TITLE VI ENFORCEMENT IN MEDICARE AND MEDICAID PROGRAMS

HEARINGS

BEFORE THE

SUBCOMMITTEE ON CIVIL RIGHTS AND CONSTITUTIONAL RIGHTS

OF THE

COMMITTEE ON THE JUDICIARY HOUSE OF REPRESENTATIVES

NINETY-THIRD CONGRESS

FIRST SESSION

ON

ENFORCEMENT OF TITLE VI OF THE 1964, CIVIL RIGHTS ACT IN MEDICARE AND MEDICAID

SEPTEMBER 12, 17, 24, AND OCTOBER 1, 1973

SERIAL NO. 28

Printed for the use of the Committee on the Judiciary

U.S. GOVERNMENT PRINTING OFFICE
27-401 WASHINGTON : 1974

COMMITTEE ON THE JUDICIARY

PETER W. RODINO, JR., New Jersey, *Chairman*

HAROLD D. DONOHUE, Massachusetts
JACK BROOKS, Texas
ROBERT W. KASTENMEIER, Wisconsin
DON EDWARDS, California
WILLIAM L. HUNGATE, Missouri
JOHN CONYERS, JR., Michigan
JOSHUA EILBERG, Pennsylvania
JEROME R. WALDIE, California
WALTER FLOWERS, Alabama
JAMES R. MANN, South Carolina
PAUL S. SARBANES, Maryland
JOHN F. SEIBERLING, Ohio
GEORGE E. DANIELSON, California
ROBERT F. DRINAN, Massachusetts
CHARLES B. RANGEL, New York
BARBARA JORDAN, Texas
RAY THORNTON, Arkansas
ELIZABETH HOLTZMAN, New York
WAYNE OWENS, Utah
EDWARD MEZVINSKY, Iowa

EDWARD HUTCHINSON, Michigan
ROBERT McCLORY, Illinois
HENRY P. SMITH III, New York
CHARLES W. SANDMAN, JR., New Jersey
TOM RAILSBACK, Illinois
CHARLES E. WIGGINS, California
DAVID W. DENNIS, Indiana
HAMILTON FISH, JR., New York
WILEY MAYNE, Iowa
LAWRENCE J. HOGAN, Maryland
WILLIAM J. KEATING, Ohio
M. CALDWELL BUTLER, Virginia
WILLIAM S. COHEN, Maine
TRENT LOTT, Mississippi
HAROLD V. FROEHLICH, Wisconsin
CARLOS J. MOORHEAD, California
JOSEPH J. MARAZITI, New Jersey

JEROME M. ZEIFMAN, *General Counsel*
GARNER J. CLINE, *Associate General Counsel*
JOSEPH FISCHER, *Counsel*
HERBERT FUCHS, *Counsel*
HERBERT E. HOFFMAN, *Counsel*
WILLIAM P. SHATTUCK, *Counsel*
H. CHRISTOPHER NOLDE, *Counsel*
ALAN A. PARKER, *Counsel*
MAURICE A. BARBOZA, *Counsel*
DONALD G. BENN, *Counsel*
FRANKLIN G. POLK, *Counsel*
ROGER A. PAULEY, *Counsel*
THOMAS E. MOONEY, *Counsel*
PETER T. STRAUB, *Counsel*
MICHAEL W. BLOMMER, *Counsel*
ALEXANDER B. COOK, *Counsel*

SUBCOMMITTEE ON CIVIL RIGHTS AND CONSTITUTIONAL RIGHTS

DON EDWARDS, California, *Chairman*

JEROME R. WALDIE, California
PAUL S. SARBANES, Maryland
ROBERT F. DRINAN, Massachusetts
CHARLES B. RANGEL, New York

CHARLES E. WIGGINS, California
ROBERT McCLORY, Illinois
M. CALDWELL BUTLER, Virginia
TRENT LOTT, Mississippi

ALAN A. PARKER, *Counsel*
RUTH O. ROBINSON, *Assistant Counsel*
ARDEN B. SCHELL, *Assistant Counsel*
LINDA CHAVEZ, *Staff Analyst*
MICHAEL W. BLOMMER, *Associate Counsel*

CONTENTS

TITLE VI ENFORCEMENT IN MEDICARE AND MEDICAID PROGRAMS

WEDNESDAY, SEPTEMBER 12, 1973

House of Representatives,
Civil Rights and Constitutional Rights Subcommittee
of the Committee on the Judiciary,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:05 a.m. in room 2226, Rayburn House Office Building, Hon. Don Edwards [chairman of the subcommittee] presiding.

Present: Representatives Edwards, Wiggins, McClory, Waldie, Drinan, and Rangel.

Also present: Alan A. Parker, counsel; Michael W. Blommer, associate counsel; and Linda Chavez, staff analyst.

Mr. Edwards. The Civil Rights and Constitutional Rights Subcommittee of the House Committee on the Judiciary meets today in the first of its series of hearings in the enforcement of Title VI of the 1964 Civil Rights Act in medicare and medicaid programs.

Title VI insures that

> No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

In June 1971, the chairman of the Judiciary Committee requested that the General Accounting Office report on title VI compliance by hospitals and other facilities under medicare and medicaid. The GAO has completed its report and will present its findings to our subcommittee this morning.

Equal access to proper health care facilities is certainly a most basic right in our democratic system. In passing the Health Insurance for the Aged Act and the medical assistance to States program, the Congress sought to guarantee that those persons unable to secure adequate health care because of age, disability, or dependency would be provided with minimal health benefits. Since both the medicare and medicaid programs are financed by Federal funds, the right of access by nonwhites to hospitals and other facilities participating in those programs is protected by title VI.

In this series of hearings, we will examine whether the antidiscrimination guarantees of title VI have been enforced, by whom, and whether nonwhites do, in fact, enjoy equal access to hospitals and other facilities participating in medicare and medicaid.

Our witness today is Mr. Gregory J. Ahart, director of the manpower and welfare division of the General Accounting Office. Mr. Ahart is accompanied by Mr. Robert E. Iffert, Jr., assistant direc-

tor of the manpower and welfare division; Mr. Horace W. Hunter, supervisory auditor; and we were supposed to have Mr. Vincent Griffiths, legislative attorney. We welcome all of you here today and look forward to your presentation.

Mr. WIGGINS. I have no opening statement, Mr. Chairman.

Mr. EDWARDS. Well, gentlemen, we welcome you here and you may proceed with your statement.

TESTIMONY OF GREGORY J. AHART, DIRECTOR, MANPOWER AND WELFARE DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY ROBERT E. IFFERT, JR., ASSISTANT DIRECTOR, MANPOWER AND WELFARE DIVISION, U.S. GENERAL ACCOUNTING OFFICE, AND HORACE W. HUNTER, SUPERVISORY AUDITOR, MANPOWER AND WELFARE DIVISION, U.S. GENERAL ACCOUNTING OFFICE

Mr. AHART. Mr. Chairman and members of the subcommittee, I am pleased to appear here today to discuss our July 13, 1972, report to the Judiciary Committee dealing with compliance with the antidiscrimination provision of the Civil Rights Act by hospitals and other facilities under the medicare and medicaid programs.

Mr. EDWARDS. May I interrupt you at this point?

When you say that this applies to all hospitals and skilled nursing facilities, under the medicaid and medicare programs, this includes just about all of the hospitals in the United States.

Mr. AHART. Virtually all of the hospitals participate in the medicare or medicaid programs, and I think a large percentage of the skilled nursing facilities do also.

Mr. EDWARDS. So, in other words title VI would apply to just about every health facility such as described in the United States.

Mr. AHART. A very large percentage. There are new ones coming in. I am sure that there are some in the country that do not participate but this would cover the great bulk of them.

Mr. EDWARDS. And most of the hospitals depend on their continuing successful financial operation on the medicare and medicaid programs.

Mr. AHART. A great percentage do have substantial portions of the services that they provide covered by one or both of these two programs.

Mr. EDWARDS. Thank you. You may proceed.

This report was issued pursuant to a request from the chairman to (1) analyze available data in selected areas of the country to obtain information as to whether the benefits of medicare and medicaid are being made available to minority groups to the same degree as to others, and (2) examine into HEW's compliance monitoring activities to see whether institutions participating in medicare and medicaid programs were complying with title VI of the Civil Rights Act of 1964.

Title VI, as you mentioned, provides that no person shall, on the basis of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program receiving Federal financial assistance.

Our review was concentrated in four metropolitan areas—Atlanta, Ga.; Birmingham, Ala.; Wayne County (including Detroit), Mich.; and Los Angeles County, Calif.

We evaluated the policies and procedures used by HEW to insure that medical institutions participating in these programs did not discriminate. In addition, we visited 66 hospitals, 41 skilled-nursing facilities, and two nursing homes in the four metropolitan areas.

At each of the hospitals and other facilities, we obtained information on admission policies and a patient census, interviewed administrative and admitting personnel, and made a tour of the institution to see if any signs of discrimination were visible.

In the four metropolitan areas, we also interviewed 79 physicians, 48 nurses, 80 patients, and representatives of 73 interested organizations including civil rights groups, medical societies, and community service organizations regarding the availability and quality of medical treatment and services afforded to minority patients.

On the basis of information obtained, we believe that most hospitals, skilled-nursing facilities, and nursing homes—participating in medicare and medicaid in the four major metropolitan areas—were in compliance with title VI. This is not to say that discrimination in providing health services to minorities was totally absent but only that it did not exist in an overt form subject to objective analysis and detection. The types of discrimination that were reported to us were indirect and subtle and did not involve overt denial by medical institutions of staff privileges to minority-group physicians or of admissions or services to minority-group patients.

Because our report was issued over a year ago, we have recently updated some of the statistical and other information to provide this subcommittee with a more current picture on the following four matters which may be of particular interest.

In our July 1972 report, we pointed out that on the basis of patient census information in the metropolitan areas reviewed, there was an apparent dual health care system in that there was a disproportionate use of Government-owned hospitals by minority-group patients in certain facilities with virtually none in others. Therefore, we have obtained updated patient census statistics for hospitals and skilled-nursing homes to see if this dual system still exists.

In our report, we made reference to four steps that HEW was taking or was proposing to take to deal with problems identified in our report or to improve HEW's compliance activities. Accordingly, we have obtained status reports from HEW officials as to their progress in completing such actions.

Third, we reported that with regard to HEW's compliance monitoring activities during 1971, HEW was making relatively few onsite visits to institutions but instead was concentrating on reviews of State and local agencies to monitor their activities including these agencies' reviews of the title VI compliance status of hospitals and nursing homes under medicaid.

To see whether HEW's emphasis has changed, we have obtained updated information on HEW monitoring activities at both the institutional and State agency levels.

Finally, our July 1972 report indicated that in the four metropolitan areas reviewed, OCR records revealed discrimination complaints against only 20 hospitals and 2 nursing homes during the 5-year period July 1966 to June 1971.

We have updated our reviews of the Office for Civil Rights regional files to see whether the recorded complaint activity—that is, charges of discrimination against hospitals and skilled-nursing facilities participating in medicare and medicaid—has increased.

In summary, we can report that:

The apparent dual health care system continues to exist.

HEW has taken action on one of the four steps mentioned in our report.

HEW has increased its compliance monitoring activity at the institutional level and decreased its activity at the State and local agency level.

And the incidence of complaints against specific institutions has not materially increased.

I will deal with each of these matters in more detail, but first I think it would be helpful to provide some background on the administration of title VI.

In December 1965 the Secretary, HEW, delegated to the Public Health Service the responsibility to see that all hospitals and other medical facilities receiving Federal funds complied with title VI.

With the enactment of the medicaid and medicare programs in July 1965—which became effective in January 1966 and July 1966, respectively—HEW made extensive efforts to determine and enforce title VI compliance. Since then, it has significantly reduced its activities in this area.

In November 1967 the Secretary, HEW, transferred title VI enforcement responsibilities for hospitals and other medical facilities to the Office for Civil Rights. The primary responsibility for securing title VI compliance now rests with the regional civil rights director in each of HEW's 10 regional offices. In the health-care area, OCR is responsible for: (1) Seeing that hospitals and other medical facilities are complying with title VI before they are permitted to participate in medicare or medicaid; (2) insuring that these institutions continue to comply with title VI; and (3) investigating complaints of title VI violations involving these institutions.

Before OCR certifies that a hospital or a skilled-nursing facility is complying with title VI—and is therefore eligible to participate in medicare—each institution is required to complete: (1) An assurance-of-compliance statement in which it agrees to comply with title VI, and (2) a compliance report—a two-page questionnaire pertaining to the nondiscriminatory policies of the institution.

OCR officials advised us that compliance reports must be submitted by all hospitals and skilled-nursing facilities applying to enter medicare and by those institutions already under medicare that have changed ownership.

States participate in many programs with the Federal Government and share the costs involved in providing services to recipients of those programs. With the enactment of title VI of the Civil Rights Act, it became the responsibility of both State and Federal agencies to insure

that no beneficiary of a federally assisted program is subjected to discrimination because of race, color, or national origin. A 1966 HEW instruction specified that the States were to be responsible for insuring that onsite compliance reviews of all nursing homes in the medicaid program are made at least annually.

State reviews have been a major part of the OCR compliance program in health and social services. When hospitals and skilled-nursing facilities participate in State medicaid or other grant-in-aid programs and these same facilities are under medicare, a dual compliance responsibility exists. The Office for Civil Rights, however, has final responsibility within HEW for insuring compliance of facilities receiving Federal funds and monitors the State's reviews to insure their validity.

Now we return to the four matters of interest summarized earlier.

We reported that many hospitals, skilled-nursing facilities, and nursing homes were treating only patients of one race—or few patients of other races—even though the facilities published open admission policies. Physicians, patients, hospital and skilled-nursing facility officials, and representatives of civil rights organizatons, medical societies, and welfare organizations have told us that minority-group patients being clustered in certain facilities is very likely not the result of overt discriminatory policies or practices but is more likely the result of: (1) Personal preferences by patients and their physicians; (2) convenience of the institutions to the minority-group communities; and (3) familiarity of the minority-group communities with the institutions from prior associations.

We found that most facilities treating principally one racial group were in areas populated predominantly by that group. Further, some of these facilities were established to serve special religious or ethnic groups or had established policies which effectively restricted admission to persons with substantial financial resources. Although their policies did not preclude admission on the basis of race, color, or national origin, they did effectively limit the numbers of patients of races not common to the religious, ethnic, or economic character of these facilities.

