can be accommo-
dated each period)

1 - Department of Radiology

1 - Department of Surgery

MEDICAL AND SURGICAL CLERKSHIPS (80 STUDENTS FOR THE YEAR)

2 - Department of Medicine

3 - Department of Surgery

During their clerkships, one of these junior medical student is on duty with the Officer of the Day until 10 PM weekdays; 9 PM Saturdays and 5 PM Sundays.

PHYSICAL DIAGNOSIS (40 STUDENTS FOR THE YEAR)

A total of 40 University of Texas Medical Branch students during two 10-week periods received instructions in physical diagnosis techniques from Public Health Service medical staff.

MEDICAL RECORD STUDENTS (3 STUDENTS FOR THE YEAR)

3 - UTMB undergraduate students

NURSING STUDENTS (178 STUDENTS FOR THE YEAR)

- 100 Galveston College students
- 56 Alvin Junior College students
- 4 UTMB students (for clinical experience)
- 18 UTMB students (for orientation)

PHYSICAL THERAPY STUDENTS (48 STUDENTS FOR THE YEAR)

- 8 UTMB students (1 month training)
- 40 UTMB students (32 hours training)

GALVESTON PHS HOSPITAL

1. TYPES OF SERVICE PROVIDED BY THE HOSPITAL (INPATIENT CARE BY CLINICAL SERVICES)-

Columns indicate total admissions and average daily patient load.

SERVICE	1969	1970
Dermatology*		
Medicine	1264 .. 54	1395 .. 53
Neurosurgery **		
Ophthalmology	59 .. 2	71 .. 3
Orthopedic**		
Otolaryngology**		
Surgery	1079 .. 57	1106 .. 58
Urology	196 .. 7	201 .. 8
Dentistry	46 .. 2	31 .. 2
Totals***	2555 .. 122	2804 .. 125

* Included in Medicine totals

** Included in Surgery totals

*** Totals exclude intra-hospital transfers and is less than the sum of the admissions to the individual services. Individual services include intra-hospital transfers.

2. NUMBER OF BEDS AVAILABLE TO THE HOSPITAL	1969	1970
Operating bed capacity	160	160
Constructed bed capacity	79	79

3. NUMBER OF PATIENTS PER YEAR

Columns indicate total admissions and average daily patient load

	American Seamen	Bureau of Employees Comp.	Coast Guard	Public Health Service Officer	Special Study	Other	Total
1969	1801 - 96	22 - 1	174 - 7	17 - *	37 - 1	17 - 1	2068 - 106
1970	1942 - 95	11 - 1	153 - 7	10 - *	28 - 1	31 - 1	2175 - 105

Reimbursable

	Dept. of Defense	Dependents DOD	Dep. CG ESSA & PHS	Foreign Seamen	Veterans	Other	Total	Grand Totals
1969	144 - 6	221 - 7	77 - 2	27 - 1	15 - *	3 - *	487 - 16	2555 - 122
1970	289 - 9	213 - 8	95 - 2	16 - *	24 - *	3 - 1	640 - 20	2815 - 125

* Average is less than 0.5

4. AVERAGE LENGTH OF STAY FOR HOSPITAL PATIENTS

1969 17.5
1970 16.1

OUT PATIENTS

	Total Visits	AS	BEC	CG	PHS	SPEC. STUDY	DEPT OF DEFENSE	DEP DOD	DEP. CG ESSA, PHS	OTHER	REIMBURSABLE FS	OTHER
1969	43, 632	18,818	217	4038	535	193	5129	8604	4081	1894	48	75
1970	45, 277	19,285	133	2947	342	164	6415	9704	4378	1833	16	60

6.	VISITS TO OUTPATIENT SERVICES 1969 - 1970	
Dermatology	643	889
General	24801	23180
Medicine	2783	2502
Neurosurgery*		
Ophthalmology	2767	3857
Orthopedics*		
Otolaryngology	259	1373
Pediatrics	23	
Surgery	3092	2840
Urology	935	1276
Dentistry - Total	9221	9147
Inpatients	1908	1715
Outpatients	7313	7432

* Included in Surgery Totals

GALVESTON PHS HOSPITAL

I. INTRA MURAL HEALTH MANPOWER DEVELOPMENT

COURSE TITLE	FULL OR PART-TIME	LENGTH	AUDIENCE DESIRED	BRIEF DESCRIPTION	NO. STUDENTS PER YEAR
Anesthesiology COSTEP	FT	10 Wks.	Junior & senior medical students both as COSTEP and Elective	Supervised clinical experience in anesthesiology	1
Commissioned Officer Orientation Program	PT	12 one hour sessions	Commissioned Officer Personnel	PHS policies, procedures, etc.	18
Community Activities, See: Dietary, Housekeeping Laboratory, Laundry, Nursing, Pharmacy & Physical Therapy					
COSTEP, See: Anesthesiology, Medicine, Ophthalmology, Pathology, Radiology, Surgery and Nursing					
Dental Internship	FT	1 year	Graduates of Class A Dental Schools	Rotating internship	2
Dermatology Resident	PT	6 Mos.	Resident	Dermatology residency	4
Dietary Dietary Aides	FT	2 Yrs.	OEO (Neighborhood Youth Corps enrollees)	Supervised training & experience in dietary skills and procedures	2
Environmental Health Trainee	PT	1 Hr.	All employees	Elementary bacteriology, Food housekeeping procedures, Hygiene	33
Handicapped Trainee	FT	1 Yr.	Mental retardees (Through Texas Rehabilitation Commission)	Supervised training & experience in dietary skills & procedures	1

Emergency Communication	PT	45 Hrs.	Volunteers	Emergency radio communications	8
Employee Training Sessions	PT	10 Hrs.	All employees	Round table discussions on personnel rules and regulations	230
Environmental Health, See: Dietary, Housekeeping Laundry, Maintenance and Nursing					
General Orientation Program	PT	4 Hrs.	New employees	Civil Service policies and procedures, EEO policies and PHS policies and procedures	35
Housekeeping Continual Training	PT	10 Hrs.	Housekeeping personnel	Lectures and demonstrations in method improvement	18
Environmental Health Trainee	PT	1 Hr.	All employees	Safety environmental controls, Isolation techniques & body mechanics	20
Housekeeping Aides	FT	10 Wks.	OEO (Neighborhood Youth Corps enrollees)	Supervised training & experience in housekeeping procedures	1
Labor Leader Training	PT	5 Hrs.	Selected Housekeeping personnel	Individual counseling	3
Laboratory Laboratory Aide	FT	2 Yrs.	OEO (Neighborhood Youth Corps enrollees)	Supervised training & experience in clinical laboratory	1
Laundry Environmental Health Trainee	PT	1 Hr.	All employees	Safety environmental controls and isolation techniques and body mechanic:	8

Laundry (continued)					
Handicapped Trainee	FT	1 Yr.	Mental retardee (through Texas Rehabilitation Comm.	Supervised training & experience in laundry procedures	1
Laundry Worker	PT	10 Wks.	OEO (Neighborhood Youth Corps enrollees)	Supervised training & experience in laundry procedures	1
Maintenance					
Environmental Health Trainee	PT	1 Hr.	All employees	Safety in hospitals; environmental control and body mechanics	22
Safety Training	PT	5 Hrs.	Maintenance personnel	Demonstrations and fire-fighting techniques	22
Medical:					
Clinical Clerkships in Medicine	PT	5 Wks.	Sophomore and junior medical students	Supervised program of clinical experience in patient management	32
COSTEP	FT	10 Wks.	Sophomore, junior or senior medical students	Supervised program of clinical experience in patient management	2
Electives	FT	10 Wks.	Sophomore, junior or senior medical students	Supervised program of clinical experience in patient management	5
Training Program in Physical Diagnosis	PT	10 Wks.	Sophomore medical school class from UTMB	Lectures and demonstrations in methods and techniques of physical diagnosis	40
Mid-level Management Trainees	FT	1 Yr.	Selected minority employees	Principles of good management	2
Neurosurgery Resident	PT	1 Yr.	Resident	Neurosurgery residency	1

Nursing Affiliation Program					
Alvin Junior College	FT	9 Wks.	Student	Supervised training & experience in clinical setting	56
Galveston College	FT	10 Wks.	Student	Supervised training & experience in clinical setting	100
UTMB	PT	8 Wks.	Student	Supervised training & experience in clinical setting	4
UTMB	PT	1 Wk.	Student	Nursing Orientation	18
COSTEP	FT	10 Wks.	Sophomore and junior nursing students	Supervised training & experience in clinical setting	4
Environmental Health Trainee	FT	1 Hr.	All employees	Elementary bacteriology and personal hygiene	30
Leadership	PT	9 Wks.	Graduate of 2 year Associate Degree Nurse Program	Scope and nature of leadership roles in nursing	3
Nursing Aides	FT	2 Yrs.	OEO (Neighborhood Youth Corps enrollees)	Basic nursing care	3
Nursing Asst. Program	PT	8 Wks.	Nursing Assistant	Basic nursing care	4
On-going In-Service Program					
Audio visual aides	PT	2 Hrs.	Hospital employees	Use of audio-visual aids	13
Monthly Teaching Program	PT	1 Hr.	Nursing staff	Improved nursing techniques	80
Nursing Orientation	PT	As needed	New employees	Nursing procedures	30

Nursing (continued)					UTMB nurses	Orientation of nurses in the UTMB Exchange Visitor Nurse Program	
On-going In-service Program	Orientation Exchange Program	PT	As needed	As needed			
	Orientation of Faculty and students from affiliated schools	PT	As needed	As indicated		Orientation to PHS Hospital	183
Pharmacology		PT	2 Wks.	L.V.N.		Basic pharmacology and pharmacy arithmetic	10
Ward Clerk		PT	4 Wks.	Newly employed ward clerks		Orientation to hospital and nursing service	1
Ward Clerk		PT	4 Hrs.	All ward clerks		Coordinate work procedures	4
Ophthalmology: Affiliated Residency		FT	1 Yr.	Resident		Ophthalmology	2
COSTEP		FT	10 Wks.	Junior or senior medical students		Ophthalmology residency	
Elective		FT	10 Wks.	Junior or senior medical students		Ophthalmology residency	1
Orthopedics Affiliated Residency		FT	1 Yr.	Resident		Orthopedics	1
Otolaryngology Affiliated Residency		FT	3 Mos.	Resident		Otolaryngology	4
Pathology COSTEP		FT	10 Wks.	Junior or senior medical students		Supervised program of clinical and anatomical experience in pathology	1

Pharmacy Pharmacy Aide	FT	2 Yrs.	OEO (Neighborhood Youth Corps enrollees)	Supervised training & experience in basic non-professional pharmacy activities	1
Physical Therapy Physical Therapy Aide	FT	2 Yrs.	OEO (Neighborhood Youth Corps enrollees)	Supervised training & experience in assisting physical therapist	1
In-school Training Program	FT	3 Wks.	Physical therapy student	Supervised advanced experience in clinical physical medicine	40
Summer Training Program	FT	1 Mo.	Physical therapy student	Supervised advanced experience in clinical physical medicine	8
Radiology COSTEP	FT	10 Wks.	Sophomore, junior or senior medical students	Supervised clinical experience in radiology	2
Elective	FT	10 Wks.	Sophomore, junior or senior medical students	Supervised clinical experience in radiology	3
Summer Employment for Youth	FT	10 Wks.	Selected by Texas Employment Commission	Training and experience	6
Surgery Affiliated Residency Program	FT	1 Yr.	Resident	Surgery	1
COSTEP	FT	10 Wks.	Junior or senior medi- cal students	Supervised clinical experience in surgery	
Elective	FT	10 Wks.	Junior or senior medical students	Supervised clinical experience in Surgery	2
Supervisory Management	FT	40 Hrs.	New supervisors	Basic PHS policies, procedures and good management principles	10

Urology Resident	PT	16 Hrs. Per Wk.	Resident	Urology	1
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II. EXTRA MURAL HEALTH MANPOWER DEVELOPMENT

Air-Sea Rescue	PT	4 Hrs.	New Commissioned Officers	Coast Guard Coordinated Program	15
Housekeeping	PT	p.r.n.	Selected housekeeping employee	Accredited Housekeeping Program	1
Licensed Vocational Nurse	FT	1 Yr.	Selected nursing employee	Galveston College Program	1
Marine Biological Institute	FT	2 Yrs.	Commissioned Officer	Tektite Project	1



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

PUBLIC HEALTH SERVICE
US PHS OUTPATIENT CLINIC
969 MADISON AVENUE, 9TH FLOOR
MEMPHIS, TENNESSEE 38104

February 9, 1971

Colonel D. George Paston
175 Adams Street
Brooklyn, New York 11201

Dear Colonel Paston:

The U. S. Public Health Service Outpatient Clinic in Memphis, Tennessee, is located in a new multi-story building at 969 Madison Avenue on the eighth and ninth floors.