Mr. WIGGINS. May I interrupt, Mr. Chairman, at that point?

Mr. EDWARDS. Mr. Wiggins.

Mr. WIGGINS. That sentence disturbs me. Would you explain more fully what you mean when you say they—meaning the institutions—"did effectively limit the number of patients not common to the religious, ethnic, or economic character of these facilities?"

That statement means to me that they did effectively discriminate on that basis. I would like to be sure what you mean, and if so, how did they discriminate?

Mr. AHART. Well, it effectively precluded patients from other than the ethnic group, for example, from admission to institutions, but largely on the basis that the other people did not want to be in the institution. I think the clearest example we have in our report is a skilled nursing facility that was built around the Japanese culture. It catered to the Japanese community, and the food and everything else in the facility was Japanese. Now, they did have an open admission policy. They would admit people from other ethnic groups and from other nationalities and so on, but it turned out that their patient population was virtually all Japanese.

Mr. McCLORY. If the gentleman from California will yield, as I interpret that sentence—and, I believe, the gentleman from California was impelled to ask the question—is that it appears there is something deliberately done by the hospitals authorities to preclude persons of other ethnic groups or racial groups from entering the hospital?

Now, from your statement, it seems that the hospital would not appeal to a particular group or persons other than this particular group as a result of the menu and personnel in the hospital. Now, that sounds to me quite different from the sentence that you read in your statement.

Is there something deliberately done by the hospital personnel that effectively prevents the person from registering or from obtaining hospital service?

Mr. AHART. No; it is a policy, Mr. McClory, that doesn't center on race—you know, precluding people on the basis of race, national origin and so on. It is a policy, on the other hand, which does effectively preclude them.

Mr. McCLORY. Because of its location, the hospital, is servicing a particular ethnic or racial group.

Mr. AHART. That can be the case.

Mr. WIGGINS. You have answered me. That is the kind of discrimination you have found. It was not an admissions policy with respect to these institutions, but was rather an incidental result to other things.

Mr. AHART. Correct.

Mr. EDWARDS. Would it be comparable to the de facto segregation of schools because of the population breakdown?

Mr. AHART. Well, as I mentioned in the statement, and which we can discuss further, Mr. Chairman, there is disproportionate use of certain facilities because of the geographic location, and in some instances simply because the hospitals are government owned and the poor people have typically used these in the past because of the availability of free or very low cost care. So, there are things which tend to result in de facto disproportionate use. There are other factors, other than overt discrimination, which cause that imbalance.

Mr. McCLORY. Would the Chairman yield?

Mr. EDWARDS. Mr. McClory.

Mr. McCLORY. The mere fact of the servicing of a predominantly racial or ethnic group does not itself imply the practicing of discrimination, does it?

Mr. AHART. That is correct.

Mr. McCLORY. Thank you.

Mr. AHART. Mr. Chairman, we do have a chart which shows the demographic information for Birmingham and which illustrates the effect of some of the things that we are talking about here and some of the factors which I would like to ask Mr. Iffert to discuss.

If you would agree, we could run through that chart quickly and try to give the subcommittee and the members that kind of information. [See pps. 11–14.]

Mr. EDWARDS. Mr. Iffert, please.

Mr. IFFERT. Well, in our statement we talk about the dual health care system. We have some charts here of both Atlanta and Birmingham that indicate the patient census that was used in our earlier report and the census figures we obtained just last month. The white represents the white patients in the institutions in 1971 and again in

August 1973, and the black represents the nonwhite patients. As you can see, there has not been much of a change.

Mr. WIGGINS. Does each bar represent a different hospital?

Mr. IFFERT. Yes, sir. This chart shows skilled nursing homes in Atlanta. As you can see, there is one institution that has historically treated black patients.

Mr. RANGEL. What is the chart supposed to tell us?

Mr. IFFERT. We are trying to illustrate that there has not been any change in the last couple of years since we issued our report. Also we are trying to illustrate what we are talking about with regard to this dual system—these institutions that serve one particular racial group as opposed to another institution which has virtually none.

Mr. RANGEL. Without saying that that is good or bad, you are not commenting on that?

Mr. IFFERT. No, sir.

Mr. MCCLORY. Could I just ask this?

Instead of establishing discrimination, what this does is to establish nonintegration, isn't it? There is no integration of patients in these institutions.

Mr. IFFERT. No.

Mr. RANGEL. You cannot say that this is not the direct result of racism, could you?

Mr. IFFERT. No.

Mr. AHART. I think, Mr. Rangel, that this is a mix of factors, including the demographic factors of the area.

Mr. RANGEL. I just wanted to balance my colleagues' question.

Mr. MCCLORY. I do not think that you can use the chart or evidence here to establish what it does prove. There are a lot of things that will not be proved or shown by testimony and that is what your statement is. What I am trying to determine is what does it show? It does possibly show nonintegration in these institutions, but whether there is discrimination or not, it is not established one way or the other by this chart.

Mr. RANGEL. I would agree, and lack of racism is not discounted by the chart either.

Mr. MCCLORY. Nor is racism established by the chart.

Mr. RANGEL. I could not agree with you more.

Mr. DRINAN. No. 5 here—that nursing home has made a change, a significant change from 20 percent to 40 percent black patients in 3 years. I wonder if that is the result of any monitoring or compliance requests.

Mr. IFFERT. I cannot answer that. I do not know.

Mr. DRINAN. It would be helpful to know because that is the only one that has changed in any way.

Mr. AHART. To put that into perspective, Bob, do you have the statistics on that particular nursing home?

Mr. IFFERT. Yes; No. 5 is Beverly Manor No. 5 in Atlanta. It has about 150 beds and the nonwhite population increased from 18 to 57.

Mr. DRINAN. Percentage?

Mr. IFFERT. No; in terms of absolute numbers.

Mr. DRINAN. But you have no reason for that. I am trying to correlate it with the monitoring that went out of HEW itself or the monitoring agency, but you have no check on that?

Mr. IFFERT. No; but according to the administrator of the facility, the increase was due to an influx of medicaid patients. This next chart shows hospitals in Atlanta.

As can be indicated by the chart, there are three institutions which primarily serve the black population in that area. The word "selected" should not be on that. These are all the hospitals that are participating in the medicare program in Atlanta. This particular institution, No. 5, is located in an area where blacks live.

Mr. RANGEL. What is the name of No. 5 and No. 6?

Mr. IFFERT. No. 6 is the Hughes Spalding Pavilion in Atlanta—virtually all its medical professional staff consists of black physicians.

Mr. RANGEL. No. 5, the name of that?

Mr. IFFERT. The Holy Family Hospital.

Mr. WIGGINS. Mr. Chairman, may I ask a question to understand this chart better?

Mr. EDWARDS. Yes.

Mr. WIGGINS. Does it represent all the hospitals, both public and private, profit and charitable classes of hospitals in this greater Atlanta area?

Mr. IFFERT. Yes, sir, participating in medicare.

Mr. WIGGINS. I see.

The hospitals, Nos. 1, 5, and 6, are public hospitals in the sense that they are owned and operated by public agencies?

Mr. IFFERT. No, sir. No. 1 is the county hospital (Grady Memorial). No. 5 is the Holy Family Hospital, which despite its name, it is not affiliated with any particular church. It is a community-operated institution. No. 6 is the Hughes-Spalding Pavilion, which is on the premises of the Grady Memorial Hospital, but it is a separate legal entity.

Mr. MCCLORY. May I inquire about No. 8? That has gone from all white to substantially mixed.

Mr. IFFERT. This is the J. P. Williams Institution. That is a very small hospital. It only has about 20 or 25 beds. So this increase really represents an influx of four patients.

Mr. MCCLORY. Twenty-five percent, pretty good.

Mr. DRINAN. Mr. Chairman—do you have any record of a request for compliance to allow black doctors and black nurses to serve in these other facilities? Do you have any track record on that? That is obviously related to the whole thing.

Mr. IFFERT. I think that there are black nurses in all of these facilities. Our interviews with black physicians in Atlanta indicated that they were not particularly interested in being on the staff of predominantly white patient hospitals.

Mr. DRINAN. That is irrelevant and immaterial. They are not interested if they cannot get on the staff, but has there been a test, are they in fact excluded from these hospitals, which are virtually all white?

Mr. IFFERT. No, sir.

Mr. DRINAN. They can, in fact, serve on those facilities?

Mr. IFFERT. If they so choose.

The next chart shows the hospitals in the Birmingham area.

Mr. WIGGINS. Excuse me, sir, but those bars are misleading because they do not—they are not correlated with bed capacity, and also the white-black population of Birmingham is not brought into those statistics. To be meaningful to me, can you supply that with your oral

testimony as to what percentage of the bed capacity is red and what percentage is white and so forth?

Mr. IFFERT. Well, yes, Mr. Wiggins, you had only 65 beds and 19 patients in this small hospital located in the so-called ghetto area, which historically has been serving only the black population in that area.

Mr. RANGEL. What is the name?

Mr. IFFERT. The Community Hospital. The second hospital is a State institution which is affiliated with the University of Alabama. It is the largest institution, having well over 600 beds. The only other that I would say is a small hospital included in this group is No. 5, the rest of them have about 200 beds or more.

Mr. MCCLORY. Can I ask this question, Mr. Chairman?

Mr. EDWARDS. Mr. McClory.

Mr. MCCLORY. Does your report indicate anything with regard to the quality of care? Personally, I would be much more interested in whether there is discrimination on the basis of quality of care. If the all black hospital gives equal care or superior care in that which is integrated that would be very meaningful to me. Does your report indicate anything of that nature?

Mr. IFFERT. Well, we did talk to physicians and they told us that the quality of care was——

Mr. MCCLORY. Substantially equal?

Mr. IFFERT. Substantially equal.

Mr. MCCLORY. So that the large community hospital would be giving care of equal quality to that of other hospitals.

Mr. IFFERT. Well, I do not want to testify here as an expert, but I would say that No. 2 as being affiliated with the medical school of the University of Alabama would probably have better quality than let's say a typical community hospital.

Mr. MCCLORY. Is hospital No. 1 affiliated with any university?

Mr. IFFERT. No.

Mr. RANGEL. You say that you asked the physicians at the hospitals if they were giving the same quality of treatment to blacks as whites?

Mr. IFFERT. Yes; and we also talked to the medical society in the area to get a broader view.

Mr. RANGEL. Do you have any black medical societies in these towns that you went to? It just appears to me that you might talk to the recipient of the service or get some outside objective organization rather than the doctors. That is just like asking a Congressman whether he is doing a good job.

Mr. IFFERT. We did talk to a number of patients.

Mr. RANGEL. The testimony will reflect the type of inquiries as it relates to the quality of service?

Mr. IFFERT. No; the report does.

Mr. RANGEL. We have copies of the report. All right.

Mr. MCCLORY. Could I ask a further question?

Mr. EDWARDS. Mr. McClory.

Mr. MCCLORY. Now, with respect to the hospitals that are integrated, is there anything in your report or anything in your findings to indicate that blacks were discriminated against in the hospitals? Were they given inferior rooms or quarters or service or anything of that nature?

Mr. IFFERT. No; the blacks that we talked to said that they were treated equally. They thought that they were being treated equally or said that they were.

Mr. RANGEL. That would depend on where they are when you asked the question.

Mr. IFFERT. This chart shows the skilled nursing facilities in Birmingham. Both at the time we made our initial review and at the time we did our updating for the subcommittee last month as indicated by the chart, there are two all-black nursing homes, and the only explanation I have for that is that these two institutions are black owned.

The next chart gives some explanation of the demographic characteristics of Birmingham and how the location of the institutions can affect its patient population. [The demographic charts have been retained in the committee's files.]

The blue and red areas are the census tracks which we would say are predominantly white. The blue areas are less than 5 percent nonwhite. In the red areas, between 5 and 30 percent of the population are nonwhite. As for the black and green areas, the black represents 95 to 100 percent nonwhite and the green indicates from 65 to 95 percent nonwhite. The all-black hospital in Birmingham is located right here and that is the Community Hospital. Its location could explain patient census population.

University Hospital, which is substantially integrated, is located right here in the downtown area. It is surrounded by a black population. As you can see, the ones with few or no black patients are located in these outlying areas, which have predominantly a white population. The nursing home picture in Birmingham is a little more confusing.

The two all black nursing homes are located here and here, which are in predominantly white areas. As I say, the only explanation that we were able to find is that they were black owned and black physicians were making referrals there.

That completes my presentation of the charts.

Mr. EDWARDS. Thank you.

Mr. AHART. I might say that the statistics that Mr. Iffert is speaking to on a hospital and nursing home basis are available and we would be glad to submit them for the record.

Mr. EDWARDS. Yes, we would like to have them for the record

[The statistics referred to follow:]

DAILY CENSUS OF WHITE AND NONWHITE PATIENTS IN SELECTED HOSPITALS AND SKILLED NURSING FACILITIES IN ATLANTA, GA.

	1971 patient census					1973 patient census				
	Number of patients			Percentage		Number of patients			Percentage	
	Nonwhite	White	Total	Nonwhite	White	Nonwhite	White	Total	Nonwhite	White
Hospitals:										
1. Grady Memorial Hospital	563	194	757	74.4	25.6	520	130	650	80.0	20.0
2. Ponce deLeon Infirmary (C)	1	19	20	5.0	95.0	1	17	18	5.6	94.4
3. Crawford W. Long Hospital	41	285	326	12.6	87.4	57	241	298	19.1	80.9
4. Emory University Hospital	21	275	296	7.1	92.9	9	283	292	3.1	96.9
5. Holy Family Hospital	107	11	118	90.7	9.3	84	2	86	97.7	2.3
6. Hughes Spalding Pavilion	117	0	117	100.0	0	63	0	63	100.0	0
7. Piedmont Hospital	10	273	283	3.5	96.5	15	277	292	5.1	94.9
8. J. P. Williams Hospital	0	20	20	0	100.0	4	17	21	19.0	81.0
9. Georgia Baptist Hospital	39	364	403	9.7	90.3	44	311	355	12.4	87.6
10. Atlanta Hospital (B)	2	35	37	5.4	94.6	4	24	28	14.3	85.7
11. Doctors Memorial Hospital	8	123	131	6.1	93.9	10	110	120	8.3	91.7
12. Northside Hospital (A)	4	210	214	1.9	98.2	12	195	208	5.8	94.2
13. South Fulton Hospital	18	202	220	8.2	91.8	21	240	261	8.0	92.0
14. DeKalb General Hospital	13	250	263	4.9	95.1	14	347	361	3.9	96.1
15. St. Joseph's Infirmary	25	194	219	11.4	88.6	29	143	172	16.9	83.1
16. West Paces Ferry Hospital	(1)	(1)	(1)	(1)	(1)	7	128	135	5.2	94.8
17. Metropolitan Eye Hospital	(1)	(1)	(1)	(1)	(1)	2	18	20	10.0	90.0
Skilled nursing facilities:										
1. South Fulton Hospital-ECF (H)	1	25	26	3.8	96.2	2	34	36	5.5	94.5
2. Kingsford Atlanta Inn	11	154	165	6.7	93.3	6	163	169	3.5	96.5
3. The Jewish Home	0	101	101	0	100.0	0	119	119	0	100.0
4. Beverly Manor No. 53 (G)	1	67	68	1.5	98.5	0	71	71	0	100.0
5. Beverly Manor No. 54	18	97	115	15.7	84.3	57	91	148	38.5	61.5
6. Wesley Woods Health Center (E)	2	164	166	1.2	98.8	4	165	169	2.4	97.6
7. Pineview Convalescent Center	115	1	116	99.1	.9	118	2	120	98.3	1.7
8. Springdale Convalescent Center (F)	4	90	94	4.3	95.7	12	86	98	12.2	87.8
9. Moody Nursing Home (D)	2	182	184	1.1	98.9	4	223	227	1.8	98.2
10. Nursecare of Atlanta, Inc	(1)	(1)	(1)	(1)	(1)	0	168	168	0	100.0

[1] Not included.
Note: Letters identify institutions on table on p. 33 of report.

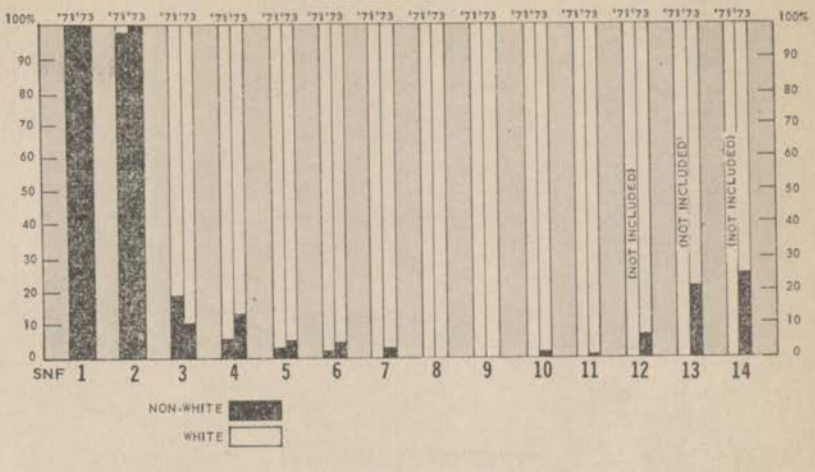
DAILY CENSUS OF WHITE AND NONWHITE PATIENTS IN SELECTED HOSPITALS AND SKILLED NURSING FACILITIES IN BIRMINGHAM, ALA.

	1971 patient census					1973 patient census				
	Number of patients			Percentage		Number of patients			Percentage	
	Nonwhite	White	Total	Nonwhite	White	Nonwhite	White	Total	Nonwhite	White
Hospitals:										
1. Community Hospital	43	0	43	100.0	0	19	0	19	100.0	0
2. University of Alabama Hospitals and Clinics	244	419	663	36.8	63.2	170	358	528	32.2	67.8
3. South Highlands Infirmary	45	171	216	20.8	79.2	42	135	177	23.7	76.3
4. Carraway Methodist Hospital	48	326	374	12.8	87.2	61	324	385	15.8	84.2
5. Eye Foundation Hospital	6	40	46	15.0	85.0	12	39	51	23.5	76.5
6. St. Vincent's Hospital	25	176	201	12.4	87.6	35	223	258	13.6	86.4
7. Baptist Medical Center, Princeton	50	372	422	11.8	88.2	42	360	402	10.4	89.6
8. Baptist Medical Center, Montclair	30	434	464	6.5	93.5	36	380	416	8.6	91.4
9. East End Memorial Hospital (I)	5	146	151	3.3	96.7	5	156	161	3.1	96.9
10. Brookwood Medical Center, Inc	(1)	(1)	(1)	(1)	(1)	25	193	218	11.5	88.5
11. Mercy Hospital	(1)	(1)	(1)	(1)	(1)	101	35	136	74.3	25.7
Skilled nursing facilities:										
1. A. G. Gaston Home for Senior Citizens	43	0	43	100.0	0	47	0	47	100.0	0
2. Burgess Nursing Home	46	1	47	97.9	2.1	50	0	50	100.0	0
3. Leigh-Ann Rest Home (M)	3	14	17	17.6	82.4	2	17	19	10.5	89.5
4. Northway Nursing Home (J)	4	65	69	5.8	94.2	9	62	71	12.7	87.3
5. Mary Lewis Convalescent Home (L)	1	35	36	2.8	97.2	2	40	42	4.8	95.2
6. Stone Craft Nursing Home, Inc. (K)	1	38	39	2.6	97.4	2	38	40	5.0	95.0
7. Civic Center Nursing Home	0	95	95	0	100.0	3	91	94	3.2	96.8
8. Hanover House Nursing Home	0	75	75	0	100.0	0	78	78	0	100.0
9. Methodist Home for the Aging	0	48	48	0	100.0	0	50	50	0	100.0
10. Rose Manor Skilled Nursing Home	0	100	100	0	100.0	2	107	109	1.8	98.2
11. St. Lukes Nursing Home	0	82	82	0	100.0	1	82	83	1.2	98.8
12. Oak Knoll Manor Nursing Home	(1)	(1)	(1)	(1)	(1)	7	89	96	7.3	92.7
13. Medicenter of America	(1)	(1)	(1)	(1)	(1)	12	44	56	21.4	78.6
14. Fairview Nursing and Convalescent Home	(1)	(1)	(1)	(1)	(1)	38	115	153	24.8	75.2

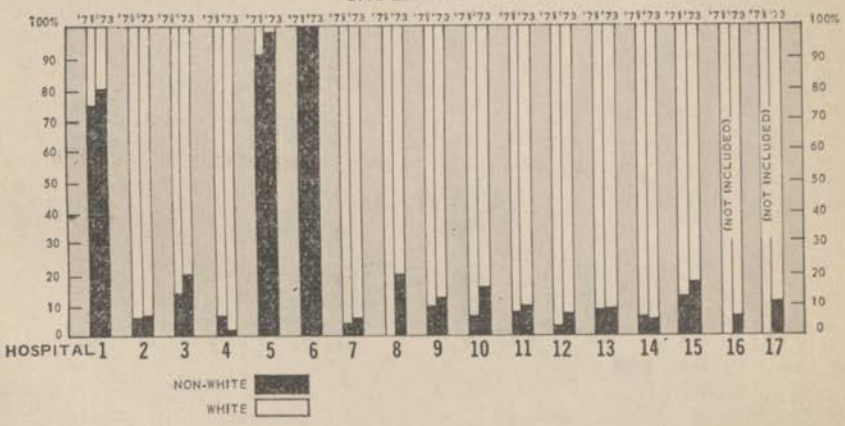
[1] Not included.

Note: Letters identify institutions on table on p. 33 of report.

PERCENTAGE OF NON-WHITE AND WHITE PATIENTS
IN SELECTED SNFs IN BIRMINGHAM, ALABAMA
1971 and 1973

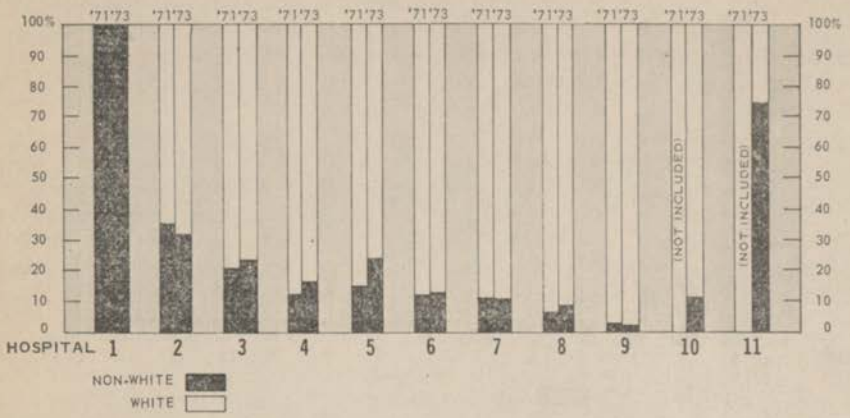


PERCENTAGE OF NON-WHITE AND WHITE PATIENTS
IN SELECTED HOSPITALS IN ATLANTA, GEORGIA
1971 and 1973

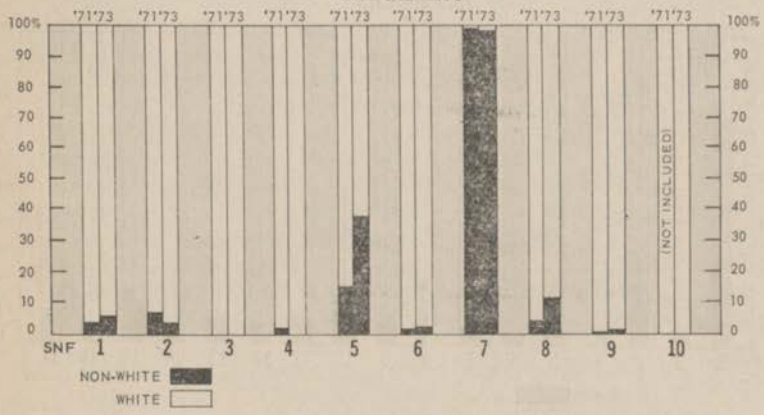


27-401—74——2

PERCENTAGE OF NON-WHITE AND WHITE
PATIENTS IN SELECTED HOSPITALS
IN BIRMINGHAM, ALABAMA
1971-1973



PERCENTAGE OF NON-WHITE
AND WHITE PATIENTS IN SELECTED
SNFs IN ATLANTA, GEORGIA
1971 and 1973



Mr. AHART. I would like to discuss the disproportionate use of Government-owned hospitals as mentioned in Mr. Iffert's presentation.

Although most hospitals participating in medicare and medicaid in the four metropolitan areas were integrated, a disproportionately large share of minority patients received their health care at State-, county-, or city-owned hospitals.

Mr. WIGGINS. I have been waiting for you to read that statement just so that I could interrupt you.

I do not know what you mean by "disproportionately." Would you explain that, please?

Mr. AHART. Both in the sense of white versus nonwhite patient ratio in relation to the white and nonwhite population ratio in the community as a whole and in the community adjacent to a particular hospital.

Mr. WIGGINS. Now, are you using the whole nonwhite population, or only the white and nonwhite population, who by reason of their income, are eligible to enter and participate in a medicare or medicaid facility?

Mr. AHART. The figures that we are using are from the census tracts Mr. Wiggins, and they are for the total population. We did not try to correlate the patient population of the hospital with the eligible medicare beneficiaries in the area, nor did we segregate the population of the hospital between those that were there with a private plan or with some other type of financing. So, it is the total patient population versus the total population of the census track or area that they are located in.

Mr. WIGGINS. If there are a thousand people in a community who would be eligible to use a facility and if 500 of those were white and 500 were nonwhite, your statistics indicate that nonwhites constitutes significantly more than 50 percent of the patient population of the Government-owned hospitals?

Mr. AHART. Yes, sir.

Mr. WIGGINS. What do you draw from that? First of all, are you satisfied that it does not represent a policy of discrimination against the whites?

Mr. AHART. Well, I think that the conclusion that we draw, Mr. Wiggins, is basically that it is disproportionate in terms of the population, in terms of the mix of the population census. We also draw conclusions as to some of the reasons for this and we will get to these later on in the statement, reasons which cause the greater utilization by one population group versus utilization by another population group. Some of these we have discussed, such as location, some longstanding policy to provide care, at low or no cost and others that we will discuss. For example, the fact that many of the people in the low-income areas do not have private physicians, either because they cannot afford them or because there is a lack of supply in the area.

Mr. WIGGINS. You have mentioned many of those things, and I may interrupt you as you go along and go a bit more into detail on some of them.

Please proceed.

Mr. AHART. Minority group patients were reported to be drawn to these hospitals because they (1) provided medical care at little or no cost to indigent patients, (2) were easily accessible to minority group communities, (3) had traditionally been used by members of

minority groups, and (4) had made special efforts to accommodate minority groups.

Mr. WALDIE. When you say "made special efforts to accommodate minority groups," you assume that other institutions did not make efforts to accommodate special minority groups.

Mr. AHART. Could I ask Mr. Iffert to address the question?

Mr. IFFERT. I think a marked example would be in the Los Angeles County Hospital, which has made special efforts to accommodate the Spanish-speaking people in that area by requiring that nurses on specific floors of a hospital be bilingual. They have made the effort to provide food which is suitable. I think that would be a good example of the special efforts that are made.

Mr. WALDIE. Would it be fair to suggest that discriminatory practices are occurring? In other words, affirmative standards required?

Mr. IFFERT. I did not get the question.

Mr. WALDIE. Well, I am attempting to find—to try to determine if those statistics are the results of discrimination, and I presume—I was not here when you made your initial presentation—your conclusion is they are not.

Mr. IFFERT. That is true.

Mr. WALDIE. And I am trying to find out if they are not the results of overt discrimination.

Would those statistics be reversed if special efforts to accommodate minority groups had been made—as the case here—and if so, is there a duty or obligation on the part of the Government——

Mr. AHART. I think that there is something of a duty there and I think that it has been recognized.

Mr. WALDIE. Then, will you summarize what special efforts you have given in these areas?

Mr. AHART. There is a recent case where OCR is requiring the Connecticut State Welfare Department to pay more attention to having people on the staff that can meet the cultural needs or know the culture of the Spanish-speaking people in that community. They are going to have to get people on the staff that can speak Spanish and can communicate with the Spanish-speaking people, mostly Puerto Ricans, in that area. And this is being done as a matter of compliance of title VI.