Following closure of the U. S. Public Health Service Hospital in Memphis in 1965, the outpatient clinic remained in the hospital building until February of 1970, when the clinic was moved into its new location. The facilities are extremely modern and all new equipment is present in the facility. In addition to well equipped medical record section, physicians, nurse's office, we have a completely equipped clinical laboratory, clinical x-ray, physiotherapy and pharmacy department. In addition we have a full dental clinic available.

During the calendar year of 1970, we had a patient load of 27,113. Approximately fifty-five percent of the total number of patients seen in our clinic were either active duty or retired military personnel and their dependents. In addition approximately eleven percent of our patients were Bureau of Employees' Compensation cases (government employees injured on the job) and twenty-six percent were merchant seaman.

The other government facilities in Memphis consist of the Kennedy Veterans' Hospital and the U. S. Naval Hospital in Millington, Tennessee.

Thank you very much for your interest in our clinic.

Yours very truly,

Robert J. Trautman, M. D.
Medical Director
Medical Officer in Charge

RJT:ew

THE NEW YORK TIMES

Medicine

Medicare:

No Cure Yet for Rising Bill

WASHINGTON—President Johnson told the nation on signing Medicare into law that "no longer will older Americans be denied the healing miracle of modern medicine — no longer will illness crush and destroy their savings — no longer will young families see their own incomes and their own hopes eaten away . . . carrying out their deep moral obligations — and no longer will this nation refuse the hand of justice to those who have given a lifetime of service . . ."

That was the hope of 1965. The reality of four and a half years of Medicare's operations has dimmed the original dream as the program has become ever more cumbersome and controversial.

Medical service to Americans aged 65 and over has increased, but in the next fiscal year this group will collectively be paying about as much in out-of-pocket funds for medical care as it paid the year before Medicare began. And there is some danger that they may have to pay more.

For the cost to the Federal Government has soared far beyond original estimates — it will reach a total of \$30-billion by summer. And for the next fiscal year alone, as seen by medical planners in the White House and the Department of Health, Education and Welfare, the cost of Medicare will be \$9.4-billion — some \$400-million above the figure set forth in President Nixon's budget. They hope to make up the difference by means of a series of economy measures; and that's where the extra pinch may come for the Medicare patient.

The exact means of effecting the economies has yet to be decided, but oblique statements of various Federal officials, including H.E.W.

Secretary Elliot L. Richardson, indicate their sights are on reducing hospitalization benefits, increasing the contributions to Medicare from its enrollees, forcing hospitals and nursing homes to economize on services, and restricting doctors' fees.

These fees, which have been the target of Congressional investigations and consumer groups for several years, were at the heart of a series of letters between Representative Samuel S. Stratton and H.E.W. officials. The New York Democrat said that Medicare beneficiaries were "being cheated" on reimbursements by H.E.W., which, he said, was not paying the share called for in the law. Mr. Stratton complained that while doctors' fees are rising, the Social Security Administration, which administers Medicare, is reducing its percentage of coverage of medical fees.

Social Security Commissioner Robert M. Ball denied Mr. Stratton's charge that revised fee procedures have been "seriously short-changing millions of American senior citizens." While conceding that some persons are paying more, Mr. Ball said that lack of action by the Social Security Administration in attempting to

contain fees "would greatly increase the cost of the program by failing to offer discouragement to increases in charges."

Mr. Ball, Mr. Stratton and other administrators and Congressmen actually are expressing a feeling of exasperation over ever higher costs and what to do about them. Both the Legislative and Executive branches of the Government have ordered Mr. Ball in the past few years to crack down on financial inefficiencies and excesses in the Medicare program. But many of the savings are effected at the cost of cuts in benefits and bring complaints. Medicare, for example, is not supposed to pay for custodial care in nursing homes, only convalescent care. This distinction was widely ignored early in the program, but it is being enforced now amid growing complaints that Medicare recipients are being euchered.

When President Nixon announces the Administration's new look health care program, probably at the end of the month, it is expected to contain some proposals aimed at forcing doctors and hospitals to be more efficient. Hospitals, for example, traditionally operate on a cost-plus basis, meaning that when their costs rise

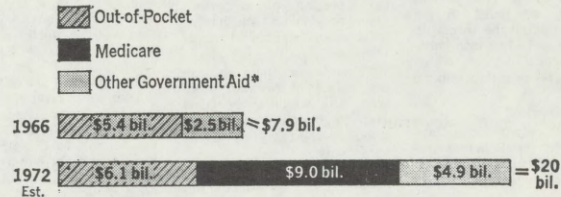
they merely pass the increases along to the consumer. Criticism of this method has mounted. Gordon Chase, New York City's Health Services Administrator, says hospitals should be paid on a "cost-minus" basis, meaning that as their costs rise their productivity and efficiency should also, thus holding down dollar outlays.

While criticism of the program mounts, the Nixon Administration says the Federal budget cannot abide unending increases in Medicare costs. Even if Congress approves a proposed \$383-million cut in benefits, Medicare outlays for the fiscal year 1972 still will go up by \$700-million.

"We're very despondent," said William Hutton, executive director of the National Council of Senior Citizens, which represents three million of the nation's elderly. The increased costs of both Medicare and out-of-pocket expenses, he said, "mean people are not going to doctors because they can't afford it." Speaking of the new proposals to cut benefits, Mr. Hutton said: "The Administration is trying to balance the budget on the backs of sick old people, and Congress will never go along with it."

—RICHARD D. LYONS

Medical care, despite Medicare, will be just as costly for the elderly, taking into account a 9% increase in their population,



*Includes all Federal, state and local medical aid



Emergency: Two Approaches

A ward at Bellevue Hospital.

By **RON HOLLANDER**

Hospital emergency rooms can respond to emergencies this way:

¶Two apartment house fire victims are unloaded from an ambulance at Bellevue with doctors already working over them. They are rushed into an intensive care emergency ward where a special burn team is already assembling from different parts of the hospital.

But they also respond this way:

¶A woman in an auto accident is brought to St. Vincent's by ambulance. She waits two hours before being X-rayed, is released the next morning and told she is fine though she cannot sit up in bed unaided. Thirty-six hours later the hospital calls and says a mistake was made in reading the X-rays: She has a broken ankle.

¶Her husband has a cast put on his broken left wrist up to his forearm. After the cast is on the hospital doctor consults a medical manual and finds out that for a broken wrist the cast is supposed to reach above the elbow. The man is brought back and the cast is lengthened.

¶A school teacher arrives at Harlem Hospital's emergency room with a corneal abrasion on her eye. She waits an hour, complains, is told to go to the eye clinic. There

NEW YORK POST, TUESDAY, FEBRUARY 9, 1971

she has to wait because she has been sent from emergency while "these other people have appointments." Sydenham Hospital tells her after an hour it cannot help. Columbia Presbyterian's Vanderbilt Clinic does help after two hours and completion of a two-page form.

¶An addict comes into Lincoln's emergency room incoherent with pain after having a tooth pulled. She is told to wait, goes outside where she takes an apparent overdose of heroin and is carried back into the emergency room. Two residents, an intern and a nurse's aide swarm over her and she recovers.

The two-and-a-half-year-old emergency room at Bellevue sees 60,000 to 70,000 patients a year. As at emergency rooms throughout the country, the majority of these patients have colds and viruses and are in the emergency room because their communities lack neighborhood health centers or family doctors.

But at other times the emergency room does what it is designed to do: treat trauma and save lives.

A man is helped through the waiting room by a friend. He clutches a bloody rag to his cheek which has a three-inch

Continued on Page 46

Emergency Care: It Can Be a Gamble

Continued from Page 3

gash in it. The cut goes through to his mouth and his teeth can be seen through his cheek.

He is taken immediately to a treatment room where a senior surgical resident checks the wound, determines that no nerve has been injured and turns the case over to an oral surgical intern who is on call.

Assisted by a fourth-year medical student, the intern sutures the wound, his hand trembling slightly as he takes stitches. The patient complains of pains in his chest and after the wound is closed he is talked into waiting for chest x-rays, which prove to be negative and he leaves.

"Call B Service"

At 11:45 on a freezing January night the Bellevue ambulance screeches up to the emergency room, its siren going.

"Siren, siren," shouts the medical resident, grabbing his stethoscope and running to the ambulance bay. Nurses and other doctors converge on the run at the double doors.

"Call B service," shouts a doctor from the ambulance doors, seeing the burned woman being handed down. B service is a medical team specializing in burns on call in the hospital.

"OB service?" asks a nurse, thinking the emergency call was for obstetrics-gynecology.

"No, B!"

•Surrounded by M.D.s

The woman is being worked on as her stretcher is wheeled into the emergency ward, a special intensive care section of Bellevue's emergency room. She has at least second-degree burns on the face.

"There's another one on the way," a fireman says from the ambulance. "One more, a male; he's not conscious: breathing about the same way."

The woman is now surrounded by doctors in the emergency ward. She is receiving intravenous fluids, oxygen and the amount of air or "gas" in her lungs is being determined.

She will survive but the man will die several days later.

Earlier in the month, at St. Vincent's, a voluntary hospital which runs an ambulance service for which the city pays, a couple was brought in from an auto accident under the West Side Hwy. at 1:30 a.m. The woman had a sprained back, two sprained wrists, a broken tooth, chest pains and blacked out briefly after the accident.

Here is her account of her stay:

"Nothing Broken"

She asks for a bedpan but does not get one all night. She is put in a bed in the emergency room's observation ward. A doctor asks her how she is feeling. She says "awful" and he goes away, ordering a full set of X-rays.

Two hours later the X-rays are taken and she goes to sleep. At 7:30 a.m. she is awakened, told nothing is broken and she can go home. She is in pain, cannot sit up without help and cannot bend her neck. She asks to be allowed to stay but is told the hospital is short on beds and she cannot.

A friend is called and takes her home to New Jersey. The next night the hospital calls and tells her she has a broken ankle. She gets it set in New Jersey.

Her husband has his wrist cast put on by a doctor checking in a manual. "Oh, oh, it says if there's a break in the wrist the cast has to

be above the elbow," the man says the doctor said after he had finished the cast up to his forearm.

Glass and Dirt

When the man has 14 stitches in his chin which were put in at the hospital taken out by his family doctor, the doctor says the wound was not cleaned properly and finds particles of glass and dirt in the wound.

St. Vincent's would not comment on these incidents because they involved "medical-legal problems," according to a spokesman. However, she did point out that St. Vincent's emergency room handles 50,000 cases yearly, many of them drug overdoses and freak-outs for which it has established a special emergency unit.

No Specialty Care

At Harlem, burdened with a 15 per cent increase in emergency cases in the last year, bringing its yearly total to about 110,000, specialty care such as for eye injuries is not present in the emergency room itself.

As at many hospitals in the city, such specialty treatment is delegated to clinics which also serve the community on an appointment basis, giving regular checkups, or to hospitals such as Bellevue or Jacobi in the Bronx which are large enough to maintain medical specialties.

The U. S. Public Health Service has provided medical care for beneficiaries in San Diego, California since 1888 when the Marine Hospital was established on the site of the Old Hide House in La Playa. This was in the vicinity of the present-day NEL Waterfront Area on Point Loma. This Outpatient Clinic has been relocated several times in the past. At one time, USPHS had medical offices in the Old Post Office Building (Federal Court House Building), still later in the Electric Building, and since 1938 in the New Post Office Building at 815 E Street. The clinic remained there until April 1966, when it was moved to the present location at 2105 Fifth Avenue.

BENEFICIARIES

Through the years various classes of beneficiaries of the Public Health Service have been added by specific Acts of Congress. The following is a partial list of the present beneficiary groups:

American Seamen:

- Government Owned Vessels
- Merchant Marine
- Military Sea Transport Service
- Navy Tankers
- Owner-Operators of Fishing Vessels
- State Maritime Academies and Ships

National Oceanic and Atmospheric Administration

Lighthouse Service, Retired Members

Uniformed Services Personnel and Dependents

U. S. Coast Guard Personnel and Dependents

USPHS Field Employees

Referrals from other Government Agencies:

- Bureau of Employee Compensation
- U. S. Customs Service
- U. S. Department of Labor
- U. S. Immigration and Naturalization Service
- U. S. Maritime Administration
- U. S. National Guard
- Peace Corps Volunteers
- U. S. Post Office Department
- U. S. Department of State

I. TOTAL VISITS BY FISCAL YEAR:

<u>1965</u>	<u>1966</u>	<u>1967</u>	<u>1968</u>	<u>1969</u>	<u>1970</u>	<u>1971*</u>
10,195	12,199	23,944	30,161	32,756	39,454	25,396

II. FY-1970 BREAKDOWN BY BENEFICIARY:

American Seamen	4,755
Coast Guard	4,140
PHS Officers	142
National Oceanic & Atmospheric Administration	99
Department of Defense	1,699
Dependents - CG, NOAA, USPHS	4,558
Dependents - Department of Defense	20,931
Bureau of Employee Compensation	608
Federal Employees (Physical Exams)	263
Innoculations & Vaccinations	1,683
Others	576
TOTAL:	39,454

III. FY-1970 BREAKDOWN BY SEX AND PEDIATRICS:

Male	13,553
Female	14,807
Children	11,094
TOTAL:	39,454

IV. ANNUAL OPERATING BUDGET:

\$425,000.00

*First Half FY-1971 (June 30, 1970 - December 31, 1970)

V. STAFFING PATTERN:A. Commissioned Corps

- 1 - Director
- 1 - Senior Medical Officer
- 4 - General Medical Officers
- 1 - Physical Therapist
- 1 - Pharmacist
- 2 - Dental Officers

B. Civil Service

- | | |
|---------------------------------------|------|
| 1 - Administrative Assistant | GS-7 |
| 1 - Clerk/Typist | GS-3 |
| 1 - Telephone Operator | GS-3 |
| 1 - Head Nurse | GS-8 |
| 2 - Registered Nurses | GS-7 |
| 1 - Licensed Vocational Nurse | GS-4 |
| 1 - Laboratory Supervisor | GS-7 |
| 2 - Laboratory Technicians | GS-6 |
| 1 - X-ray Technician | GS-6 |
| 2 - Dental Assistant | GS-4 |
| 1 - Pharmacy Assistant | GS-5 |
| 1 - Medical Records Supervisory Clerk | GS-6 |
| 4 - Medical Records Clerk/Typists | GS-4 |
| 1 - Supply Clerk | GS-5 |

C. Coast Guard

- 1 - Coast Guard Representative
- 2 - Dental Technicians

FACILITIES AND SERVICES

The clinic is equipped to provide outpatient medical and dental examinations and care for selected beneficiaries as authorized by Congress. The clinic is composed of medical and dental staffs supported by a full complex of ancillary services with approximately 50,000 patient visits annually. The supportive services include administrative and clerical activities, pharmacy, nursing, medical records, clinical laboratory, x-ray, physical therapy, EKG, and general services. Specialty consultation is also available through the USPHS facilities in San Pedro and San Francisco, the U. S. Naval Hospital in San Diego, and thru contract physician specialists from the local medical community. A preventive medicine program is also in effect for the early detection and prevention of disease, including well baby care and immunizations.

The clinic is a Designated Yellow Fever Vaccination Center, providing yellow fever vaccinations for international travelers, the service being provided without charge to the traveler. The Yellow Fever Clinic is scheduled every Wednesday at 9:00 AM on an appointment basis.

Located also within the clinic complex is the Employee Health Unit which provides occupational health services for Federal employees of participating agencies in San Diego offering health maintenance examinations and immunizations, including screening for visual acuity, glaucoma, audiometry and diabetes.



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

February 11, 1971

PUBLIC HEALTH SERVICE
USPHS OUTPATIENT CLINIC
1520 MARKET STREET
ST. LOUIS, MISSOURI 63103

D. George Paston
175 Adams St.
Brooklyn, N.Y. 11201

Ref: Memo 2-4-71

Dear Mr. Paston:

The following clinic statistics are for calendar year 1970.

Clinic visits - 15,236				
	<u>Active</u>	<u>Retired</u>	<u>Act. Dep.</u>	<u>Ret. Dep.</u>
Coast Guard	2,934	191	1,234	303
Public Health Service 105		21	84	27
U.S. Army	101	253	726	568
U.S. Air Force	136	267	787	521
U.S. Marine Corp.	45	100	281	272
U.S. Navy	18	11	105	87

DOD Total 9,177

The balance of visits, 6,059 are American Seamen, Government Employees injured in the line of duty, etc.

Hope the above is the requested information.

Sincerely,

Veraminette Barsachs
Veraminette H. Barsachs
Administrative Officer



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

PUBLIC HEALTH SERVICE
USPHS OUTPATIENT CLINIC
P.O. BOX 4768
JACKSONVILLE, FLORIDA 32201

February 9, 1971

D. George Paston
175 Adams Street
Brooklyn, New York 11201

Dear Sir:

The U.S.P.H.S. Outpatient Clinic, Jacksonville, Florida is a small general medical-surgical operation. In Fiscal Year 1970 there were 13,252 patient visits. In Fiscal Year 1969 there were 11,296 patient visits by 4,820 individuals of which 2,008 were American Seamen and 417 were Coast Guardsmen. There was a total staff of 1-1/2 physicians, 2 nurses and 3 clerical to provide these services. X-ray and laboratory services were contracted locally as were emergency inpatient care.

Approximately 18 months ago the clinic acquired additional space with the intention of adding dental, pharmacy, laboratory, x-ray, physical therapy and special consultative clinic services. The space is here, the patient potential and need is here, the costs would be nominal, but because of lack of administrative support our ability to render services is severely limited.

Ambulatory care facilities at other federal installations in this area are severely strained - staff and space-wise. There have been numerous articles in the local press that this county and city needs 150 additional physicians. In fact, the County Medical Service and the Mayor's office made intensive efforts during the recent holding of examinations for licensure by the Florida State Board of Medical Examiners in this city to recruit approximately 150 of the 1,400 M.D.'s being examined.

Sincerely yours,

Charles M. Gillikin
Charles M. Gillikin, M. D.
Medical Director, USPHS
Medical Officer in Charge



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

OUTPATIENT CLINIC
338 FEDERAL BUILDING
828 SOUTH BEACON STREET
SAN PEDRO, CALIFORNIA 90731

February 10, 1971

REFER TO:

Col. D. George Paston, Chairman
Disabled Officers Association
175 Adams Street
Brooklyn, New York 11201

Dear Col. Paston:

We have received your letter requesting factual data pertaining to the operation of our clinic here in San Pedro.

This clinic is a facility comprising about 20,000 square feet and offering general medical outpatient services to its beneficiaries. The clinic staff fluctuates between 50 and 60 employees of whom approximately 2/5ths are commissioned officers and the rest are Federal Civil Servants. The commissioned officers in the main constitute the professional staff which consists of 10 physicians, 3 dentists, 2 physical therapists, 1 medical record librarian, and 3 pharmacists. The services provided include laboratory, pharmacy, radiology, physical therapy, dental and specialty clinics such as optometry, ophthalmology, ENT, dermatology, orthopedic, psychiatric, allergy, and well baby pediatrics. With respect to dermatology, a leprosy clinic is conducted at this facility with approximately 100 patients afflicted with this disease being followed or treated at this installation, as well as approximately 500 to 600 family contacts. Patients requiring hospitalization are referred to our hospital in San Francisco or, if local hospitalization is required, use of a contract or local military facility is made.

An average of over 300 patients daily is seen in this clinic for an annual total of approximately 80,000. Of these approximately one-half are American seamen. Military personnel and their dependents with Coast Guard predominating constitute approximately 30% of the case load. Aliens requiring examination for adjustment of their status make up approximately 10% of the case load with the remaining 10% constituting annual and fitness for duty physical examinations on federal employees, and immunizations for overseas travelers and other beneficiaries. In addition, we serve as a yellow fever immunization facility in the Los Angeles area.

As you can see from the above data, even though we are just an outpatient clinic the volume and scope of our functions provide a major health contribution to the populace of this area. In addition to this, of course, is the impact of the \$600,000 employee payroll on the economic climate of this community. The relatively sudden closing of this installation could not help but have a disrupting influence on this area.

We appreciate your interest in the plight of the hospitals and clinics and hope that this information will be of value to you.

Sincerely,

Charles J. Buhrow, M.D.
Charles J. Buhrow, M.D.
Medical Director
Acting Medical Officer in Charge

CJB:am

Over Fifty Years of Serving Disabled Officers

Disabled Officers Association

Organized in 1919

NATIONAL HEADQUARTERS
1612 K STREET, N. W.
WASHINGTON, D. C. 20006
802-847-3401

LT. M. S. STEVENSON, DSC
NATIONAL COMMANDER
EMERITUS
1958-1967

MAJOR WALTER J. REILLY
CHIEF OF STAFF

NATIONAL EXECUTIVE COMMITTEEMEN

EASTERN AREA
LIEUT. MARVIN H. NEW, PA.
COL. D. GEORGE PASTON, N.Y.

CENTRAL AREA
CAPT. DALE G. ACKERSON, MICH.
MAJ. JOSEPH H. LIEBERSTEIN, ILL.

SOUTHERN AREA
LT. COL. HOWARD CARLETON, JR., OKLA.
LT. COL. SYDNEY G. OSBORNE, FLA.

WESTERN AREA
MAJOR FRANK E. BACHELDER, CALIF.
CAPT. R. L. EVANS, ARIZ.

CHAIRMAN
NATL. LEGISLATIVE COMMITTEE
COL. D. GEORGE PASTON
178 ADAMS STREET
BROOKLYN, N.Y. 11201

February 22, 1971.

President Richard M. Nixon,
The White House,
Washington, D. C.

Opposing closing of USPHS Hospitals and Clinics.

Dear Mr President,

Supplementing my January 28th, February 1st., and February 11th letters, I enclose the facts concerning the

USPHS Hospital, Norfolk, Va (Exhibit 21),
" Clinic, Detroit, Mich (" 22), and the
" Hospital, Baltimore, Md (" 23).

The USPHS Clinic, Portland, Oregon, is 120 miles from the nearest military facility with a physician or dentist. The local Veterans Administration facility, which does not accept active-duty servicemen for care, provides only partial care for the retired. No medicine is provided for a condition not noted on a disability evaluation. This USPHS facility, with 3 physicians, 1 dentist, 1 administrative assistant, 2 registered nurses, 1 technician (Laboratory, X-ray, EKG), 1 dental assistant, and 3 secretaries, averages between 1700 and 1800 patient visits a month. Besides group general medical practice including dental care, it dispenses a wide stock of medicines, is the area center for Yellow Fever immunizations and the area source of information regarding immunizations for international travel, all at a relatively low cost. If this facility were closed and the beneficiaries forced to resort to a CHAMPUS styled program, the cost to the government and the beneficiaries would be exceedingly higher, and most patients would not travel 120 or more miles for routine medical care at a military installation which would defeat the object of preventive medicine to detect the onset of disease as early as possible and halt its proliferation.