Mr. WIGGINS. I am confused. You said a "duty" to reverse the statistics. You mean a duty to get more whites into Government-owned hospitals?

Mr. WALDIE. Perhaps, or a duty to get more Spanish-speaking people spread throughout the hospital system, a duty to at least make the charts look differently then they are.

Mr. WIGGINS. Your question related to the chart, not to the statement that the Government-owned hospitals had a disproportionate number of nonwhites?

Mr. WALDIE. Not to that statement, to the chart.

I guess, what I am really saying, is, do we have an affirmative action program to eliminate discrimination and I would assume that you find where there is affirmative action made, special efforts to accommodate minority groups or ethnic groups in those particular hospitals—it seems to me to be positive. Then, I guess my question would be more specific—you have said that there is no discriminatory practices, and I can well believe that, but have there been any affirmative steps taken

to eliminate that pattern, which is not a desirable pattern? I would assume that would be a further conclusion that you would agree with, or would you?

Mr. AHART. I am not sure that I am the one to make that judgment.

Mr. WALDIE. But if the judgment is to be made—and I would make it—that is not desirable. Is there an obligation on the part of HEW to take affirmative steps to accommodate minority groups?

Mr. AHART. I think, as in the Connecticut case, where there are practices which might be impediments to the quality of assistance which the applicant gets—and, certainly, the lack of effective communication between the potentially eligible population and the staff must have something to do with the quality of assistance I would think. I think that he Office for Civil Rights in the Connecticut case is demonstrating some affirmative action to overcome those barrierse or impediments is necessary to be in compliance with title VI.

Mr. WALDIE. Do you gather that you find the mix of population racially better in the public institutions than the proprietary because of essentially the referral practices of the physicians that own the proprietary?

Mr. AHART. Yes, and I am going to dimiss that in the next portion of the statement.

Where a person does not have a private physician, he cannot get admitted to the private hospital. His recourse is often to go to the emergency room or the outpatient clinic of the public hospital and then if he is in need of inpatient hospitalization, he is admitted. That is one factor which does operate to increase the minority and poor population in the publicly owned hospitals and I am not sure, in going back to your statement, is it good or bad? One of the hospitals that you noticed on the charts on Atlanta was publicly owned and the vast majority of the total patient population was nonwhite.

Mr. WALDIE. Just one final question.

I suspect that if you went to the Martin Luther King Hospital in Los Angeles County, you would find the same population.

Mr. IFFERT. About 80 percent black.

Mr. WALDIE. I have no further questions.

Mr. DRINAN. Mr. Chairman, let me, if I may, try to develop the implicit issues that were developing here and jumping ahead in your testimony. You say that there are 15 States that have no compliance machinery whatsoever and that in these States there is a racial discriminatory pattern, and that in the State of California there is no method whatsoever of having this annual onsite review of the skilled nursing facilities, and despite that, HEW says disproportionate use and nonuse by minority groups does not necessarily prove the existence of discrimination.

Can you gentlemen conclude or tell us what HEW says is discrimination in view of this racially discriminatory pattern, in view of the fact that 15 States have no compliance and California particularly has nothing for skilled nursing facilities, does HEW say that that adds up to discrimination, or do they state that it does not necessarily prove discrimination?

Mr. AHART. I think what we are dealing with here, Congressman Drinan, is that mere imbalance is not characterized as being overly discriminatory under the philosophy of the Office of Civil Rights,

which tries to find something tangible which can be corrected by the hospital or facility itself that tends to squeeze out minorities or some other groups of people, I would think that, if you take a look at the kind of statistics which Mr. Iffert presented and as we characterized in the report, you will find a dual system. Now, whether that is due to the practices by the hospitals or the skilled nursing facilities or whether it is due to the fact of the long history of economic discrimination, discrimination in the educational field, or a geographic population pattern that has grown up around these areas, are factors that cannot be solved by that individual hospital; that is something else.

Mr. DRINAN. Well, the administration has developed these programs to educate all of these, that they can go to the private hospitals and so on.

What is the Medical Service Administration; who selects them; is that strictly an arm of HEW; and what does HEW think of the MSA's proposal that we educate these consumers?

Mr. AHART. Well, first of all, the Medical Services Administration is a component of the social and rehabilitation service of the Department of HEW. It is basically responsible for the administration of the medicaid program. The Office of the Civil Rights in turn is in the Office of the Secretary and has the basic enforcement responsibility for title VI as it relates to HEW programs.

Mr. DRINAN. What does the Secretary, the present Secretary think? Has he ever said anything, he has been there a few months, has he said anything about what the Medical Service Administration of HEW says about breaking down these racial, segregated patterns by the education of the consumer?

Mr. AHART. I do not think that there is any disagreement that an educational program for the potential recipient would be beneficial. The advice that we have received from the Administration is that at this point in time they lack the staff and the resources to mount the kind of program which would do some good in this particular area. This goes back to the reassurance that they gave to us—as mentioned in the 1972 report—that this would be worked upon. They have made very little progress at this point.

Mr. DRINAN. They have done nothing since your excellent report here a year ago. Am I unfair in concluding that?

Mr. AHART. On the consumer education portion, that is correct.

Mr. DRINAN. Well, that means that what they have done to express their concern about the racial discriminatory patterns in Georgia, Alabama and elsewhere—I am concluding from what I see—that they have not done anything and I conclude they really do not think it is a problem.

Mr. AHART. The Office for Civil Rights would not characterize it as being a pattern which evidenced or proved overt discrimination. I am sure that the Medical Service personnel have discussed these patterns with the officials in the localities of jurisdictions concerned. Now, beyond that, I am not sure what they have or could or should do.

Mr. DRINAN. I think that that demonstrates my point.

Thank you, sir.

Mr. AHART. At most private hospitals, patients can be admitted only by a physician having admitting privileges. Because physicians are in short supply in many areas where minority groups live, persons in

such groups often must rely on outpatient clinics at Government-owned hospitals for their general medical needs. When hospitalization is necessary, they are admitted to these institutions as inpatients.

Our updated patient census of hospitals and skilled-nursing facilities—we did this last month basically—in the four metropolitan areas shows that (1) a disproportionate number of minority group patients continue to be treated by only a few institutions, (2) a heavy concentration of minority-group patients receive treatment at the traditionally used government-owned hospitals (State, county, or city) rather than receiving treatment at private hospitals which they are entitled to use under their medicare or medicaid coverage, and (3) a number of institutions located in census tracts with a high minority population had low minority utilization.

As an example of the disproportionate use of minority groups of only a few institutions, we reported that the patient census taken for us at the 24 hospitals of 20 ECP's that were participating in medicare in the Atlanta and Birmingham areas showed that 67 percent of the black patients had been treated at five institutions.

In August 1973, about 60 percent of the black patients in these areas were being treated at the same five institutions plus one other hospital that had been approved for medicare participation in September 1972.

I would like to turn now to the followup of HEW actions. In our July 1972 report, we mentioned four actions that HEW was taking or proposing to take to deal with problems identified in our report to improve its compliance activities. These actions were to lead to:

> Investigations by OCR and the Medical Services Administration of the Social and Rehabilitation Service of the nursing home referral process which would include onsite visits to skilled-nursing facilities in each State.
>
> A consumer education program to help insure that each medicaid recipient was informed of all medicaid benefit and services.
>
> A detailed reporting form to help monitor title VI compliance in skilled-nursing facilities under medicaid.
>
> Demonstration projects sponsored by the Health Services and Mental Health Administration (HSMHA) to develop model ombudsmen units to provide another vehicle for people to lodge discrimination complaints.

Our followup in August 1973 revealed the following status for each of these proposed actions.

In our July 1972 report, civil rights groups and HEW officials were cited as having reported that patterns of predominantly black of white skilled-nursing facilities and nursing homes are partially caused by the practices of State and local health and welfare departments in referring patients to these facilities. HEW officials advised us that regional office personnel from OCR and the Medical Services Administration would investigate the referral process and would perform a number of onsite visits to skilled-nursing homes in each State beginning on July 1, 1972.

In July and August 1972, OCR made studies of minority utilization of skilled-nursing facilities under medicare in Richmond, Va. and San Antonio, Tex. OCR concluded that, although the existence of discriminatory practices could not be ruled out, discrimination did not appear to be a factor in minorities using skilled-nursing facilities in either

study. However, OCR recommended that further attempts be made to rule out possible discriminatory practices in referring minority patients to skilled-nursing facilities which included efforts to contact persons in the minority community and persons directly involved in the referral of patients, their families, physicians, social workers, and hospital chaplains; and second, an examination of the referral practices and procedures of the State agencies involved.

Thus, both GAO and HEW reports last summer pointed out the need for an examination of the nursing home referral process; yet HEW officials informed us that, as of July 1, 1973, OCR and MSA personnel had not jointly made investigations of the referral process. The MSA checklist project, however—which I will discuss later—did include some questions on the State and local agency referral practices.

Turning to the education of medicaid recipients—for two of the four metropolitan areas included in our review (Wayne County and Los Angeles County), we reported that minority group patients were often unaware that their medicare and medicaid coverage entitled them to use private hospitals as an alternative to the traditionally used Government-owned hospitals. As stated earlier, our recent patient census information continued to show heavy concentration of minority-group patients receiving care at State-, county- or city-owned hospitals.

We concluded that measures to increase the awareness of minority group patients of their benefits under medicare and medicaid might result in greater use of private hospitals. HEW officials advised us that the Medical Services Administration had developed a proposal for consumer education to help ensure that each medicaid recipient is informed of all medicaid benefits and services available in his State.

In July and August 1973, we inquired of officials of the Medical Services Administration as to the current status of this project. We were informed that, while the education of medicaid recipients might lead to greater utilization of private hospitals, the proposal was never implemented by HEW. A lack of staff and a lack of funds were cited as reasons why the proposal never got past the embryo stage of development.

Turning now to the checklist, in July 1972, we reported that HEW officials had advised us that the Medical Services Administration had developed a detailed reporting form for regional office use in cooperation with OCR regional offices to monitor compliance with title VI in skilled-nursing homes under medicaid. The form was designed for use by HEW regional personnel that visited State and local agencies to determine the extent that the States were enforcing compliance with title VI. The checklist was also used by HEW to investigate title VI compliance in skilled-nursing facilities. We understand, however, that this checklist project will not be an ongoing program.

In January 1973, the Medical Services Administration received and analyzed the completed checklists and concluded that three major problem areas existed with regard to the State title VI enforcement activities.

Specifically, six States were not making annual onsite reviews; five States lacked complaint mechanisms; and four States failed to dele-

gate to anyone at the State level the responsibility for assuring compliance with title VI.

The Medical Services Administration's checklist indicated the following problems within the four States where we made our review: Michigan—Annual onsite reviews of skilled-nursing homes are not being made in all counties as required by HEW instructions, however Wayne County was making such reviews. Also, at the State level, no one has been assigned the responsibility for assuring title VI compliance.

Georgia—a significant number of facilities continues to participate in medicaid despite what MSA termed as racially discriminatory patterns which could be identified. Also referral sources culminated in a pattern of practice which MSA termed as often discriminatory.

Alabama—facilities which MSA indicated as having racially discriminatory occupancy patterns continued to participate.

California—the State does not have methods or procedures for conducting annual onsite reviews of skilled-nursing facilities to assure civil rights compliance.

In commenting on the results of the MSA checklist project, OCR officials pointed out that occupancy patterns involving the disproportionate use or nonuse of facilities by minority groups does not necessarily prove the existence of discrimination.

Our July 1972 report stated that, under HEW's current efforts to enforce nursing-home standards, it was promoting the establishment of investigative ombudsmen units in each State government to review and follow up complaints made by, or on behalf of, nursing home patients. According to HEW officials, one feature of the ombudsmen units was that they should provide another avenue available to people in local communities for lodging civil rights complaints. We reported that the Health Services and Mental Health Administration of HEW was sponsoring demonstrations in five States to develop model units.

In August 1973, a HSMHA official advised us that these projects had never focused on title VI compliance and that no discrimination complaints had been encountered by the units.

In summary, Mr. Chairman, it appears to us that of the four HEW actions mentioned in our report, HEW has taken positive steps to follow through on only one—the development and use of a civil rights checklist to look into title VI compliance by skilled-nursing facilities under medicaid.

Now, I would like to turn to the thrust of HEW compliance activities.

In our July 1972 report, we stated that HEW was making relatively few onsite visits to hospitals, skilled-nursing facilities, or nursing homes. HEW officials advised us that during 1971, its Office for Civil Rights made 950 reviews of hospitals and extended-care facilities to determine their compliance status; slightly over 300 of these reviews were onsite visits.

Instead, HEW was relying more on information reported by institutions participating in medicare and medicaid; on compliance reviews by State and local agencies; and on complaints by beneficiaries, physicians, and others to identify institutions which may require enforcement action. HEW officials advised us that in 1971 OCR made

over 1,700 visits to State and local agencies to monitor their civil rights compliance activities, including these agencies' reviews of the compliance status of hospitals and nursing homes under medicaid.

However, during the next 15-month period—January 1, 1972, through March 31, 1973—OCR increased its compliance activities of hospitals and skilled-nursing facilities by an additional 1,550 reviews of these institutions, about 600 of which were onsite reviews.

During this same time period, HEW decreased its monitoring of State and local agencies' compliance activities, making only 900 visits.

OCR officials stated that in 1971, emphasis was placed on making visits to State and local agencies to monitor their compliance activities of skilled-nursing facilities and to negotiate with these agencies to make periodic title VI reviews of hospitals participating in medicare and medicaid. Once initial efforts were completed in getting these agencies to make title VI reviews, OCR could then spend less time checking on the State and local agencies' compliance activities and more time on making compliance reviews of hospitals and skilled-nursing facilities.

I would like to turn now to the incidence and disposition of discrimination complaints. For the 5-year period July 1966 to June 1971, we reported the following complaint activity for the four metropolitan areas based on our reviews of the records in the OCR regional offices.

For Atlanta and Birmingham, OCR records contained 39 charges of discrimination against hospitals participating in medicare in the Atlanta and Birmingham areas. The charges were directed against 14 hospitals and most of them involved discrimination by the hospital against patients or minority group physicians.