Respectfully submitted,

D. George Paston
D. George Paston,
175 Adams St.,
Brooklyn, N.Y. 11201.



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

February 10, 1971

U.S.P.H.S. HOSPITAL
6500 HAMPTON BLVD.
NORFOLK, VA. 23508

Col. D. George Paston
Disabled Officers Association
175 Adams Street
Brooklyn, N.Y. 11201

Dear Col. Paston:

In response to your letter of February 4, 1971 requesting facts and statistics about the Norfolk Public Health Service Hospital, the following information is supplied:

1. Fiscal Year 1971 Budget - \$4,052,255
2. Cost per Average Patient Day - \$61.04 - all inclusive
3. Cost per Outpatient Visit - \$9.13 - all inclusive
4. Personnel - 332
 - a. Commissioned Officers - 42
 - b. Civil Service - 290

5. Average Daily Patient Load - Fiscal Year 1965-70

	<u>Total</u>	<u>Primary</u> ^{1/}	<u>Secondary</u> ^{2/}
1965	169	112	57
1966	158	104	54
1967	138	93	45
1968	133	89	44
1969	127	85	42
1970	142	95	47

6. Outpatient Visits - Fiscal Year 1965-70

	<u>Total - All Beneficiaries</u>
1965	72,998
1966	76,453
1967	75,425
1968	86,088
1969	85,704
1970	92,983

7. Operating Bed Capacity - 210

- ^{1/} Primary Beneficiaries include American Seamen, Bureau of Employees Comp., Coast Guard and PHS
- ^{2/} Secondary Beneficiaries include Dept. of Defense Active Duty, Foreign Seamen, Veterans Admin. and Dependents and Retired Personnel of Dept. of Defense, Coast Guard, NOAA and PHS

8. Training Programs -

- a. Eight (8) Rotating Medical Internships
- b. USPHS Co-Step Training Program in Medicine, Dentistry, Physical Therapy, Social Work, Pharmacy and Medical Records
- c. Nursing Education of Nursing Students

- (1) Old Dominion University, Norfolk, Virginia
- (2) Norfolk State College, Norfolk, Virginia

d. Social Service Education

- (1) Richmond School of Social Work, Virginia Commonwealth University, Richmond, Virginia

e. Physical Therapy Clinical Education

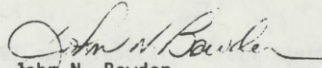
- (1) Virginia Commonwealth University, Richmond, Virginia
- (2) University of Pennsylvania, Philadelphia, Penn.
- (3) Marquette University, Milwaukee, Wisconsin

9. General Statement - This hospital is a well equipped general medical hospital, capable of providing a full range of medical service. Those services not available (psychiatry, neurology, neurosurgery, etc.) at the hospital, are readily available from community physicians on a contractual basis. Although structurally old (built in 1922) the building is functionally and structurally sound. This hospital is as fine a hospital as one could find of comparable size in this area.

Hopefully, this is the type of information you have requested. If not, please feel free to contact us for further detail.

Thank you for your very welcome interest in our hospital.

Very truly yours,


John N. Bowden
Asst. Admin. Officer

JNB:sc



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
USPHS Outpatient Clinic

ADDRESS REPLY TO:
MEDICAL OFFICER IN CHARGE
U.S. PUBLIC HEALTH SERVICE HOSPITAL
14700 RIVERSIDE
DETROIT, MICHIGAN 48215

February 12, 1971

Col. D. George Paston
175 Adams Street
Brooklyn, New York 11201

Dear Col. Paston:

The USPHS Outpatient Clinic in Detroit is a general clinic authorized 38 positions of which 36 are now filled. We have four staff physicians and two dentists. We have X-ray, laboratory, physical therapy and pharmacy sections. We have a full consultant staff available for our primary beneficiaries which include the American Seamen, Coast Guardsmen, and PHS personnel along with a few other smaller groups. These ancillary services are not normally available for Department of Defense personnel and their dependents or other so called secondary beneficiary groups because the cost is prohibitive. Secondary beneficiaries are seen on an availability basis for whatever services we have within the clinic, but we do not assume additional expenses or make additional arrangements for the patients.

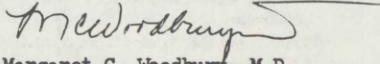
The Clinic is located on the far east side of Detroit on the Detroit River as it opens into Lake St. Clair. It is easily accessible from the metropolitan area by automobile, and accessible by public transportation with only moderate delay and difficulty.

Our average daily census ranges from 113 to 177 patients. Dependents and Department of Defense including active duty and retired servicemen, vary from 1200 to 1500 visits per month. Many Department of Defense beneficiaries use the CHAMPUS program for both outpatient and inpatient care. Any patients followed in our Clinic who require hospitalization make their own arrangements for such hospitalization and either use personal insurance or the CHAMPUS program. The Public Health Service is only responsible for hospitalizations of primary beneficiaries. I understand from a number of patients that have used the CHAMPUS program that the delay in payment to the doctor or hospital is large ~~as~~ as is the delay in reimbursement if the patient has paid the charges directly. The paper work is also rather involved. The deductibles required of the patient are often large and constitute a financial hardship but this department is not directly involved with that program and we are unable to make further comment or recommendation.

The VA hospital is located in Allen Park which is approximately 12 miles west of Detroit. It is also readily accessible by private transportation but is poorly accessible by public transport. Any questions you have concerning the capabilities of the VA hospital would be better referred to the Director of that hospital, Dr. Bernard W. Robinson, VA Hospital, Allen Park, Michigan 48101. The capacities and capabilities of the non-federal hospitals are variable. We have no statistics in this regard in the local office. I would suggest that the Office of the Secretary of DHEW may have more information.

I trust that this additional information will be helpful to you in preparing your report.

Sincerely yours,

A handwritten signature in dark ink, appearing to read "M Woodbury", with a long horizontal flourish extending to the right.

Margaret C. Woodbury, M.D.
Medical Officer in Charge



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

DIRECTOR, PHS HOSPITAL
U.S. PUBLIC HEALTH SERVICE HOSPITAL
3100 WYMAN PARK DRIVE
BALTIMORE, MARYLAND 21211

February 12, 1971

Mr. D. George Paston
Chairman
Disabled Officers' Association
175 Adams Street
Brooklyn, New York 11201

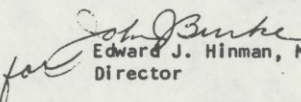
Dear Mr. Paston:

Reference is made to your letter of February 4, 1971, concerning statistical data regarding the U.S. Public Health Service Outpatient Clinic, Pittsburgh, Pennsylvania.

The following statistical information is furnished:

	<u>FY 1970</u>	<u>FY 1971</u>
Annual Budget:	\$115,552.00	\$95,623.00
Total No. of Employees:	7 on duty 1 in training	6 full time 1 part time
Total No. of Visits:	7,850	3,676 (July 1 - Dec. 31, 1970)

Sincerely yours,

for 
Edward J. Hinman, M.D.
Director

MARITIME TRADES DEPARTMENT

815 SIXTEENTH STREET, N.W.
WASHINGTON, D.C. 20006 (202) 638-0282

PAUL HALL, PRESIDENT
JACK McDONALD, VICE-PRESIDENT

PETER M. MCGAVIN, EXECUTIVE SECRETARY-TREASURER
O. WILLIAM MOODY, JR., ADMINISTRATOR

AFFILIATES:

American Guild of Variety Artists
The Journeymen Barbers, Hairdressers
and Cosmetologists' International
Union of America
International Brotherhood of Boilermakers,
Iron Ship Builders, Blacksmiths,
Forgers and Helpers
International Brotherhood of Bookbinders
Bricklayers, Masons and Plasterers International
Union of America
United Brotherhood of Carpenters and
Joiners of America
United Cement, Lime and Gypsum
Workers International Union
Communications Workers of America
Distillery, Rectifying, Wine and Allied
Workers' International Union of America
International Union of Dolls, Toys,
Playthings, Novelties and Allied
Products of the United States and
Canada, AFL-CIO
International Brotherhood of Electrical
Workers
International Union of Elevator Constructors
International Union of Operating
Engineers
International Association of Fire
Fighters
International Brotherhood of Firemen
and Oilers
American Federation of Grain Millers
Hotel and Restaurant Employees'
and Bartenders' International Union
International Association of Bridge, Structural
and Ornamental Iron Workers
Laborers' International Union of
North America
AFL-CIO Laundry and Dry Cleaning
International Union
International Leather Goods, Plastics
and Novelty Workers Union
Lithographers and Photoengravers International
Union
International Association of Machinists
and Aerospace Workers
Industrial Union of Marine and
Shipbuilding Workers of America
Amalgamated Meat Cutters and Butcher
Workmen of North America
Office and Professional Employees
International Union
Oil, Chemical and Atomic Workers
International Union
International Brotherhood of Painters and
Allied Trades
Operative Plasterers' and Cement Masons'
International Association of the United States
and Canada
United Association of Journeymen and
Apprentices of the Plumbing and
Pipe Fitting Industry of the
United States and Canada
International Brotherhood of
Pottery and Allied Workers
International Brotherhood of Pulp, Sulphite and
Paper Mill Workers of the United States
and Canada
Brotherhood of Railway, Airline and Steamship
Clerks, Freight Handlers, Express
and Station Employees
Retail Clerks International Association
Retail, Wholesale and Department Store Union
Seafarers International Union of
North America
Sheet Metal Workers International
Association
American Federation of State, County
and Municipal Employees
American Federation of Technical
Engineers
United Telegraph Workers
United Textile Workers of America
Upholsterers' International Union of
North America

May 24, 1971

The Honorable Edward M. Kennedy, Chairman
Subcommittee on Health of the Labor
and Public Welfare Committee of
the U. S. Senate
Room 4226, New Senate Office Building
Washington, D. C. 20510

Dear Senator Kennedy:

Enclosed are statements together with documentation of five cases of seamen who encountered difficulty in receiving care in United States Public Health Service Hospitals. These seamen were either uninformed of their rights concerning medical care or were impeded from receiving immediate or proper care by the self-defeating bureaucratic procedures established by the regional public health service centers.

These cases show a pattern of time consuming referral from contract doctor to contract doctor, from clinic to clinic and from clinic to public health hospital, often with the result that the seaman patient dropped out of the USPHS "system" and turned to private medicine for treatment. The result of this practice also resulted in interruption of employment to the detriment of the seaman and his employer and in contravention of the intent of Congress in creating the United States Public Health Service Hospitals.

The cases and supporting documents attached hereto are submitted in response to your inquiry during my testimony before the subcommittee on March 8, 1971.

Sincerely yours,

O. W. Moody Jr.
O. William Moody, Jr.
Administrator

Encls.

CASE NO. 1

P.O. Box 936
Bellevue, Florida
2/5/71

Dear Sir:

I have wrote and got a letter from the USPHS, Chicago, Illinois. It is dated the 16 June 1970 through October 30, 1970 with the diagnosis. The 13th of June was on a Saturday and they ask if I could wait until Monday - 15th. As my home was in Kentucky, they told me to report to the USPHS in Lexington. I reported on Monday. They sent me back to Chicago and was there on the 16th, was sent to the VA hospital in Chicago and sent me to the VA in Lexington, Ky. After I got there, they would not forward any records and I was sent back to Chicago. They sent me back to Louisville, Ky. to the USPHS in Louisville who returned me back to the USPHS in Chicago. I got very tired of fooling with them. I went to see my own doctor who performed a minor operation, put me in the hospital. After my release I had medical records sent to the USPHS along with the bills. They didn't pay it. They paid none of my transportation, or expenses. We are supposed to have free medical care, but it is cheaper in the long run to go and get your own doctor and pay him if everybody had to go through with what I had to go through. We are most certainly going to have to have some changes made. I got about three weeks supply of Darvon and it cost me in the vicinity of \$600. I hope you won't make me get the report from Lexington, Ky. for the two days. As records show that I had to get off the Ben W. Collier for a medical check up with a back injury and with a masters certificate. I hope this clears things up.

I remain,

Curtis Baker (GLD)

SS-XXXXXXXXXX
XXXX

SAFARIERS
LEFT
PLAN

BELLEVIEW,
F.N.A.
ONEIDA, KY 40972

Bellevue Fla.