Each of the 14 hospitals was visited by OCR at least once during its investigations of the 39 complaints. Of the 39 complaints 28 were resolved without visits. OCR records did not show whether the remaining five complaints were resolved.

For the 34 resolved complaints, the charges of discrimination either could not be substantiated or were substantiated and corrective action was promised by the hospitals. None of the hospitals was removed from medicare.

Mr. EDWARDS. That is not a large number of charges of discrimination in a 5-year period. Are there facilities that would assist someone who wants to make a complaint in this large area so that the complaint can be made rather readily without undue stress and is there some machinery to encourage the use of complaints where discrimination might exist?

Mr. AHART. I think that Mr. Iffert might want to correct me on this, the complaints may come indirectly from the aggrieved patient or physician or might come in through a civil rights organization of some type. Now, one of the things which HEW had indicated that they would experiment with would be an ombudsman unit specifically to handle complaints from persons in nursing homes. Now, as we mentioned, that has not really gotten off the ground as it relates to civil rights matters. That would require an additional piece of machinery to assist in getting complaints from the aggrieved individuals to the OCR for investigation and disposition.

Mr. EDWARDS. If I am a patient in Birmingham, how do I know that I can make a complaint?

Mr. AHART. Can you answer that, Mr. Iffert?

Mr. IFFERT. I guess, if you happen to know of a civil rights organization, they might give you assistance, or if you are familiar with the provisions of title VI and your rights under that, and you know where to go with it—to the regional office of OCR. If you do not know these things, it might be difficult. If you are over 65, the district offices of the Social Security Administration provide a vehicle for complaints, but people that complain do not complain about discrimination. Most of them are concerned with really two things. First, they are sick or they would not be in these institutions and they are very concerned about their personal well-being and the quality of the care that they are receiving. Second, they are very concerned about the financial impact of being sick. And, as you are probably well aware, medicare does not pay for everything. In terms of a long-term illness, where the person looks down the road and knows that for the rest of his life he has a chronic problem, he is faced with a severe financial problem. Those are the types of complaints that they make, and generally they are also registered to the Social Security Administration.

Mr. AHART. I might add to that that a person who is in a hospital or needs rather intensive care in a nursing home perhaps is not the one inclined to complain about civil rights.

Turning to Wayne County, OCR records covering the 5-year period ending in June 1971 contained no charges of discrimination against medical institutions in Wayne County in admitting or caring for patients or in granting staff privileges to physicians.

Los Angeles County, OCR records showed that for the same 5-year period, it has received charges of discrimination against six hospitals and two skilled-nursing homes in Los Angeles County. Complaints against six of the organizations could not be substantiated. For the remaining two, OCR substantiated the charges and was able to persuade the institutions to correct the situations. Accordingly, neither institution was denied participation in federally assisted programs.

Mr. RANGEL. May I interrupt you here to find out the nature of this type of complaint? What was corrected?

Mr. AHART. Do we have the details with us on the nature of those particular complaints, or did we discuss them before?

Mr. IFFERT. We do not have the details on the complaints summarized in our report with us, but I would be happy to furnish those for the record.

Mr. RANGEL. Let me rephrase.

Since segregation is accepted as not being overt racism, when there is some movement, what type of complaint generates that type of activity?

Mr. IFFERT. I will characterize the complaints that we discussed in our report in Los Angeles to the best of my recollection.

Some of them were physicians who were asserting that they were denied staff privileges at a particular institution on the basis of their race; to the extent that it can be substantiated that race is the basis of their denial of staff privileges, that institution is out of compliance. As often is the case, black physicians are usually general practitioners,

and a hospital may adopt a policy of adding to its medical staff by taking only specialists. In such an instance, they will not take a general practitioner, whether he is white or black, and that would be considered by OCR as not discriminatory.

Mr. RANGEL. I can appreciate what they will dismiss, but I am trying to get a feel for the type of thing that OCR will say what they have corrected, in the last 5 years. These are conditions that we have found on overt discrimination, and we have corrected it as opposed to the situations that you just revealed, that they just turn the guy out because he happens to be black.

Mr. AHART. There is also an example that comes to my mind, Mr. Rangel, which indicates the type of complaint and one which is being corrected.

It is a hospital in Los Angeles County which issued instructions to the nursing staff that the nurses would speak only English in the hospital, and OCR found that to be discriminatory, and it was rescinded, and taken care of.

Mr. RANGEL. I can appreciate that somebody may be sick in a nursing home and would not be prepared to march to Washington for the civil rights, but I just cannot see in a community where there has been a long history of discrimination that the review would indicate that they may have found some situations that have come up that nonwhite may have been adversely affected, but certainly not the institution to do that. I still have not gotten a handle on something that OCR would be proud of that they corrected. I mean, if the discrimination in these institutions are that some unknowing supervisors said that the nurses only speak English and this hospital has a high population of Spanish-speaking——

Mr. AHART. I think that there has been quite a bit of progress made since the 1964 Civil Rights Act in eliminating what can be characterized as overt discrimination. There are institutions that did not admit minority groups, or different ethnic groups.

Mr. RANGEL. And a lot of minorities would not want to test their civil rights on an operating table.

Mr. AHART. But there still exist different patterns, geographic patterns, and other than things such as the need for specialties on a hospital staff or policies of some hospitals to give admission privileges to private doctors that are associated with those that are already on the staff, which operate in a discriminatory manner, but not overtly on the basis of race or color or creed or national origin or anything else. They discriminate against some white doctors, also nonwhite doctors, because unless a doctor is affiliated with a particular practice group he is denied privileges in that hospital.

Mr. RANGEL. Having lived in New York all of my life, I can understand how that would operate but I was trying to find in all of the complaints, did OCR find overt discrimination in any case, and did they, in fact, either threaten to use their powers, or use the power or ultimately correct that type of situation?

Mr. AHART. Well, one does come to mind. It happened to be in the State mental health system in Mississippi, in which they had facilities where patients were segregated on the basis of race. OCR did get them desegregated. So they were integrated. In one case, however, it

took a period of years before that was accomplished, but it was accomplished in the final analysis.

Mr. RANGEL. I understood that they discriminated against whites in this mental institution in Mississippi, but I think that it is safe to say that throughout the testimony that you did not find—or OCR did not find—a substantial difference in the quality of service that was offered to whites as opposed to nonwhites.

Mr. AHART. It has not come to our attention and we would be the first to admit that a differential in the quality of service between two institutions or even between patients in a particular hospital is a difficult thing to evaluate even for a qualified practicing physician.

Mr. RANGEL. I just meant to the common layman in terms of facilities available and services being offered. I am not talking about it in a very technical sense, that you need a particular specialist and he does not get there, but certainly you do not walk away feeling that any lack of service was based on color.

Mr. AHART. That is correct.

Mr. RANGEL. Thank you. I am sorry to interrupt, Mr. Chairman.

Mr. EDWARDS. It is very useful, Mr. Rangel.

The Chair might point out that down the road in a week or so we have scheduled a number of witnesses who are going to testify very rigorously that there is overt and covert discrimination in the delivery of health care in the United States.

Mr. RANGEL. Congressman Drinan and I were discussing that and most of the hearings that we newcomers in the Congress have had a chance to attend—some of them testified before—they would come later to testify, and so many times we were not even prepared to ask an intelligent question.

Mr. EDWARDS. In this instance, we will be prepared because we will have the General Accounting Office then various—I describe them as adverse witnesses, and the last witness will be the Office of Civil Rights of the HEW.

Mr. RANGEL. Very good, thank you very much, Mr. Chairman.

Mr. WALDIE. I do not know of whom I should ask this question, but the report deals with the possibility of the examination of discrimination with hospitals, and other facilities. There are similar reports relative to examining the question of discrimination on the part of the medical profession, is it the doctors, the physicians?

Mr. AHART. We do not have a similar report on that.

Mr. WALDIE. That would be similarly proscribed.

Mr. IFFERT. Under medicare, it would not be proscribed.

Mr. WALDIE. It would not be?

Mr. IFFERT. It would not be. There is no contractual relationship between the Government and the private physician.

Mr. WALDIE. The doctor could discriminate in terms of the race of the patients that he would accept and still be entitled to draw medicare?

Mr. IFFERT. That is correct.

Mr. WALDIE. Is that right?

Mr. IFFERT. It is an insurance program, in effect, indemnifying the patient.

Mr. WALDIE. Is that true also of medicaid?

Mr. IFFERT. No, sir.

Mr. WALDIE. Why is it different in medicaid?

Mr. IFFERT. Because the medicaid doctors often participate through agreement with the States.

Mr. AHART. It is a question of privity of contract. The contract in the medicare program is basically between the physician and the patient. The Government merely indemnifies the patient.

Mr. WALDIE. Is it in terms of the Government and the hospital?

Mr. AHART. Yes, sir. There is a contractual relationship between the Government and the hospital.

Mr. WALDIE. Not the patient——

Mr. AHART. Yes, sir, that is correct.

Mr. WALDIE. So that you might come up with a very clean record on the part of the institution and the doctor is the one that is participating in the discriminatory practices and it ends up that the institution is being given a clean bill of health but, in fact, the doctor is the vehicle from which the discrimination occurs and there is nothing we can do about that.

Mr. AHART. I think that that would be a fair assessment.

Mr. WALDIE. Let me pursue this a little further.

Within the hospitals, the role of the physician then becomes subject to examination as to discriminatory practices, does it not?

Mr. AHART. The hospitals practice in terms of giving privileges to various doctors. In the hospital, we get into the fuzzy area of the private practitioner who has staff privileges at the hospital. If there is any discrimination practiced, it would be in the characteristics of the physician's practice. So, I am not sure how you would get to it. As far as the employed hospital staff is concerned, and the medical practitioners employed by the hospital—we are covered.

Mr. WALDIE. But this private fellow who is out there examining patients, his exemptions come with him, right?

Mr. AHART. Yes, and, I think that to the extent that he is discriminating, he started by the patients that he has accepted.

Mr. WALDIE. And no report has been made of what discriminatory practices exist in that program through the physicians?

Mr. AHART. There may have been studies made of it but I am not aware of them.

Mr. WALDIE. You mean to tell me that if there is a doctor that says I am not going to treat black patients, because I am a racist, he is entitled to make that discrimination and still participate in the medicare program?

Mr. IFFERT. Yes.

Mr. WALDIE. All right, I yield.

Mr. WIGGINS. Thank you, Congressman Waldie.

We are in a very delicate area as to what title VI does, in fact extend to. My guess is, had we argued this on the floor, the traditional professions of law and of the medical field would have proclaimed their exemption from title VI even though they might get the bulk of their income from the government programs. Before you conclude that the possibility of discrimination may exist by the private practitioners, I think you would have to admit that your conclusion is that it is a possibility, but you have not done a study on it as a fact.

Mr. AHART. That is correct. I do not know that we are saying whether it does or does not exist. We are saying that there is no provision under title VI with the medicare program against it.

Mr. WIGGINS. I would certainly agree that it is a possibility, and I would speculate that it does, in fact, exist, but we should not indict a group without some evidence that it in fact does exist.

Mr. WALDIE. My own point in that—and it would seem to me to be a healthy area to examine—if we are looking at a hospital with a population all black or all white and we draw the conclusion that there are discriminatory practices under title VI, and we then examine and say that it is there, how do we explain it?

We would explain it because of the population and a variety of reasons. We could also explain it because we are dealing with a group of racist physicians who are referring patients to that particular institution. I mean, that possible explanation cannot be eliminated by our hot desire that it be eliminated without exploring it. In fact, you alluded to it in your statement, one of the problems is the practice of referring doctors who refer their choice of patients to their choice of institutions, and if their choice is predicated by racism, they have, in fact, created the situation that appears to be discriminatory in the institution by a mechanism over which we have no control.

Mr. AHART. I think that a good example of that—and this is kind of the reverse situation—is at the Hughes Spalding Pavilion in Atlanta. It is not a large hospital, a hundred and some beds. It was built under a Hill-Burton grant in 1949 as a black private patient hospital. As it exists today, it has a totally black patient population. The hospital medical staff has 82 doctors, of which 72 are blacks. There are some other minority groups, and some foreign doctors that have come in.

Now, HEW has struggled with this for a number of years. What do we do about this kind of situation? There are no white patients; it is virtually an all black hospital staff, black doctors. It is kind of an impasse. What do you do? It is difficult to deal with.

An alternative considered, was to convert it to an extended care facility, and then the doctors would have to find another hospital in which to have staff privileges. The black doctors in that hospital were in the top echelon on the staff.

The other side is that the doctors do not want to lose the privileges in their hospital and some of them may live in the community where their patient population are the people who live close to them. You can certainly share their concern.

Mr. WALDIE. I have had some opportunity to look into their management operations on this in the Blue Cross-Blue Shield program. And you folks fool yourselves. I do not know of any decision in the medical field that is not made by a physician, including the patient load of hospitals. Particularly the patient load of hospitals. If we are looking for the discriminatory practices, we should be looking at the practices of the physicians and until we start examining the source of patient referrals, and patient treatment, I do not think we will get to the bottom of this problem. There may be no discrimination, but if we leave out the examination of the doctors' practices we are never going to find an answer to whether there is or is not.

It would be interesting to have that report made, and maybe the act requires some amendment.

Do you have the authority to make that examination now?

Mr. AHART. No, sir, not to my knowledge.

Mr. WALDIE. I have no further questions, Mr. Chairman.

Mr. EDWARDS. Proceed.

Mr. AHART. I would like to turn to the updated status of complaint activity.

For the 18-month period January 1972 through June 1973, our updated examination of the regional OCR files revealed the following complaint activity in the four metropolitan areas.

First, Atlanta and Birmingham. OCR records contained six charges of discrimination against hospitals and skilled-nursing homes participating in medicare and/or medicaid in the Atlanta and Birmingham areas. The charges involved two hospitals and two skilled nursing facilities in Birmingham and two hospitals in Atlanta.

The six charts pertained to such things as discrimination on room assignments, inappropriate patient care, lack of use of courtesy titles, and discrimination in employment.

OCR referred the employment complaint to the Equal Employment Opportunity Commission. Of the remaining five complaints, only one involving inappropriate patient care at a skilled nursing facility in Birmingham was substantiated and corrective action was taken.

I might add, however, that it was inappropriate patient care that was substantiated and it was not clear whether or not discrimination was involved.

In Wayne County OCR records covering the 18-month period ending June 30, 1973, contained no complaints involving discrimination by medical institutions in Wayne County. One complaint was filed with the Michigan Civil Rights Commission pertaining to discrimination in a hospital training program, which was dismissed as unfounded.

Finally, Los Angeles County. OCR records revealed four complaints involving three hospitals and one skilled-nursing facility in Los Angeles County. Three complaints pertained to alleged inadequate or inappropriate patient care which were investigated and not substantiated. The remaining complaint involved a hospital directing to nursing personnel that only English could be spoken at the hospital. OCR found this directive to be discriminatory and it was rescinded.

To turn now to comments of HEW officials and representatives of civil rights groups, HEW officials have told us that the type of discrimination existing today is substantially different from that existing when title VI was first enacted. They said that the law was aimed at remedying forms of overt discrimination which had existed in some States; discrimination in health facilities today is not overt and is very hard to detect or prove.

HEW officials have advised us that, in gaining access to the health system, discrimination against the poor is prevalent but cannot be dealt with under title VI of the Civil Rights Act of 1964.

On the basis of discussions with HEW officials and representatives of organizations interested in civil rights matters and our reviews at

hospitals, skilled nursing facilities and nursing homes, it appears that title VI has done much to remedy the forms of overt discrimination that existed in the past in the health care area. These officials and representatives have told us that title VI may not be adequate to deal with today's more complex forms of discrimination—such as the general attitudes of whites toward nonwhites or the lack of understanding by white hospital staff of the cultural or economic backgrounds of minority group patients.

With regard to the latter problem we were informed by OCR that it has recently made a title VI noncompliance determination for the failure of a State welfare department to deal adequately with language and cultural barriers facing Spanish-speaking and other minorities.

According to some HEW officials, to deal with the subtle forms of discrimination existing today, it may be necessary to modify the law so that instances such as gross underrepresentation of minority group patients in a hospital compared with community population are considered prima facie evidence sufficient for HEW to compel a facility to take affirmative action to increase the number of its minority patients or demonstrate why more minority patients are not served.

With regard to the lack of progress in completing the four actions mentioned in our July 1972 report, several HEW officials informed us that other civil rights issues such as education and other health-related projects such as implementation of the enactment of H.R. 1 in October 1972, had been given higher priority. Moreover, HEW officials cited insufficient funds and lack of manpower to be the primary reasons why more efforts were not devoted to civil rights matters and title VI compliance activities in the health area.

That concludes my prepared statement, Mr. Chairman. We will be glad to respond to any further questions that you or the members may have.

Mr. EDWARDS. Thank you, Mr. Ahart.

How many hospitals and skilled-nursing facilities participated in the medicare program during 1971?

Mr. AHART. In 1971 approximately 6,700 hospitals participated in medicare programs and about 4,000 extended care facilities. The latest figures are for March of 1973, and again you have almost 4,000 skilled-nursing facilities and 6,768 hospitals participating.

Mr. EDWARDS. You have, therefore, about 10,000 institutions.

How many visits were made by the HEW staff to these 10,000 institutions in 1 year?

Mr. AHART. As I mentioned in my statement, for the early period that we covered in our review OCR made 950 reviews including 300 onsite visits to the institutions participating in the program. In the more recent 15 months ending March 3, 1973, they made about 1,550 reviews including 600 onsite visits to the institutions on the title VI compliance matter.

Mr. EDWARDS. So, about 10 percent were reviewed and fewer than 3 percent were actually visited.

Mr. AHART. That would be correct for 1971.

Mr. EDWARDS. Well, how can the Office of Civil Rights tell us that discrimination is not overt in these 10,000-odd institutions?

Mr. AHART. Well, again, the Office of Civil Rights area of concentration was in reviewing the compliance activities of the States and local units of the government and, I assume that the reason they put emphasis on that would be to see if they could place some reliance on a day-to-day basis on the civil rights compliance activities of the States at all types of facilities. If OCR was successful at that, they could do a better job of using their limited resources in going into areas where they did not have that much faith in the State and local agencies, and in handling the direct complaints from the areas where they were having particular problems with title VI.

I think in theory that makes sense. I think a lot of OCR activity, even though they have limited resources, is going in to investigate individual complaints as well as making the necessary compliance checks involving changes of the ownership of the nursing homes and the new institutions wanting to enter into the program.

Mr. EDWARDS. But there are practically no complaints.

Mr. AHART. There are very few complaints.

Mr. EDWARDS. Mr. Wiggins.

Mr. WIGGINS. I have no questions.

Mr. EDWARDS. Mr. Waldie.

Mr. WALDIE. I have no questions.

Mr. EDWARDS. Mr. Rangel.

Mr. RANGEL. No questions.

Mr. EDWARDS. Mr. Parker.

Mr. PARKER. I just have one question, Mr. Chairman.

Mr. Ahart, in terms of your report, you talk about no overt discrimination. Was there any check made of biracial room assignments in extended care facilities?

I understand that there is no sign over the door that says "whites only." After admission, was there any check made within these facilities to see if they were actually biracial in terms of wards and so on?

Mr. AHART. In regular title VI reviews of institutions, it should be covered as to what the hospital policy is on that. In our walkthrough of the facilities that we visited—this is one of the things that would be a visible sign of possible dicriminatory policies—to my knowledge, we did not find this.

Mr. IFFERT. In the wards you can notice it and it was not noticeable. Of course when you get into a private or semiprivate room situation, it is something else.

Mr. PARKER. One other question. And you touched on it near the end of your testimony.

In reference to comments of HEW officials, you talked today of more complex forms of discrimination, one being the lack of understanding by white hospital staff of a cultural or economic background and the fact that title VI might not be adequate to deal with that form of discrimination, and yet, with regard to that problem, your statement that OCR indicated—is it more that the law covers it and that the enforcement of the law has not been adequate rather than just the law itself does not cover these types of discrimination?

Mr. AHART. I think it is in the mix of the hospital staff in terms of their culture, their background. If it is the same thing that happened in the Connecticut Welfare Department case—that the language bar-

rier denied equal benefits to Spanish-speaking minorities—then I think that you can get to it through title VI, but certainly other things, lack of understanding, functional racism in that the white medical staff is not well versed in nor understands the culture of the black, of the chicano, of the others, I am not sure that you can reach this under title VI.

I would not know how to do it.

Mr. PARKER. Thank you.

I have no further questions.

Mr. EDWARDS. Mr. Blommer.

Mr. BLOMMER. I would like to follow that up.

You used the words in your statement that title VI was enacted to reach overt discrimination. Is it not a fact that there is no such limitation in the law, whether it is overt or covert or invidious or insidious, discrimination is against the law, that is correct, is it not?

Mr. AHART. I guess the words speak clearly, no one should be denied.

Mr. BLOMMER. I am a little unclear on what HEW told you. You said that according to some HEW official, to deal with these subtle forms of discrimination existing today it may be necessary to modify the law.

Do you mean title VI there?

Mr. AHART. I think they were referring to title VI. I was making these statements with attribution to HEW officials. We have not made an independent analysis of the extent that title VI would cover these more subtle kinds of discrimination or of the extent that as a practical matter you could reach them under the enforcement mechanisms of title VI. I am speaking in a broad way.

Some of the disproportionate uses of certain facilities is not the product of anything that goes on in the hospital, it is the product of where the hospital is located and a lot of history. Really, I am not sure that individual institutions are in a position to do a lot about some of the factors which control their patient mix.

Mr. BLOMMER. Well, in your statement, you say that some HEW officials believe it is necessary to modify the law to reach these subtle forms of discrimination. Is that law title VI of the Civil Rights Act?

Mr. AHART. I assume that is, yes.

I think that what we are talking about is shifting the burden of proof. Where you have what seems to be a disproportionate patient mix, to place the burden of proof on the other side—not having the Government prove discrimination but having the other side explain why this can happen without discrimination.

Mr. BLOMMER. I understand.

Mr. WIGGINS. Let me add a thing here.

It is very clear from the legislative history of the Civil Rights Act that it functions to give meaning to the 14th amendment, in particular to the equal protection clause, and it is also to prohibit individual use discrimination. So, I think it would have to be concluded on the basis of where we are right now that the Civil Rights Act is aimed at the individual use of discrimination and not just discrimination from happenstance. You may not agree with that, but if you do not I disagree with you.

Mr. BLOMMER. Absolutely not, I agree.

Mr. PARKER. I have one other question on your prepared statement. You refer to your updated patient census a number of institutions located in the census tract with a high minority population with low minority utilization. Now, that pattern seems to contradict with your previously stated theory that the patient census of one particular race is in a hospital because that hospital is located in an area populated by persons of that same race. It seems to be a contradiction. Could you comment on that?

Mr. AHART. It is contradictory in that there are exceptions to the general proposition that people go to health care institutions near where they live. I could give you examples of particular institutions where we found this to exist. Of course, the reverse was true also in Birmingham, as I have pointed out, with the two nursing homes with virtually an all black population that were located in a predominantly white area. The only reason that we could find for that was that the nursing homes were black owned and operated and perhaps more attractive in the referral process.

Mr. PARKER. What is more interesting would be hospitals located in high minority populated areas with very low minority patients populations.

Mr. AHART. I do have some examples. I hope that I can locate them here.

Mr. EDWARDS. In the meantime, does HEW actually cut off funds or participation to institutions that are found by them to be indulging in racial discrimination?

Mr. AHART. That is the ultimate step, yes, sir.

Mr. EDWARDS. It does not show historically.

Mr. IFFERT. Well, 16 health care institutions have been terminated from participating in federally assisted programs because of discriminatory practices. Fourteen of them corrected the problem and reapplied and were once again approved to participate. Two institutions were closed. Further effective to one nursing home in California was kicked out of the medicaid program.

Mr. EDWARDS. Sixteen.

In these years, has HEW ever dragged its feet when a complaint has been made and the investigation has just dragged on?

Mr. AHART. Well, I think the situation with regard to the mental health institution in Mississippi, where the proceedings were initiated in 1967 would be a good example of that. Two of the institutions were ultimately integrated but the third was allowed to slowly become integrated as the facilities were rebuilt. The problem wasn't really resolved until September of 1972.

Mr. EDWARDS. Five years then.

Mr. IFFERT. That is right and they were allowed to participate fully during that time.

Mr. EDWARDS. Now, there is one in Atlanta according to your report on page 34 that has no white patients and has been the concern of HEW for many, many years.

What is the problem in Atlanta with this particular hospital?

Mr. IFFERT. Well, that is the Hughes-Spalding Pavilion, which Mr. Ahart referred to in connection with an earlier inquiry.

That hospital was historically built for private pay black patients. That is patients that had their own physicians not charity cases that

would normally go to a county institution. In the OCR investigation of that hospital and our findings showed that there was no restrictive policy of admission and when the institution first came into the medicare it had a racially integrated medical staff. As we have said earlier it continued to be virtually an entirely black institution.

Mr. WALDIE. Does it also continue to be essentially a private patient referral?

Mr. IFFERT. Yes, sir.

Mr. WALDIE. Is not that the answer?

Mr. IFFERT. Well, its entire medical staff is virtually black.

Mr. WALDIE. But, I mean the patient load is black, black doctors are referring black patients.

Mr. IFFERT. That is right.

Mr. EDWARDS. I hesitate to bring up this question with Mr. Waldie and I both sitting here.

On page 12 and 13 you state that various States were mentioned by the Medical Services Administration as having civil rights compliance problems under the medicaid. Has any State been cited for noncompliance?

Mr. AHART. It is an apparent inconsistency of the HEW policy that they did cite California for noncompliance because it did not have the mechanism and procedures for the annual onsite review of nursing home facilities.

California was one of six States where they had the same finding in the Medical Service Administration's Title VI Compliance Review at the State level. The other five States were not so cited and there are also other problems in other States as well as in California where there was apparent noncompliance with title VI. Perhaps, this is because of the decentralization of enforcement mechanisms under HEW; the regional office basically makes the determination as to what is compliance and when it is necessary to formally cite the State as being out of compliance with title VI.

Mr. EDWARDS. Has California since that time complied?

Mr. AHART. There has been discussion and there was a letter that went to California, I believe earlier this month, which explained the requirements very specifically as to what would be required to bring the State into compliance. I assume the State is working toward full compliance with the onsite review requirement of the title.

Would you like me to get back to your examples, Mr. Parker?

Mr. PARKER. Yes.

Mr. AHART. These are examples where the population mix did not seem to be consistent with the population racial mix in the area.

One example which was discussed on page 38 of our July 1972 report was the Springdale Convalescent Center which happened to be located on the border of census tract which has about a 1 percent black population and another area which has about a 49 percent black population. We reported that of the 94 patients in the facility 90 were white. Further in August 1973, of the 98 patients in the facility 86 were white. There were three examples from Birmingham, Ala., where a nursing home had no black patients, and two nursing homes had fewer than five black patients. These facilities were located in a census tract where 22 percent of the population was black. Other cases involved an area where 10 to 12 percent of the population was black. One

skilled nursing facility had 82 white patients and no blacks in 1972. In another facility, out of 39 patients, there were 38 blacks.

So these illustrate the kind of situation that we referred to in the statement.

Mr. PARKER. Thank you very much.

I read an article in the George Washington Law Review on the impact of title VI on the health facility situation. They more or less concluded this article by discussing title VI as a viable tool to get hospitals to improve their—HEW compliance in the future to investigate areas as underutilization by getting resident publicizing of clinic services, ambulance patterns and the convenience of the outpatient hours and facilities.

I gathered from your report that you did not find that the compliance staff has not done what they stated they would do in 1968.

Mr. AHART. Well, they cover a lot of areas in their compliance reviews under title VI. I would have to check to see what they cover under what you are talking about here.

Mr. RANGEL. Excuse me. Do you not conclude that HEW did not do it because of the lack of staff and lack of funds?

Mr. AHART. Yes. As far as the educational aspect of this, that is true.

Mr. RANGEL. Underutilization of the hospital?

Mr. AHART. They have not reached that.

Mr. RANGEL. I think that the record is abundantly clear that HEW says they are not doing it because they have no money.

Mr. AHART. As far as that particular complaint, yes.

Mr. EDWARDS. On Monday, September 17, we will have Clarence Mitchell and Marilyn Rose of the Leadership Conference on Civil Rights. On that same day we will have Mrs. Bertha Williams and Ms. Barbara Page from Aiken County, S.C. On Monday the 24th, the American Public Health Association and two public witnesses and then on Monday, October 1, we have invited—and they have accepted—the Office for Civil Rights from HEW.