PO Box 936

17/5770

Mr. Robert L. Koepe

Dear Sir,

I have wrote & got a letter from the ASDPHS. Chicago Ill. it is dated the 16 June 1970 - through Oct. 30 - 1970 with the Dingman. the 13th of June was on a Sat. & they ask if I could wait untill Monday 15th, or my home was in Kentucky, they told me to report to the ASDPHS. in Lexington I reported on Monday, they sent me back to Chicago, arrived there on the 16th, was sent to the V.A. Hospital in Chicago, who sent me to the V.A. in Lexington Ky. after I got there they would not forward any records. & I was sent back to Chicago, they sent me back to Louisville to the ASDPHS. there from there, they sent me back to the V.A. Hospital in Louisville Ky. they sent me back to the ASDPHS in Louisville who returned me back to the ASDPHS in Chicago. I got very tired of dealing with them I want to see my own Dr. who performed a minor operation

then put me in the hospital
 after my release I had medical
 records sent to the asphy
 along with the bill they deduct
 for it. they gave none of my trans-
 portation or expenses, we are supposed
 to have free medical care, but
 it is cheaper in the long run
 to go & get your own Dr. & pay
 him if everybody had to go through
 with what I had to go through
 all are most certainly going to
 have to have some changes
 made, I got a last 3 wk supply
 of Darvon, & it cost me in the
 vicinity of \$600.00 I hope you wont
 make me get the report from
 Lexington Ky. for the two days
 or records there that I had to
 get off the Ben. W. Collins for a
 medical check up. with a back
 injury. & with a master certificate
 I hope this clears things up.

\$ Remain

CURTIS BAKER

SS. XXXXXXXXXXXX

XXXX

Curth Baker

SENATOR JOHN S. COOPER, KY.

12/8/70 - 1/19/71

3/27/71

IN RE: U.S. P.H.S.

A CASE IN POINT
AND A SHADOW OF
THINGS TO COME UNDER
ADMINISTRATIVE
PROPOSAL.

P/S
~~THE SEAMAN CAN NOT~~
~~ONLY RECEIVE PROPER~~
~~MEDICAL ATTENTION~~
CAN NOT RECEIVE
PROPER MEDICAL ATTEN-
TION, NOR PROPER RECORDS
TO SUPPORT CLAIM.

WITNESS' ADDRESS

*BASIC SEATIME REQUIREMENT:

List one (1) day's seatime in the last six (6) months:

Vessel: SEAL W. CALLAN Date on 4-25-70 Date off JUNE 12-70

List ninety (90) days' seatime in the last calendar year prior to the date of application, injury or death, whichever occurs first, and/or provision of benefit:

Vessel: SEAL A. M. P. S. K. Date on C. 15-1969 Date off JAN 17-1970

CC

ADMINISTRATOR, SEAFARERS WELFARE PLAN
275-20TH STREET, BROOKLYN, N.Y. 11215

X Application Page 3

OPTICAL

Application Page 4

ility for every benefit is one day's ...
the last calendar year prior to the date
or provision of benefit.

TE APPLIED Aug. 14, 19702-3446 TEL. NO. XXXXZIP CODE 40977ZIP CODE 40977PORT ISSUED DETROIT 2 #10949545'11" WEIGHT 165 HAIR Brown EYES Blue

LIFEBOAT TICKET: YES () NOW

DATE GRADUATED

RELATIONSHIP DATE OF BIRTH

SON MAY 19, 1964RELATIONSHIP SON40977

foregoing nomination with respect to
under the Seafarers Welfare Plan, still

DATE SIGNED Aug. 14, 1970ZIP CODE 40977

Page 1

Application
Page 2Application
Page 4X Application
Page 3

DEATH

LOAN

OPTICAL

Application
Page 2Application
Page 4Application
Page 4

BASIC SEATIME REQUIREMENT: The basic eligibility for every benefit is one day's time in the last six (6) months and 90 days seatime in the last calendar year prior to the date of application, injury or death, (whichever occurs first) and/or provision of benefit.

PORT APPLIED DETROIT MICH DATE APPLIED AUG 14 1970

NAME CURTIS BAKER S.S.# XXXX TEL. NO. XXXX

HOME ADDRESS ORLEANS KY ZIP CODE 40977

MAILING ADDRESS ORLEANS KY ZIP CODE 40977

BOOK # prc6 DATE BOOK ISSUED JAN 1970 PORT ISSUED DETROIT 2 #1094954

DATE OF BIRTH DEC 15 1948 PLACE OF BIRTH LITTLE ROCK KY HEIGHT 5'11 WEIGHT 165 HAIR BR EYES BLU

DEPARTMENT SENG RATING OVER LIFEBOAT TICKET: YES () NO (X)

H.L.S.S. GRADUATE? YES () NO (X) PORT GRADUATED _____ DATE GRADUATED _____

LIST DEPENDENT'S NAME

RELATIONSHIP

DATE OF BIRTH

1. CURTIS BAKER JR. SON MAY 19 1964

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

NAME OF BENEFICIARY CURTIS BAKER JR. RELATIONSHIP SON

ADDRESS OF BENEFICIARY ORLEANS KY 40977

I revoke all previous beneficiary nominations and make the foregoing nomination with respect to all benefits provided now or at any time in the future under the Seafarers Welfare Plan, still reserving to myself the privilege of other and further changes.

MEMBER'S SIGNATURE Curtis Baker DATE SIGNED AUG 14 1970

WITNESS' SIGNATURE [Signature]

WITNESS' ADDRESS 12220 52 ZIP CODE 90088

*BASIC SEATIME REQUIREMENT

List one (1) day's seatime in the last six (6) months:

Vessel: SEAL W CALVIN Date on 4-28-70 Date off JUNE 12-70

List ninety (90) days' seatime in the last calendar year prior to the date of application, injury or death, whichever occurs first, and/or provision of benefit:

Vessel: SEAL A 69054E Date on AUG 15 1969 Date off DEC 17 1970

ADMINISTRATOR, SEAFARERS WELFARE PLAN
275-2070 STREET, BROOKLYN, N.Y. 11215

ZIP CODE _____

Accident occur at work? () No () Yes ()

Emergency treatment? Yes () No ()

Name of hospital _____

ZIP CODE _____

Date discharged _____ Dates you visited patient in hospital: _____

Charge per visit _____

Your complete diagnosis _____

(Please attach your bill to this form and indicate it paid)

Signature of Attending Physician _____

If surgery performed, give date and particulars _____

If not performed in hospital, where performed _____

(Please attach your bill to this form and indicate it paid)

Signature of Attending Surgeon _____

Verified By: _____

Plan or Union Representative _____

SICKNESS & ACCIDENT BENEFIT:

ELIGIBILITY—Basic seetime requirement, (see page 1). For in-patient or out-patient benefits, claim must be filed within 60 days of discharge from hospital or from first day of disability. For out-patient benefits, Seafarer must file U.S.P.H.S. medical abstract. Seafarers who have not been hospitalized, must be out-patients and not fit for duty for seven (7) days before they can receive benefits which are retroactive to the fifth day. If the eligible Seafarer is entitled to receive M. & C. from the employer, or unemployment benefits, then he cannot receive S. & A. benefits.

Nature of illness Back injury

Was illness or injury reported in Log Book? Yes () No (X) Did you get a Master's Certificate? Yes (X) No ()

Were you hospitalized? Yes (X) No () Date in 7-7-76 Date out 7-13-76 What hospital? S. C. Hospital

Where? Seafarers Key Have you taken up your injury with anyone? Yes (X) No () If yes, with whom? SEAFARERS KEY What was done? SEAFARERS MEDICAL CLUB FOR SEAFARERS

Is this a recurring illness or injury? Yes (X) No () If yes, explain Back Dis.

Is illness or injury in any way attributed to misconduct on your part? Yes () No (X) If yes, explain _____

If you were hospitalized prior to becoming an out-patient and collected in-hospital benefits of \$5.00 per day, what was the last day you were paid for _____

Have you applied for unemployment benefits? Yes () No (X)

I hereby certify that to the best of my knowledge the above statements are true, and do also hereby authorize my attending physician (Hospital or Clinic) to furnish and disclose all facts concerning my condition.

Verified By: _____

Plan or Union Representative _____

Signature of Applicant _____

BELLEVIEW,
FKA.

S. Howell Fla.

PO Box 936

7/5/71

Mr. Robert C. Kneefe

Dear Sir,

I have wrote & got a letter from the ASDPHS. Chicago Ill. it is dated the 16 June 1970 - through Oct. 30-1970 with the Diagnosis. the 13th of June was on a Sat. & they ask if I could wait untill mondy. 15th, on my home was in Kentucky, they told me to report to the ASDPHS. in Lexington I reported on mondy, they sent me back to Chicago, arrived there on the 16th, was sent to the V.A. Hospital in Chicago, who sent me to the V.A. in Lexington Ky after I got there they would not forward any records. & I was sent back to Chicago, & they sent me back to Louisville to the ASDPHS. there from there they sent me back to the V.A. Hospital in Louisville Ky they sent me back to the ASDPHS in Louisville who returned me back to the ASDPHS in Chicago I got very tired of dealing with them I want to see my own Dr. who performed a mental operation

I put me in the hospital
 after my release I had medical
 records sent to the asphy
 along with the ^{BIRTH} cert. they don't
 pay it. they gave none of my trans-
 portation or expenses. all are supposed
 to have free medical care, but
 it is cheaper in the long run
 to go & get your own Dr. & pay
 him if everybody had to go through
 with what I had to go through
 all are most certainly going to
 have to have some changes
 made, I got a last 3 wk's supply
 of DARVIN, & it cost me in the
 vicinity of \$60.00 I hope you want
 make me get the report from
 Lexington Ky. for the two days
 as records show that I had to
 get off the Gen. W. Carver for a
 medical check up. with a back
 injury. & with a motor certificate
 I hope this clears things up.

I Remain
 On the Water
 CURTIS BAKER (GLD)
 SS-255-32-3496
 2-1094954

CASE NO. 2

Route 2, Box 291-A
Ashland, Wis. 54806
March 29, 1971

Great Lakes Seaman's
Job Security Program
10227 West Jefferson
River Rouge, Mich. 48218
Director of Seniority

Dear Sir:

I wish to report to you that I am unable to report aboard the Steamer John P. Reiss as oiler as I had a back injured on Sept. 5, 1970 and I am unfit for duty. I am to see the doctor on April 12, 1971. I will go back to work as soon as I am fit for duty. Right now the doctor wants me to see a specialist at Duluth but he informed me that the U.S.P.H.S. will not pay this. If possible will you please let me know (as) soon as possible what to do about it. Thank you.

Yours truly,

S/S Raymond Jurkovic
Book No. 10820

(Enc. 1)

Great Lakes Seaman's Job
Security Program.
10227 W. Jefferson Avenue
River Rouge Mich 48218
Director of Seniority

Route 2 Box 291A
Ashland Wis 54806
March 29, 1971

RECEIVED
GREAT LAKES SEAMEN'S
APPEALS BOARD & WELFARE PLAN

APR 1 1971

AM 7, 8, 9, 10, 11, 12, 1, 2, 3, 4, 5, 6 PM

Dear Sir

I wish to report to you that I am unable to report aboard the steamer John P. Reiss as oiler as I had a back injured on Sept 5 1970 and am unfit for duty. I am to see the Doctor on April 12th 1971. I will go back to work soon as I am fit for Duty.

Right now the Doctor wants me to see a Spacklist at Duluth but he informed me that the USSMS will not pay for that whom will have to pay this if possible will you please let me know soon as possible what to do about it. I thank you

Yours Truly
Raymond Jurkovic

Book no 10820



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

March 1, 1971

To whom it may concern:

Re: Raymond Jurkovic M. S.
Route 2, Box 201A
Ashland, Wisconsin 54806
BK 083578
Oiler SS: John P. Reiss
Boland & Cornelius, Inc.

*Tealson N1
3044*

The above captioned seaman who was injured on September 9, 1970, aboard ship was seen by us again on 2/25/71. He continues to have some limitation of motion and strength of the lumbar spine, limitation being imposed by pain. It is my impression that he is improved and certainly is able to tolerate leaving his back brace off for longer periods.

He is still unfit for duty. He is to be rechecked in our office in one month.