Gentlemen, we thank you.

Mr. RANGEL. I am sorry. I just wanted to find out whether Mr. Hunter had an opportunity to engage in this field.

Mr. HUNTER. I did not, no, in the field work per se. I did comparison statistics that came in, but that is the extent of my work. I did not participate in the report.

Mr. RANGEL. You just dealt with the hard data given to you?

Mr. HUNTER. More or less.

Mr. RANGEL. Thank you, Mr. Chairman.

Mr. EDWARDS. Thank you for coming here.

The hearing for tomorrow has been canceled. The next hearing is on Monday.

[Whereupon, the committee adjourned, at 12 noon.]

TITLE VI ENFORCEMENT IN MEDICARE AND MEDICAID PROGRAMS

MONDAY, SEPTEMBER 17, 1973

House of Representatives,
Civil Rights and Constitutional Rights Subcommittee
of the Committee on the Judiciary,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:05 a.m., in room 2226, Rayburn House Office Building, Hon. Don Edwards [chairman of the subcommittee] presiding.

Present: Representatives Edwards, Wiggins, McClory, Butler, and Lott.

Also present: Alan A. Parker, counsel; Michael W. Blommer, associate counsel; and Linda Chavez, staff analyst.

Mr. Edwards. The subcommittee will come to order.

The Civil Rights and Constitutional Rights Subcommittee of the House Committee on the Judiciary meets today in its continuing hearings on the enforcement of title VI of the Civil Rights Act in programs receiving medicare and medicaid funds.

We are pleased to have with us this morning two witnesses from the Leadership Conference on Civil Rights. I want to welcome Mr. Clarence M. Mitchell, legislative chairman of the Leadership Conference, and Ms. Marilyn G. Rose, chairperson of the Health Task Force.

Mr. Mitchell, in addition to his role with the Leadership Conference and, in addition, to being a friend of mine, has for many years served as director of the Washington bureau of the NAACP. I am sure we are all aware and familiar with Mr. Mitchell's truly outstanding record on civil rights. He was instrumental in the passage of all of the major civil rights legislation of nearly two decades and helped lead a successful fight in 1970 to extend the Voting Rights Act.

Mr. Mitchell is a graduate of the University of Maryland Law School and attended Lincoln University in Pennsylvania as an undergraduate. Mr. Mitchell, we welcome you, once again before this subcommittee and look forward to hearing you.

Accompanying Mr. Mitchell is Ms. Marilyn G. Rose, who chaired the Leadership Conference's Health Task Force, and Ms. Rose is currently the Washington counsel for the National Health Law program. She was previously the chief civil rights attorney in the Health Branch, Office of General Counsel of the Department of Health, Education, and Welfare. Ms. Rose is a graduate of Brandeis University and Harvard Law School.

We welcome you both here today. Mr. Mitchell, you may proceed.

TESTIMONY OF CLARENCE M. MITCHELL, LEGISLATIVE CHAIRMAN, LEADERSHIP CONFERENCE ON CIVIL RIGHTS, ACCOMPANIED BY MARILYN G. ROSE, CHAIRMAN OF THE HEALTH TASK FORCE, LEADERSHIP CONFERENCE ON CIVIL RIGHTS

Mr. MITCHELL. Thank you, Mr. Chairman.

I want to say that, as always, we are very happy to come before you and those of your colleagues who share your views, because you have worked so long and hard to get these laws passed, and are unlike some who, after they get them passed, forget about the laws, you have continued your oversight and I must say it is a very important thing to do.

In the Leadership Conference, we are fortunate in having a large number of experts in various fields. We, therefore, divide our organization into various task forces, some of which work on legislation and others of which work on oversight legislation. The distinguished lady who is with me today is the chairperson of our Health Task Force and I would not want to take up the time of the committee in any way, attempting to analyze her testimony because it is most impressive. At this point, I would yield to her to make her statement.

Mr. EDWARDS. Thank you.

Ms. Rose, you may proceed.

Ms. ROSE. Thank you, gentlemen.

Gentlemen, I thank you for the opportunity to testify before this committee today. Although I have headed the Health Task Force for the Leadership Conference for a relatively short period of time, since January of this year, my background and concern in this area commenced on a professional basis in the summer of 1966; for almost 6 of the years since that time I have been employed as an attorney engaged in the field. From August 1966, until March 1968, I was the health civil rights attorney for the U.S. Department of Health, Education, and Welfare. Much of the knowledge I have stems from that experience, being deeply involved in the governmental effort to desegregate the southern hospitals in the early days of medicare. From October 1969 to date, I have been a senior attorney with the national health law program, the OEO funded backup center for legal service in the health area. My area of expertise, and the litigation in which I have been engaged with local legal service attorneys across the country, has been the denial to the poor and minorities of access into a health system which has been built by and is currently funded with an enormous amount of Federal dollars. In context of the latter experience I have learned both the interrelationship between poverty and lack of health care for minorities, and conversely, how too often that that has been an excuse; that is, that a significant portion of minority population is covered by medicare, medicaid, Blue Cross and private insurance, just as with white Americans, but the system is organized so as to deny them access except into the overcrowded, underequipped, and underfinanced public hospitals of this country.

The Leadership Conference is highly concerned with the fact that 20 years after the Supreme Court rejected a dual school system in Brown, 10 years after the court of appeals for the fourth circuit rejected a dual hospital system in private hospitals constructed with

public funds under the Hill-Burton Act—that is the *Simkins* v. *Moses Cone Memorial Hospital*, 323 F2d 959—and 9 years after that *Simkins* decision led not only to the repeal of the separate but equal clause in Hill-Burton by Congress but also helped birth title VI on the Senate floor, we still have a very separate and unequal hospital and health system. What is equally tragic is the fact that Government officials, charged with the responsibility to assure that minorities are not denied access into health programs funded with the Federal dollar, have abdicated their role. This abdication has come in two ways;

First: Officials of the Office for Civil Rights, presumably with the acquiescence of their superiors in the Department of Health, Education, and Welfare, have been guilty of nonenforcement, hiding behind incorrect legal premises, nonaffirmative and woefully unimaginative approaches to problems, refusals to proceed promptly against institutions and State agencies which discriminate, and unacceptable excuses of inadequate funds.

Second: Officials of the Department of Health, Education, and Welfare have continued to operate programs which continue to pour huge amounts of money into facilities which continue policies and practices which exclude minorities.

I shall direct my statement to both matters.

The nonenforcement of title VI by the Office for Civil Rights:

As a major factor in this nonenforcement stems from incorrect legal premises, and this committee directed several highly relevant questions to the GAO investigators at the hearing on September 12, and received inadequate answers; I shall direct my attention first to the issue of the legal scope of title VI.

Title VI of the Civil Rights Act of 1964 provides:

> No person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

There is nothing on the face of this provision which restricts its applicability to acts of overt discrimination. To the extent that the Office for Civil Rights asserts that it is limited to correcting acts of overt discrimination, there is reflected a total misunderstanding and misstatement of the law as it has developed in the courts under the 5th and 14th amendments as well as title VI. Policies, practices, customs, and methods of operation and delivery of services which have the effect of denying access to a group can be and are as discriminatory as the sign on the entrance door.

The courts have long since recognized that Government must be cognizant of realities and of the present effect of past, purposeful discrimination upon the delivery of public benefits. To ignore these realities and to perpetuate the effect in the present of past discrimination runs afoul of the constitutional obligations of governmental officials. Thus, for example, the court of appeals for the fifth circuit has found that disparities in municipal services between white and black sections of town, whatever the intention of public officials, violates the equal protection clause; that case is, *Hawkins* v. *Town of Shaw*, 437 F. 2d 1286 (C.A. 5, 1971), en banc aff'd 461 F. 2d 1171 (1971). That case relied heavily upon a decision by the court of appeals for the second

circuit which reversed the lower court dismissal of a challenge to the discriminatory effect of a relocation plan, that case is *Norwalk CORE* v. *Norwalk Redevelopment Agency*, 396 F. 2d 920 (C.A., 1968). In Norwalk CORE the court stated:

> Equal protection of the laws means more than merely the absence of governmental action designed to discriminate; . . . . we now firmly recognize that the arbitrary quality of thoughtlessness can be as disastrous and unfair to private rights and the public interest as the perversity of a willful scheme.

The court then went on to recognize realities in the housing market thus:

> Where the relocation standard set by Congress is met for those who have access to any housing in the community which they can afford, but not for those who, by reason of their race, are denied free access to housing they can afford and must pay more for what they can get, the state action affirms the discrimination in the housing market. This is not "equal protection of the law."

In *Griggs* v. *Duke Power*, 401 U.S. 424 (1971) the Supreme Court, recognizing that past discrimination in education means that blacks will less likely have high school diplomas and will score lower on general examinations, found that such requirements have a discriminatory effect and—where not job related—violates title VI of the Civil Rights Act.

Thus, it is peculiarly obtuse to argue, as does the Office for Civil Rights, that a hospital has not violated its obligation to afford publicly funded benefits to persons without racial discrimination because the hospital limits access to patients of private staff physicians and these staff physicians only treat whites. Whether we are focusing upon nonprofit hospitals, in which physicians are granted staff privileges, or proprietary hospitals, which may operate similarly or which may be owned in fact by the staff physician, there can be no legal justification for such an excuse.

First, no institution can pass its legal responsibilities to another party, and then disclaim responsibility for that party's actions. The privilege accorded a physician to admit his patients to a hospital is a privilege. Hospitals revoke staff privileges for all kinds of reasons, and impose duties upon physicians in exchange for staff privileges. At teaching hospitals, for example, so many hours a month are usually required to be given free by the physician for training interns and residents and for treating indigent patients as part of that training program. An individual physician or all physicians on the staff should not be permitted to impose their personal prejudices or preferences upon the institution so as to deny benefits, public programs, and of access to minority persons.

Further if its staff has only white patients, whether intentionally or not, a hospital participating in public programs must be obligated to consider alternative mechanisms for access to the facility for minorities. For example, historically innercity hospitals did have outpatient clinics. A hospital located in an innercity ghetto, but with a virtually all-white patient load, by establishing or reestablishing outpatient clinic services, can serve its immediate community and change its all white character.

In *Hawkins* v. *Town of Shaw*, the fifth circuit required the town to come up with an affirmitive plan to correct the inequality in municipal

sevices existing between the white and black sections of town. That concept of affirmative action was not new in civil rights cases. Several years ago the courts began requiring affirmative plans for desegregating the dual school system, and that such plans be meaningful and produce results. As stated by the full fifth circuit, "The only school desegregation plan that meets constitutional standards is one that works." *U.S.* v. *Jefferson County Board of Education*, 372 F. 2d 836, 847, aff'd en banc 380 F. 2d 385 (C.A. 5, 1967).

This concept of affirmative action is really not foreign to the obligations imposed upon the hospital and nursing home system, at least in theory. The HEW guidelines for health facilities, first promulgated in 1965, have long recognized a need for affirmative action to correct policies, and practices which have the effect of denying access. In this regard, guideline 1 for both hospitals and nursing homes requires:

> . . . The hospital ensures that staff physicians do not consider race, color, or national origin as a factor in selecting hospitals for their patients. Where there is significant variation between the racial composition of the patient census and available population census data for the service area or potential service area, the hospital has a responsibility to determine the reason for such variation and to take whatever action may be necessary to correct any discrimination.

HEW has never followed through with a legal test of that guideline, and the obligations which it imposes. Before giving the details of a current case where the issue has been raised, let me give some history on the subject.

In 1966, the office of equal health opportunity, which was part of the public health service, did commence a legal test of the issue. Data was obtained from all the medicare participating hospitals in several cities to show staff physicians at each hospital and their admissions to the hospitals by race for a given period of time. Out of the several cities where such investigation was being conducted—Mobile, Ala.; New Orleans, La.; Altanta, Ga.; Chicago, Ill.; Detroit, Mich.; Memphis, Tenn.—the investigation went the furthest and was the most complete in Mobile. In fact, a notice of noncompliance with title VI was served upon the 500-bed Mobile Infirmary. Details of the facts and the positions of the different staff persons within HEW are fairly accurately summarized in an article on title VI enforcement appearing in the September 1968 issue of the George Washington Law Review—to which Mr. Parker referred at the hearing on September 12.

The facts may be summarized thus: The city of Mobile, Ala., is approximately 30 percent black—and I think it is actually 35 percent; Mobile Infirmary, which is a Hill-Burton constructed black hospital and, incidentally, has received either the highest or the second highest total of Hill-Burton grant moneys in the State of Alabama—four or five grants totaling several million dollars—served approximately 70 percent of the white patient load in the city at that time; Mobile Infirmary did not admit any black patients until the summer of 1965—at the time the case was dropped by orders of Department officials its black patient census was only 3 percent of its total patient load; it refused to abide by guideline 1 with respect to imposing affirmative duties upon its staff; a significant number of its physicians had dual staff privileges at all the hospitals in the city; the rates charged at the hospitals were comparable; and there were not transportation diffi-

culties in relationship to both the location of both the black population and the location of the hospitals, incidentally, most of which were located within walking distance of each other.

What is the current picture in Mobile? It appears pretty much the same as it did in the summer of 1967 when the case was dropped. According to the records of the Office for Civil Rights, from a 1-day patient census it took in 1969, the Mobile hospitals, all of which participate in medicare, had the following patient census:

For the hospitals, Doctors Hospital, which was a proprietary hospital that did not come into the medicare program until after the Mobile Infirmary was cleared for medicare, in 1969, of its 106 total patients, they only had 2 black patients that day;

Mobile Infirmary. Of their 576 total patients, they had only 35; Martin de Porres, of their total 43 patients, all 43 patients were black; of Mobile General, of their 188 total patients—and these aren't the public cases—104 were black patients; of Providence's 233 total patients, 70 were black.

Mr. EDWARDS. Why was the case dropped by HEW?

Ms. ROSE. Well, I think the article in the George Washington Law Review maybe got into it. It is really difficult for me to say. I was on a middle level in the bureaucracy and the attorney on the case. There was a difference of opinion, I think, higher up in the bureaucracy whether or not guideline 1 should be enforced. There was an enormous campaign, that is, pressure by the local medical society every day from January through June of 1967. There were newspaper ads taken out in all of the Mobile papers, and constant copies of the newspapers were sent to the Alabama Delegation Congress. Senator Hill, of course, was a very prominent member of the Alabama delegation and the decision was made far above me that the case should be dropped.