Very truly yours,

B. C. Prentice, M.D.

B. C. Prentice, M. D.
Medical Officer in Charge
USPHS OP Clinic
Ashland, Wisconsin 54806

BCP:jj

*I was rechecked on march 25-71
still un fit for Duty.*

RECEIVED
GREAT LAKES SEAMEN'S
APPEALS BOARD & WELFARE PLAN

APR 1 1971

7:8:9:10:11:12:13:14:15:16

4

CASE NO. 3

SEAFARERS' WELFARE PLAN



NEW YORK OFFICE
PRICE C. SPIVEY
ADMINISTRATOR
275 20th St.
BROOKLYN, N.Y., 11215
212 - 768-6005

DETROIT OFFICE
GREAT LAKES DISTRICT
10227 W. Jefferson Ave.
RIVER ROUGE, MICH. 48218
313 - 843-3932

May 14, 1971

Mr. Bob Vahey
Transportation Institute
2000 L Street, N.W.
Washington, D.C. 20036

Dear Mr. Vahey:

Herewith please find enclosed copy of letter from Henry Collins that possibly will help on the United States Public Health situation.

I will have one or two more as soon as I finish up on them in the next week or two.

Very truly yours,

SEAFARERS' WELFARE PLAN

Dick Hollingsworth

DICK HOLLINGSWORTH
Field Representative

DH:joy
opeiu-10-afl-cio

Enc. 1

cc: Mr. Roy Murdock

SEAFARERS' WELFARE PLAN

NEW YORK OFFICE
PRICE C. SPIVEY
ADMINISTRATOR
275 20th St.
BROOKLYN, N.Y. 11215
212-768-6005

DETROIT OFFICE
GREAT LAKES DISTRICT
10227 W. Jefferson Ave.
RIVER ROUGE, MICH. 48218
313-843-3932

May 4, 1971

Mr. Henry Collins
4477 Winona Court
Denver, Colorado 80212

Dear Mr. Collins:

I am in receipt of your medical report from Dr. Tosseland whereas you reported December 11, 1970. In order to cover you for medical, please forward to this office medical report from the attending physician in Denver, Colorado showing all dates visited and his diagnosis.

Your prompt attention in this matter would be appreciated.

Very truly yours,

SEAFARERS' WELFARE PLAN

Dick Hollingsworth

DICK HOLLINGSWORTH
Field Representative

DH:joy
opeiu-10-afl-cio

Dear Mr. Hollingsworth

I was told by our Chief Engineer to report to U.S.P.H. when I get to Denver. I did report to Mr. Sherman who is in charge of U.S.P.H. here in Denver, and he gave me the Bros. N.Y. he said I should go to Seattle or San Francisco. Dr. Tosseland told me Mr. Sherman should be taken care of here in Denver. I am doing as Dr. Tosseland instructed Physiotherapy. Pain medication and heat.

Yours truly
Henry Collins

waiting to be called on the O.M. Reis
hope she fits out soon

CASE NO. 4

SEAFARERS' WELFARE PLAN
MEDICAL DEPARTMENT
685 THIRD AVENUE
BROOKLYN, N. Y. 11232

TELEPHONE-660001
 965-2440-1-2-3-4-

JOSEPH B. LOGUE, M. D.
 MEDICAL DIRECTOR

April 26, 1971

Jack Butler, M. D.
 Medical Director
 Federal Health Programs Service
 U. S. Public Health Service
 5600 Fishers Lane
 Rockville, Maryland 20852

RE: SANE, Thomas J.
 SS# XXXX

Dear Dr. Butler:

The attached correspondence relative to the above named is self-explanatory.

Mr. Sane was referred to the University Hospital, Madison, Wisconsin, by the Public Health Service physician in Ashland, Wisconsin.

It was Mr. Sane's impression that since he was referred by the Public Health Officer that the bills would be a cost to the Public Health Service.

Please investigate to determine if the Public Health Service will pay this hospitalization; also a similar situation with Mr. Jurkovic (see correspondence attached).

We would greatly appreciate information as to the status of seamen in the Great Lakes area who require definitive medical care and hospitalization.

Thanking you, I remain

Sincerely,

J. B. LOGUE, M. D.
 MEDICAL DIRECTOR

April 20, 1971

Dr. Joseph Logue
683 3rd Avenue
Brooklyn, New York

RE: SAME, Thomas J.
Pensioner-GLD
SS# XXXXXXXXXXXX

Dear Dr. Logue:

Herewith please find all correspondance pertaining to the above. As you will note by the members letter, he was referred to the University Hospital, Madison, Wisconsin, by the U.S. Public Health attending physician in Ashland, Wisconsin.

As you will note by the letter from Edwin Byrd, Administrator, United States Public Health, dated August 27, 1970, this was referred to Chicago, Out Patient Clinic. As of this date, there has been no communication back from Chicago with respect to the above's confinement.

This man went on the Disability Pension approximately three (3) months ago and is in no position to pay this bill. It is my own thinking that the U.S. Public Health is responsible as they referred him.

I would appreciate you forwarding the necessary material in to the U. S. Public Health in Maryland.

April 20, 1971

Page Two

Dr. Joseph Logue
683 3rd Avenue
Brooklyn, New York

Re: SAME, Thomas J.
Pensioner-GLD
SS# XXXXXXXXXXXX

I am also attaching a letter from Raymond Jurkovic who was also treated by this doctor. The doctor wants him to go to a specialist but states, as you will note in his letter, that the U.S. Public Health will not pay for it. I have given copies of this to Price Spivey here in Detroit this date.

Very truly yours,

SEAFARERS' WELFARE PLAN

DICK HOLLINGSWORTH
Field Representative

DH:foj
opelu-10-afl-cio

Enclosures

cc: ✓ Mr. Price Spivey, Administrator
Mr. Robert O'Keefe, Claims Director

AFFILIATED UNIVERSITY PHYSICIANS
1300 UNIVERSITY AVENUE
MADISON, WISCONSIN 53706

March 1, 1971

Mr. Thomas Same
Mellen, Wisconsin

Dear Mr. Same:

Attached is a copy of our Physicians' Service Report which was sent to Seafarer's Welfare Fund on March 10th of 1970.

We have forwarded a copy of your letter to University Hospitals so that they will send you a copy of your hospital bill for your 1/19/70 admission.

We hope this information will be satisfactory .

Sincerely,

A. K. Cunningham
(Mrs.) Annes K. Cunningham
Insurance Department

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

January 22, 1971

Mr. Dick Hollingsworth
Seafarers' Welfare Plan
10227 West Jefferson Avenue
River Rouge, Michigan 48218

Re: Thomas J. Sams
SS [REDACTED]
Box 573
Mellen, Wisconsin 54546

Dear Mr. Hollingsworth:

The above captioned merchant seaman as you know has been having a long and difficult battle with his disease, namely Parkinsonism. He has had treatment by Dr. G. G. Colesia at the University of Wisconsin Hospitals at Madison, Wisconsin and he is indeed still receiving treatment for his disease. We have seen him periodically, but I last saw him on January 20, 1971. It has become perfectly clear that this man is from henceforth permanently unfit for duty aboard ship. It is my understanding that he will be eligible for pension benefits and this I thoroughly approve of, reasons outlined above.

I would like to thank you for your help to this patient, and I offer my assistance if you might need it in any way.

Very truly yours,

B. C. Prentice, M. D.

B. C. Prentice, M. D.
Medical Officer In Charge
USPHS OP Clinic
206 Sixth Avenue West
Ashland, Wisconsin 54806

AUG 28 1970

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Date: August 27, 1970

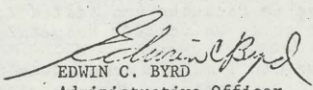
Reply to
Attn of: Administrative Officer, USPHS Outpatient Clinic, Detroit Michigan

Subject: Medical Correspondence (SAME, Thomas John SS#XXXXXXXXXX)

To: Mr. Dick Hollingsworth, Field Representative Seafarers' Welfare Plan

Reference to your letter dated August 11, 1970 and related correspondence pertaining to the above mentioned subject. At the time of treatment the area involved was under the Chicago Outpatient Clinic.

All information has been forwarded to them so that appropriate action can be taken.


EDWIN C. BYRD

Administrative Officer

August 5, 1970

TO WHOM IT MAY CONCERN:

I was on the steamer John A. Kling and got off the vessel sick in Escanaba, Michigan October 23, 1969. I went to the United States Public Health doctor in that port, Dr. Lemire. Upon reporting to him, I was told I had Parkinson's disease. He told me to go to a specialist.

I then went home as I was not feeling well at all. The following week on a Tuesday or Wednesday I went to see Dr. Prentice in Ashland, Wisconsin. He is the attending United States Public Health physician. I was so sick my wife had to drive me to his office. When I saw Dr. Prentice on this date I asked him what I should do. I told him what the doctor in Escanaba had stated to me. He then made arrangements for me to go to University Hospital in Madison, Wisconsin.

At no time did I make a request to be sent to the University Hospital in Madison, Wisconsin. When he made these arrangements I assumed that the United States Public Health would pay these bills. Also, during our conversation he made no mention of sending me to another United States Public Health Hospital. Until I entered the University Hospital I was under treatment by Dr. Prentice. I still have outstanding some \$1,700.00 in hospital bills that certainly should not be my responsibility as I followed the proper procedures.

Prior to this sickness, I was under treatment by him and he always arranged for me to get into the hospital and each and every time the United States Public Health assumed the charges.

Very truly yours,

Thomas Same

THOMAS SAME



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

August 25, 1970

Mr. Dick Hollingsworth
Seafarers' Welfare Plan
10227 West Jefferson Avenue
River Rouge, Michigan 48218

Re: Thomas J. Same
SS [REDACTED]
Mellen, Wisconsin 54546

Dear Mr. Hollingsworth:

I have in hand your request for information relative to the above captioned seaman. We first saw this man in December 1966 at which time he had had an injury involving his right hand and arm. He had suffered this injury some four or five months prior to our seeing him and had seen a variety of public health physicians beginning with one in East Chicago where the injury occurred. We originally mis-diagnosed this case as a brachial plexus injury but after seeing him enough times I came to the correct diagnosis of Parkinsonism and he was seen by us and by a neurosurgeon at the Duluth Clinic, Duluth, Minnesota a number of times throughout the course of the year. He was finally seen in October of 1969 at which time he was really quite disabled by his Parkinsonism and he was as you know, referred to Dr. Celestia at the University of Wisconsin Hospitals in Madison, Wisconsin. Here he underwent some rather specialized therapy for his disease with a reasonable success and was subsequently seen by us on March 24, 1970 at which time he was considered to be fit for full duty as of April 1, 1970. He was given several copies of a letter to that effect as well as several copies of another letter indicating his therapeutic program. I would assume that he would have sent you a copy of each of these letters but for your files I send you copies of these letters at this time.

To the best of my knowledge Mr. Same is presently working as a seaman on the Great Lakes and discharging his duties in a satisfactory manner.

If I may be of any further help to you or to Mr. Same feel free to call on me.

Very truly yours,
B. C. Prentice, M. D.
B.C. Prentice, M. D.
Medical Officer In Charge
205 Sixth Avenue West
Ashtabula, Ohio 44004

BCP:mla
enc:

August 11, 1970

Dr. Woodbury
U. S. Public Health Service
14700 Riverside Drive
Detroit, Michigan

Re: SAME, Thomas John
SS#-XXXX

Dear Dr. Woodbury:

Enclosed herewith please find letter from the above regarding outstanding hospital bill which is self-explanatory. Also enclosed are letters from Dr. Prentice from Ashland, Wisconsin.

I would appreciate your checking into this matter at your first opportunity.

Very truly yours,

SEAFARERS' WELFARE PLAN

DICK HOLLINGSWORTH
Field Representative

DH:joy
opeiu-10-afl-cio

Enc.

June 8, 1970

Dr. J. W. Prentice
USPHS Hospital
206 Sixth Avenue, W,
Ashland, Wisconsin

Re: Thomas J. Sams
Str. John A. Kling

Dear Dr. Prentice:

With reference to the above who was confined at University Hospital of Wisconsin January 22, 1970. The above received a billing in the amount of \$2,140.10 for this confinement. He was referred to this hospital by you. He also received a doctor bill in the amount of \$337.00.

Would you please advise if the USPHS is assuming charges on this.

Would you also please advise me by letter or on a medical duty status report all dates he visited you from the time he was discharged and when he was found fit for duty.

Very truly yours,

SEAFARERS' WELFARE PLAN

DICK HOLLINGSWORTH
Field Representative

DM:jcm
open-10-11-cio

cc: Mr. Thomas J. Sams
Mr. Robert O'Keefe.

*March*

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

March 25, 1970

To Whom It May Concern

Re: Thomas J. Same M. S.
Box 573
Mellen, Wisconsin 54546

Sirs:

The above captioned merchant seaman was seen in our office on 3-24-70 and his Parkinson's disease is very much improved. He is fit for full duty as of April 1, 1970.

If we may be of further help to you or Mr. Same feel free to call on us.

Very truly yours,

B. C. Prentice, M. D.

BCP:mla



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

March 25, 1970

To Whom It May Concern

Re: Thomas John Same M.S.
Mollen, Wisconsin 54546

Sirs:

This gentleman was last seen in our office in October of 1969 at which time it was clear that he had an incapacitating Parkinson's disease. He ultimately was seen at the University of Wisconsin Hospitals by Dr. G. G. Colesia of the Department of Neurology. He was completely evaluated and was then placed on therapy with Komedrin and L-Dopa. He is to see Dr. Colesia again on April 6, 1970 but has been told that he can return to work when his call comes. He has been totally disabled in the interim and about this there is no question whatever.

If we may be of any further help to you or to Mr. Same feel free to call on us.

Very truly yours,

B. C. Prentice, M. D.
B. C. Prentice, M. D.

BGP:mia

SMITH, M.D.
 PRENTICE, M.D.
 BENTLEY, M.D.
 ARNOLD, M.D.

SMITH, M.D.
 PRENTICE, M.D.

SMITH - PRENTICE MEDICAL GROUP

266 BIRTH AVENUE WEST
 ASHLAND, WISCONSIN
 54806

November 13, 1969

Department of Neurology
 University Hospitals
 1300 University Avenue
 Madison, Wisconsin 53706

Re: Thomas J. Same, Box 573, Mellen, Wisconsin - Age 58

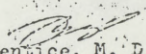
Sirs:

Enclosed is a copy of my letter of October 29, 1969, relative to Thomas Same. Mr. Same called me today and indicated that he had not as yet heard from you relative to an appointment in your department. Perhaps someone could check into this and arrange an appointment for Mr. Same as discussed in my letter of October 29th, and write to Mr. Same telling him when and where you would like to see him.

If there is some misunderstanding or some other procedure you wish me to pursue, be kind enough to bring it to my attention in order that I might better serve my patient.

Thank you again for your time and trouble in this matter. We look forward to hearing from you in the very near future.

Very truly yours,


 B. C. Prentice, M. D.

ECP:jj
 Enc: 1

CC: Mr. Same

October 29, 1960

Department of Neurology
University Hospitals
1300 University Avenue
Madison, Wisconsin 53706

Re: Thomas J. Sama, Box 573, Mellen, Wisconsin -- Age 50

Secret

The above captioned patient was originally seen by us in 1956, and a diagnosis ultimately made of Parkinsonism. He has been treated with L-dopa with some degree of success. However, his disease has been advancing. He is a Seaman on the Great Lakes Steamboats and his disease has presently progressed to the point where he is at virtually disability level. He was seen by us today and requested that we arrange a consultation for him in your department.

Would you be kind enough at your convenience to write to Mr. Sama at the above address and tell him when and where you would like to see him.

I would like to thank you in advance for your time and trouble in this matter and we look forward to hearing from you about him in the future.

Very truly yours,

[Signature]
E. C. Grentico, M. D.

202-66



UNIVERSITY OF WISCONSIN
UNIVERSITY OF WISCONSIN MEDICAL CENTER 927
1300 UNIVERSITY AVENUE • MADISON, WISCONSIN 53706
PHONE (608) 263-6000 • 263-7771

PAGE 1

THOMAS

GA

UNIVERSITY OF WISCONSIN
UNIVERSITY OF WISCONSIN MEDICAL CENTER 927
1300 UNIVERSITY AVENUE • MADISON, WISCONSIN 53706
PHONE (608) 263-6000 • 263-7771

THOMAS GARE
MIL 572
MELLEN WIS

DETACH AND RETURN TOP SECTION WITH YOUR REMITTANCE

1/15/73		DAYS STAY 21					
HOSPITAL BILL#				AMOUNT		ESTIMATED TOTAL CHARGE	
X-RAY/CHEST-TWO VIEWS	2	\$	10.00				
LHE/BLOOD OCCULT	3		2.25				
LYN/DIRECT COAGULS TEST	3		4.00				
LYN/ANTIBODY SCREEN & IDENT	3		8.00				
LHE/HEMATOLOGY SURVEY	3		7.00				
LHE/DIFFERENTIAL COUNT BLOOD	3		3.50				
LHE/URINALYSIS ROUTINE	3		3.50				
LCA/CHEMISTRY SURVEY	3		14.50				
LHE/BLOOD OCCULT	3		2.25				
ECG ROUTINE	1		8.00				
LHE/BLOOD OCCULT	3		2.25				
LCA/PROTEIN BOUND IODINE PBI	3		6.00				
ELECTROENCEPHALOGRAM	1		25.00				
X-RAY/GI-UPPER	2		19.50				
STATE LAB-MISCELLANEOUS	3		2.00				
P/T/THERAPEUTIC EXER-1/2 HR	1		7.50				
X-RAY/SINUS	2		18.00				
LCA/CULTURE SPUTUM	3		3.50				
LHE/URINALYSIS ROUTINE	3		3.50				
LHE/HEMATOLOGY SURVEY	3		7.00				
LHE/DIFFERENTIAL COUNT BLOOD	3		3.50				
LCA/CHEMISTRY SURVEY	3		14.50				
LYN/DIRECT COAGULS TEST	3		4.00				
LYN/ANTIBODY SCREEN & IDENT	3		8.00				
LCA/PROTEIN BOUND IODINE PBI	3		6.00				
STATE LAB-MISCELLANEOUS	3		2.00				
STATE LAB-MISCELLANEOUS	3		2.00				
P/T/THERAPEUTIC EXER-1/2 HR	1		7.50				
P/T/THERAPEUTIC EXER-1/2 HR	1		7.50				
ECG-INITIAL	1		7.00				
ECG ROUTINE	1		6.00				
LCA/PROTEIN BOUND IODINE PBI	3		6.00				
LHE/URINALYSIS ROUTINE	3		3.50				
LHE/HEMATOLOGY SURVEY	3		7.00				
LHE/DIFFERENTIAL COUNT BLOOD	3		3.50				
LYN/DIRECT COAGULS TEST	3		4.00				
P/T/THERAPEUTIC EXER-1/2 HR	1		7.50				



UNIVERSITY OF WISCONSIN MEDICAL CENTER
1300 UNIVERSITY AVENUE, 9th FLOOR, WISCONSIN 53706
PHONE: AREA CODE 414 225-2211

MR THOMAS

GA

HISTORY 609181 DATE 10/10/70
A-1000 C-1000
PLEASE USE THESE NUMBERS ON ALL CORRESPONDENCE

THOMAS SA4E
BOX 573
MELLEN WIS

DETACH AND RETURN TOP PORTION WITH YOUR REMITTANCE

DATE 1/19/70 DAYS STAY 21		PARTIAL BILL		AMOUNT		ESTIMATED INSURANCE COVERAGE	
09	P/T THERAPEUTIC EXER-1/2 HR	1	\$	7.50			
06	RM NR311, 21 DAYS \$56.00, 2BD	6	\$	1,176.00			
	TOTAL		\$	1,464.75			
	SUMMARY						
	OF						
	BILLING						
	1. MISC			78.50			
	2. XRAY			47.50			
	3. LAB			155.75			
	4. DRUGS			.00			
	5. SUPPLIES			7.00			
	6. DAILY CARE			1,176.00			
	TOTAL CHARGES			1,464.75			

NOTE: REMITTANCE COVERAGE IS ESTIMATED ONLY AND IS SUBJECT TO APPROVAL BY YOUR CARRIER.
THE CARRIER MAY, IN ADDITION TO DEDUCT CHARGES AND WILL BE BILLED BY
AFTER INSURANCE COVERAGE DEDUCTIBLE.

AMOUNT DUE [1,464.75]
AFTER INSURANCE

CASE NO. 5

JAMES H. QUILLEN
FIRST DISTRICT, TENNESSEE

WASHINGTON OFFICE:
Room 102
CANDON HOUSE OFFICE BUILDING 20515

DISTRICT OFFICE:
Room B-8
FEDERAL (POST OFFICE) BUILDING
KINGSPORT, TENNESSEE 37662

COMMITTEES:
RULES
COMMITTEE ON
COMMITTEES

Congress of the United States
House of Representatives
Washington, D. C.

April 16, 1971

Dear Mr. Spivey:

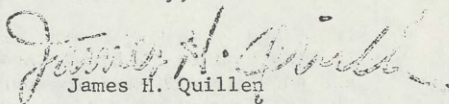
Re: Henry Bruce Williams
Route 7, East Carters Valley
Kingsport, Tennessee
SS No. XXXXXXXXXXXX
USMM Doc. No. Z-780 168

The subject has been in touch with me relative to
a matter of great concern to him.

Mr. Williams advises that he was hospitalized in
Holston Valley Community Hospital, Kingsport, Tennessee,
from December 14, 1971, until March 9, 1971. He is
wondering if he is entitled to any medical coverage as
a Merchant Seaman for that period.

I will appreciate your checking your records in
this regard and advising.

Sincerely,


James H. Quillen

Mr. Price Spivey
Seafarers' Welfare Plan
275 20th Street
Brooklyn, New York 11215

SEAFARERS' WELFARE PLAN

275 20TH STREET

BROOKLYN, NEW YORK 11215

ADMINISTRATOR

SO. 8-6005

PRICE C. SPIVEY

April 27, 1971

Honorable James H. Quillen
 Congress of the United States
 House of Representatives
 Cannon House Office Building, 102
 Washington, D. C. 20515

Re: Henry Bruce Williams, SS XXXXXXXXXXXX
 Z XXXX
 Route 7, East Carter Valley
 Kingsport, Tennessee

Dear Congressman Quillen:

Receipt is acknowledged and thank you for your inquiry of April 16, 1971, relative to the above identified seaman-constituent.

Our records reflect that Mr. Williams was employed aboard merchant vessels for 151 days during 1970 and during 1970 as follows:

2/10 - 3/4/70 - 23 days (S/S Azalea City)
 3/12 - 5/14/70 - 64 days (S/S Yaka)
 6/2 - 11/12/70 - 164 days (S/S Citrus Packer)

Thus, and according to the enclosed U. S. Public Health Service booklet "Medical Care for Seafarers" - which is issued and known to all maritime personnel, it would appear that Mr. Williams would, under normal conditions, be qualified and entitled to receive medical treatment at government expense during his illness of December 14, 1970, to March 9, 1971, inclusive.

It will be noted that we say "under normal conditions", because the Administration and the Secretary of Health, Education and Welfare are currently engaged in a campaign to discourage

Page 2

eliminate medical care for seamen and other beneficiaries as we know it in direct opposition to Congressional Mandate, and have, in fact, reduced and discouraged medical service, particularly in the Illinois-Ohio-Kentucky-Tennessee area, toward total elimination of the U. S. Public Health Service Hospital System, in the final analysis.

For your further information, also enclosed is a copy of the March 1971 issue of the Seafarers Log on that subject and our opposition in behalf of the American seaman, as well as copy of several typical letters from seamen in that area to further illustrate the seriousness of the situation being created by the Administration under the guise of economy. There is no question but that making medical attention difficult to obtain will save money for the Government, and they are well on the road to success at the expense of the American seamen.

In conclusion, and as all of this directly effects your constituent, our records further reflect that incident to admission at the Holston Valley Community Hospital, Kingsport, Tennessee, on December 14, 1970, both the admitting physician and the hospital were on notice that Mr. Williams was a merchant seaman, and inasmuch as he was eligible for and entitled to medical treatment at government expense this office, pursuant to the Rules and Regulations of the Trust, had no alternative but to deny payment of his hospital bill in the amount of \$4,655.53, and medical bill in the amount of \$132.00, with notice to all concerned on March 23, 1971, a copy of which is enclosed and felt to be self-explanatory.

We, of course, very much regret being unable to be of greater assistance in the instant matter, but strongly suggest that it be called to the attention of the Department of Health, Education and Welfare for possible consideration.

Very truly yours,

SEAFARERS WELFARE PLAN

Price C. Spivey
Administrator

PCS:jk
Encs. (7)

SEAFARERS' WELFARE PLAN

2715 BOND STREET
BROOKLYN, NEW YORK 11212

SO. 8-5005

PRICE C. SPIVEY,
ADMINISTRATORMr. Henry G. [unclear]
[unclear]
[unclear]
[unclear]

Subject:

CLAIM FOR

DATE

Dear Mr. [unclear]:

We wish to advise you that our office is in receipt of a claim filed by you for the above benefit.

The rules governing the payment of benefits for employees state that an employee is entitled to be reimbursed in accordance with the Dependent Schedule of Benefits from the Seafarers' Welfare Plan, provided he fulfills the basic seafaring requirement with companies signatory to the Seafarers' Welfare Plan of 90 days of employment in the previous calendar year and one day of employment in the six month period immediately preceding the date the claim accrued if:

- (a) He is not eligible to care at a United States Public Health Service facility.
- (b) He required emergency hospitalization and the USPHS, after being duly notified of his confinement, denied liability or is not responsible for the charges. In all cases, the employee must notify the nearest USPHS facility within 48 hours of the beginning of his confinement.
- (c) He received emergency treatment at a hospital which did not involve confinement.

According to your employment record, you were eligible to care at a USPHS facility at the time this claim accrued.

If you notified the USPHS, and if they denied responsibility, please send us a copy of their letter of denial.

However, if you did not notify the USPHS, we regret to inform you that there are no benefits payable as a result of this claim.

Very truly yours,

used for Typewriter — Marks for Tabulator Appear on the _____
 To _____ Hospital. This certifies that _____ is insured for the following
 Group Hospital Benefits (in behalf of his dependent _____) By _____
 Seafarers Welfare Plan

BENEFITS FOR OTHER THAN MATERNITY CASES

A. HOSPITAL ROOM AND BOARD (INCLUDING GENERAL NURSING SERVICES)
 ACTUAL HOSPITAL CHARGES UP TO \$ _____ FOR EACH DAY OF HOS-
 PITIALIZATION UP TO _____ DAYS.

B. OTHER HOSPITAL CHARGES FOR HOSPITAL CARE AND TREATMENT
 (EXCLUDING CHARGES FOR NURSES' AND PHYSICIANS' SERVICES AND TAKE
 HOME DRUGS) \$ _____

BENEFITS FOR MATERNITY CASES

HOSPITAL ROOM AND BOARD (INCLUDING GENERAL NURSING SERVICE) AND
 OTHER HOSPITAL SERVICES . . . ACTUAL CHARGES UP TO \$ _____
 OR

1. HOSPITAL ROOM AND BOARD (INCLUDING GENERAL NURSING SERVICES)
 \$ _____ FOR EACH DAY OF HOSPITALIZATION UP TO _____ DAYS
2. OTHER HOSPITAL CHARGES FOR HOSPITAL CARE AND TREATMENT
 (EXCLUDING CHARGES FOR NURSES' AND PHYSICIANS' SERVICES, AND TAKE
 HOME DRUGS) \$ _____

THE MINIMUM HOUR HOSPITALIZATION REQUIREMENT WILL BE MET IF _____

GROUP POLICYHOLDER ADDRESS PHONE
United States Merchant Marines
 BY (Name and Title) ABOVE CERTIFICATION VALID FOR ONLY SEVEN DAYS
 FROM THIS DATE (Exception — Maternity Cases) DATE

**HOSPITAL COMPLETE FOLLOWING
 AND FURNISH COPY TO**

NAME OF PATIENT AGE DATE ADMITTED TIME ADMITTED DATE DISCHARGED TIME & DISCHARGED
Williams, Mr. Henry Bruce 42 12-18-70 AM 3-09-71 AM
 IF PATIENT HAD OTHER THAN SEMI-PRIVATE ROOM, INDICATE SEMI-PRIVATE RATE \$ _____ OTHER INSURANCE BENEFITS CITED BY HOSPITAL RECORDS, IF YES, NAME OF COMPANY
☒ NO ☐ YES

DIAGNOSIS FROM RECORDS OF Injury, Give Date and Place of Accident

Admitting Diagnosis — Obstruction, Lower Bowel Dr. Templeton
 OPERATIONS OR OTHER MEDICAL PROCEDURES PERFORMED (Signature and Date)

HOSPITAL CHARGES (Complete This Section or Attach Copy of Itemized Bill Showing Information Below)

ROOM AND BOARD		DAYS AT \$	TOTAL	\$
☐	WARD			
☒	SEMI-PRIVATE	10 DAYS AT \$ 33.00	TOTAL	\$ 594.00
☒	PRIVATE	6 DAYS AT \$ 44.75	TOTAL	\$ 268.50
☒	OTHERS — PRIVATE	59 @ \$35.75		\$ 2,109.25
OTHER CHARGES	OPERATING OR DELIVERY ROOM			133.25
	ANESTHESIA			17.80
	X-RAY			27.00
	LABORATORY			362.00
	EKG B.M.R.			
	PHYSICAL THERAPY			
	AMBULANCE			
	MEDICAL AND SURGICAL SUPPLIES			383.00
	PHARMACY (Except Take Home Drugs)			657.73
	INHALATION THERAPY			
	INTRAVENOUS SOLUTIONS			7.50
	EMERGENCY ROOM FEE			
	TOTAL			\$ 4,055.53

TOTAL CHARGES \$ _____
 \$ _____
 \$ _____
 \$ _____

THIS FORM APPROVED BY THE HEALTH
 INSURANCE CO. AND ACCEPTED BY
 THE AMERICAN HOSPITAL ASSOCIATION
 FOR USE BY HOSPITALS (see explanatory
 Instructions).



HOSPITAL **HOLSTON VALLEY COMMUNITY HOSPITAL** ADDRESS **KINGSDORF, TENNESSEE**
 TAKEN FROM RECORDS

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the above named hospital to release the information requested on this form.
 Date 19____ Signed *Henry B. Williams*
 Patient (Parent if a Minor)

AUTHORIZATION TO PAY INSURANCE BENEFITS: I hereby authorize payment directly to the above named hospital of the Group Hospital Benefits herein specified
 and otherwise payable to me but not to exceed the hospital's regular charges for this period of hospitalization. I understand I am financially responsible to
 the hospital for charges not covered by this authorization.

Date 19____ Signed *Henry B. Williams*
 Insured

HEALTH INSURABLE CLAIM - GROUP OR - INDIVIDUAL

COMB - 1 (10-67)

PART A

TO BE COMPLETED BY PATIENT (INSURED)

Spaced for Typewriter - Marks for Tabulator Appear on this Line

PATIENT'S NAME AND ADDRESS Williams, Mr. Henry Bruce, Route 7, East Carter's Valley, Kingsport, Tenn.		DATE OF BIRTH 12/05/08
INSURED'S NAME (IF PATIENT IS A DEPENDENT) Same (Chief Petty Officer United States Merchant Marines)		37660
NAME OF INSURANCE COMPANY Seafarers Welfare Plan	POLICY NUMBER 780168 (R)Z M-11406	INSURED'S SOCIAL SECURITY NUMBER
F GROUP INSURANCE, NAME OF POLICYHOLDER i.e., Employer, Union or Association through whom insured) United States Merchant Marines		
AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE UNDERSIGNED PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR HIS SERVICES AS DESCRIBED BELOW BUT NOT TO EXCEED THE REASON- ABLE AND CUSTOMARY CHARGE FOR THOSE SERVICES. AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.		
SIGNED (PATIENT, OR PARENT IF MINOR) DATE Henry B. Williams 2-1-71		

PART B

ATTENDING PHYSICIAN'S STATEMENT

1. DIAGNOSIS AND CONCURRENT CONDITIONS (IF DIAGNOSIS CODE OTHER THAN ICD-9* USED, GIVE NAME!)		Colon resection and appendectomy.	
1. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? YES ☐ NO ☒		PREGNANCY? YES ☐ NO ☒	
2. REPORT OF SERVICES (OR ATTACH ITEMIZED BILL) (IF PREVIOUS FORM SUBMITTED TO THIS CARRIER, YOU NEED SHOW ONLY DATES AND SERVICES SINCE LAST REPORT)		IF YES, APPROXIMATE DATE PREGNANCY COMMENCED. DATE	
DATE OF SERVICES	PLACE OF SERVICES	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	CHARGES
1/18/71	IH	Administration of Anesthesia Anesthesia time: 4 hours	132.00
			132.00
TO - Doctor's Office H - Patient's Home *ICDA - International Classification of Diseases **CPT - Current Procedural Terminology (current edition)		CHARGES AMOUNT PAID BALANCE DUE	
4. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED.		5. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION.	
6. PATIENT EVER HAD SAME OR SIMILAR CONDITION? YES ☐ NO ☒ IF "YES" WHEN AND DESCRIBE:		7. PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES ☐ NO ☒	
8. PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK). FROM THRU		9. PATIENT WAS PARTIALLY DISABLED. FROM THRU	
10. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK.		11. PATIENT WAS HOUSE CONFINED. FROM THRU	
12. DOES PATIENT HAVE OTHER HEALTH COVERAGE? YES ☐ NO ☒ IF "YES" PLEASE IDENTIFY			
DATE 1/27/71 PHYSICIAN'S NAME (PRINT) John J. Kennedy CITY OR TOWN Kingsport, Tenn. STATE OR PROVINCE 37660 DEGREE M. D. TELEPHONE 247-2641 ZIP CODE			

MEMORANDUM REGARDING DISPOSITION OF THIS FORM ON REVERSE SIDE

Approved by Council on Medical Service, A.M.A. 10-67

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
Washington, D.C., March 26, 1971.

Reference : FHPS-FM

Mr. ROBERT VAHEY,
Transportation Institute,
Washington, D.C.

DEAR MR. VAHEY: The enclosed tables have been prepared to give the information you requested for care of Public Health Service primary beneficiaries in non-Federal hospitals in fiscal 1970 and the costs for transportation of primary beneficiaries in 1969 and 1970 fiscal years.

Sincerely yours,

JACK BUTLER, M.D.,
Assistant Surgeon General,
Director, Federal Health Programs Service.

TRAVEL AND TRANSPORTATION OF PATIENTS

Station	1969		1970	
	Patient and escort	Ambulance and taxis—patients	Total	Total
Baltimore.....	\$30,026	\$590	\$30,616	\$39,474
Boston.....	2,631	1,593	4,224	5,431
Galveston.....	3,285	24,289	27,574	27,419
New Orleans.....	31,142	25,241	56,383	64,927
Norfolk.....	9,651	8,684	18,335	22,416
San Francisco.....	57,304	23,096	80,400	92,652
Seattle.....	17,536	14,338	31,874	28,346
Staten Island.....	23,452	2,207	25,659	26,004
Atlanta.....	186	15	201	244
Washington, D.C.....		150	150	150
Headquarters.....	16,000		16,000	16,500
Total.....	191,213	100,203	291,416	323,563

CARE FOR PHS PRIMARY BENEFICIARIES, IN NON-FEDERAL HOSPITALS, FISCAL YEAR 1970

Control hospital	Inpatient days					Amount	Average cost per day
	Total	AS	CG	ESSA	PHSO		
Baltimore.....	519	469	48		2	\$65,446	126.10
Boston.....	508	463	40		5	64,059	126.10
Galveston.....	1,114	1,033	72		9	140,476	126.10
New Orleans.....	4,104	3,904	179		21	517,517	126.10
Norfolk.....	1,419	1,159	256	4		178,937	126.10
San Francisco.....	1,394	1,319	75			175,785	126.10
Seattle.....	2,326	1,923	381	14	8	293,310	126.10
Staten Island.....	8,936	8,293	601	14	28	1,126,836	126.10
Independent clinics (Atlanta and Washington, D.C.).....	48	31			17	6,053	126.10
Total.....	20,368	18,594	1,652	32	90	2,568,419	126.10

Senator KENNEDY. I want to thank you, gentlemen, again, and the subcommittee goes into the recess until 9:30 tomorrow morning.

(Whereupon at 3:15 the subcommittee recessed, to reconvene at 9:30 a.m., Tuesday, March 9, 1971.)