Mr. EDWARDS. Thank you.

Ms. ROSE. In 1971, HEW obtained a 1-day census report from those hospitals which it found had "questionable" statistics. Of the Mobile hospitals they gathered the following information:

Doctors Hospital, of their 116 total patients, only six were black; Mobile Infirmary Hospital, of 623 patients, 34 were black; Mobile General, of their 243 patients, 143 were black.

Doctor's Hospital and Mobile Infirmary together serve some 60 percent of the hospital population in a city 30 percent black, but only 5 percent of the combined hospital population at these hospitals was black for these two 1-day census. It should be noted that all persons at all the hospitals were admitted by staff physicians; this is not the case of persons not having a staff physician.

Nothing has been done to date in Mobile, nor in any other city in the country where similar disparate patterns of service exist. The Mobile case is not a typical.

In July 1970 eight poor black women, at least six of whom have at all times since the commencement of the suit been beneficiaries of the medicaid program, brought a class action against all the Hill-Burton constructed hospitals in metropolitan New Orleans, charging those hospitals with violating their obligations under Hill-Burton to provide a reasonabe volume of services to persons unable to pay, and to serve

all persons in the territorial area, and with violating their obligations under title VI of the Civil Rights Act and the 14th amendment by denying access to persons on the basis of race. That case is *Cook et al.* v. *Ochsner Foundation Hospital et al.*, Civ. Act. No. 70–1969, E.D. La., 1970.

Subsequently HEW and two non-Hill-Burton hospitals were named as defendants in the civil rights aspect of the case. All the hospitals participate in medicare, but not in medicaid. HEW was named as a defendant in May 1971, but 2 months previous to that time, I, as one of the attorneys for plaintiffs, sent a letter to the regional office of the OCR, giving the information which had been gathered from answers to interrogatories, which clearly demonstrated the disparate patient census of most of the New Orleans hospitals.

I won't go into the statistics themselves, but they show that kind of strong pattern with the exception of one or two hospitals. The exhibits were given and attached to the statement and they should also be put into the record.

Mr. EDWARDS. Thank you. They will be included at this point.

[The statistics referred to follows:]

STATEMENT OF THE HEALTH TASK FORCE, LEADERSHIP CONFERENCE ON CIVIL RIGHTS—CLARENCE MITCHELL, LEGISLATIVE CHAIRMAN MARILYN G. ROSE, CHAIRPERSON, HEALTH TASK FORCE

THE FAILURE OF THE U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE TO ENFORCE TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WITH RESPECT TO HEALTH FACILITIES

Gentlemen, I thank you for the opportunity to testify before this Committee today. Although I have headed the Health Task Force for the Leadership Conference for a relatively short period of time, since January of this year, my background and concern in this area commenced on a professional basis in the summer of 1966; for almost six of the years since that time I have been employed as an attorney engaged in the field. From August 1966 until March 1968, I was the health civil rights attorney for the U.S. Department of Health, Education, and Welfare. Much of the knowledge I have stems from that experience, being deeply involved in the Governmental effort to desegregate the Southern hospitals in the early days of Medicare. From October 1969 to date, I have been a senior attorney with the National Health Law Program, the O.E.O. funded back-up Center for legal service in the health area. My area of expertise, and the litigation in which I have been engaged with local legal service attorneys across the country, has been the denial to the poor and minorities of access into a health system which has been built by and is currently funded with an enormous amount of Federal dollars. In context of the latter experience I have learned both the inter-relationship between poverty and lack of health care for minorities, and conversely, how too often that that has been an excuse, i.e., that a significant portion of minority population is covered by Medicare, Medicaid, blue cross and private insurance, just as with white Americans, but the system is organized so as to deny them access except into the over-crowded, under-equipped, and under-financed public hospitals of this country.

The Leadership Conference is highly concerned with the fact that twenty years after the Supreme Court rejected a dual school system in *Brown*, ten years after the Court of Appeals for the Fourth Circuit rejected a dual hospital system in private hospitals constructed with public funds under the Hill-Burton Act (*Simkins* v. *Moses Cone Memorial Hospital*, 323 F2d 959), and nine years after that *Simkins* decision lead not only to the repeal of the "separate but equal" clause in Hill-Burton by Congress but also helped birth Title VI on the Senate floor, we still have a very separate and unequal hospital and health system. What is equally tragic is the fact that Government officials, charged with the responsibility to assure that minorities are not denied access into health programs

funded with the Federal dollar, have abdicated their role. This abdication has come in two ways:

First: Officials of the Office for Civil Rights, presumably with the acquiescence of their superiors in the Department of Health, Education, and Welfare, have been guilty of nonenforcement, hiding behind incorrect legal premises, non-affirmative and woefully unimaginative approaches to problems, refusals to proceed promptly against institutions and State agencies which discriminate, and unacceptable excuses of inadequate funds.

Second: Officials of the Department of Health, Education, and Welfare have continued to operate programs which continue to pour huge amounts of money into facilities which continue policies and practices which exclude minorities.

I shall direct my statement to both matters.

The nonenforcement of title VI by the Office for Civil Rights

As a major factor in this nonenforcement stems from incorrect legal premises, and this Committee directed several highly relevant questions to the GAO investigators at the hearing on September 12, and received inadequate answers; I shall direct my attention first to the issue of the legal scope of Title VI.

Title VI of the Civil Rights Act of 1964 provides:

"No person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

There is nothing on the face of this provision which restricts its applicability to acts of overt discrimination. To the extent that the Office for Civil Rights asserts that it is limited to correcting acts of overt discrimination, there is reflected a total misunderstanding and misstatement of the law as it has developed in the Courts under the Fifth and Fourteenth Amendments as well as Title VI. Policies, practices, customs, and methods of operation and delivery of services which have the effect of denying access to a group can be and are as discriminatory as the sign on the entrance door.

The Courts have long since recognized that Government must be cognizant of realities and of the present effect of past, purposeful discrimination upon the delivery of public benefits. To ignore these realities and to perpetuate the effect in the present of past discrimination runs afoul of the constitutional obligations of governmental officials. Thus, for example, the Court of Appeals for the Fifth Circuit has found that disparities in municipal services between white and black sections of town, whatever the intention of public officials, violates the equal protection clause. (*Hawkins* v. *Town of Shaw*, 437 F. 2d 1286 (C.A. 5, 1971), in banc aff'd 461 F. 2d 1171 (1972)). That case relied heavily upon a decision by the Court of Appeals for the Second Circuit which reversed the lower Court dismissal of a challenge to the discriminatory effect of a relocation plan. (*Norwalk CORE* v. *Norwalk Redevelopment Agency*, 395 F. 2d 920, 931 (C.A. 2, 1968)). In *Norwalk CORE* the Court stated,

"Equal protection of the laws' means more than merely the absence of governmental action designed to discriminate; . . . we now firmly recognize that the arbitrary quality of thoughtlessness can be as disastrous and unfair to private rights and the public interest as the perversity of a willful scheme."

The Court then went on to recognize realities in the housing market thus:

"Where the relocation standard set by Congress is met for those who have access to any housing in the community which they can afford, but not for those who, by reason of their race, are denied free access to housing they can afford and must pay more for what they can get, the state action affirms the discrimination in the housing market. This is not 'equal protection of the law.'"

In *Griggs* v. *Duke Power*, 401 U.S. 424 (1971) the Supreme Court, recognizing that past discrimination in education means that blacks will less likely have high school diplomas and will score lower on general examinations, found that such requirements have a discriminatory effect and (where not job related) are unlawful under Title VI of the Civil Rights Act.

Thus, it is peculiarly obtuse to argue, as does the Office for Civil Rights, that a hospital has not violated its obligations to afford publicly funded benefits to persons without racial discrimination because the hospital limits access to patients of private staff physicians and these staff physicians only treat whites. Whether we are focusing upon non-profit hospitals, in which physicians are granted staff

privileges, or proprietary hospitals, which may operate similarly or which may be owned in fact by the staff physicians, there can be no legal justification for such an excuse.

First, no institution can pass its legal responsibilities to another party, and then disclaim responsibility for that party's actions. The privilege accorded a physician to admit his patients to a hospital is a privilege. Hospitals revoke staff privileges for all kinds of reasons, and impose duties upon physicians in exchange for staff privileges. At teaching hospitals, for example, so many hours a month are usually required to be given free by the physician for training interns and residents and for treating indigent patients as part of that training program. An individual physician or all physicians on the staff should not be permitted to impose their personal prejudices or preferences upon the institution so as to deny access to minority persons.

Further if its staff has only white patients, whether intentionally or not, a hospital participating in public programs must be obligated to consider alternative mechanisms for access to the facility for minorities. For example, historically inner city hospitals did have outpatient clinics. A hospital located in an inner city ghetto, but with a virtually all white patient load, by establishing or re-establishing outpatient clinic services, can serve its immediate community and change its all white character.

In *Hawkins* v. *Town of Shaw*, the Fifth Circuit required the town to come up with an affirmative plan to correct the inequality in municipal services existing between the white and black sections of town. That concept of affirmative action was not new in civil rights cases. Several years ago the Courts began requiring affirmative plans for desegregating the dual school system, and that such plans be meaningful and produce results. As stated by the Fifth Circuit, "The only school desegregation plan that meets constitutional standards is one that works." *U.S.* v. *Jefferson County Board of Education*, 372 F.2d 836, 847, aff'd en banc 380 F. 2d 385 (C.A. 5, 1967).

This concept of affirmative action is really not foreign to the obligations imposed upon the hospital and nursing home system, at least in theory. The HEW Guidelines for health facilities, first promulgated in 1965, have long recognized a need for affirmative action to correct policies and practices which have the effect of denying access. In this regard, Guideline One for both hospitals and nursing homes requires:

" . . . The hospital ensures that staff physicians do not consider race, color, or national origin as a factor in selecting hospitals for their patients. Where there is significant variation between the racial composition of the patient census and available population census data for the service area or potential service area, *the hospital has a responsibility to determine the reason for such variation and to take whatever action may be necessary to correct any discrimination.*"

HEW has never followed through with a legal test of that Guideline, and the obligations which it imposes. Before giving a detail of a current case where the issue has been raised, let me give some history on the subject.

In 1966 the Office of Equal Health Opportunity did commence a legal test of the issue. Data was obtained from all the Medicare participating hospitals in several cities to show staff physicians at each hospital and their admissions to the hospitals by race for a given period of time. Out of the several cities where such investigation was being conducted (Mobile, Alabama; New Orleans, Louisiana; Atlanta, Georgia; Chicago, Illinois; Detroit, Michigan; Memphis, Tennessee), the investigation went the furthest and was the most complete in Mobile. In fact a Notice of Noncompliance with Title VI was served upon Mobile Infirmary. Details of the facts and the positions of the different staff persons within HEW are fairly accurately summarized in an article on Title VI enforcement appearing in the September 1968 issue of the George Washington Law Review (to which Mr. Parker referred at the hearing on September 12.)

The facts may be summarized thus: the city is approximately 30% black; Mobile Infirmary (a Hill-Burton constructed hospital) served approximately 70% of the white patient load in the city at that time; Mobile Infirmary did not admit any black patients until the summer of 1965; at the time the case was dropped by orders of Department officials its black patient census was only 3% of its total patient load; it refused to abide by guideline one with respect to imposing

affirmative duties upon its staff privileges; a significant number of its physicians had dual staff privileges at all the hospitals in the city; the rates were comparable; and there were not transportation difficulties.

What is the current picture in Mobile? It appears pretty much the same as it did in the summer of 1967 when the case was dropped. According to the records of the Office for Civil Rights, from a one day patient census it took in 1969, the Mobile hospitals, all of which participate in Medicare, had the following patient census:

	Total patients	Black patients
Hospital:		
Doctors Hospital [1]	106	2
Mobile Infirmary	576	35
Martin de Porres	43	43
Mobile General	188	104
Providence	233	70

[1] Doctors Hospital, which also had been historically, lily-white, applied for medicare participation and was permitted to participate after the Mobile Infirmary case was dropped.

In 1971 HEW obtained a one day census report from those hospitals which it found had "questionable" statistics. Of the Mobile hospitals they gathered the following information:

	Total patients	Black patients
Hospitals:		
Doctors Hospital	116	6
Mobile Infirmary Hospital	623	34
Mobile General	243	143

Doctor's Hospital and Mobile Infirmary together serve some 60% of the hospital population in a city 30% black, but only 5% of the combined hospital population at these hospitals was black for these one day census. It should be noted that all persons were admitted by staff physicians; this is not the case of persons not having a staff physician.

Nothing has been done to date in Mobile, nor in any other City in the country where similar disparate patterns of service exist. The Mobile case is not atypical.

In July 1970 eight poor black women, at least six of whom have at all times since the commencement of the suit been beneficiaries of the Medicaid program, brought a class action against all the Hill-Burton constructed hospitals in metropolitan New Orleans, charging those hospitals with violating their obligations under Hill-Burton to provide a reasonable volume of services to persons unable to pay, and to serve all persons in the territorial area, and with violating their obligations under Title VI of the Civil Rights Act and the Fourteenth Amendment by denying access to persons on the basis of race (*Cook et al.* vs. *Ochsner Foundation Hospital et al.*, Civ. Act. No. 70–1969, E.D. La., 1970). Subsequently HEW and two non-Hill-Burton hospitals were named as Defendants in the civil rights aspect of the case. All the hospitals participate in Medicare, but not in Medicaid. HEW was named as a Defendant in May 1971, but two months previous to that time, I, as one of the attorneys for Plaintiffs, sent a letter to the Regional office of OCR, giving the information which had been gathered from answers to interrogatories, which clearly demonstrated the disparate patient census of most of the New Orleans hospitals. (A copy of that letter is attached hereto). To date HEW has done nothing about this picture, and we can expect no action until the day a Court orders them to enforce Title VI. (Concentration of the parties and the Court on the Hill-Burton aspects of the case has put the civil rights aspects on a back-burner until recently.)

The 1970-census from Orleans and Jefferson Parishes indicates the following population figures:

Orleans Parish: White, 319,428; black, 264,930 (45 percent black). Jefferson Parish: White, 291,987; black, 41,435 (12.5 percent black).

For the three year period covered by the Answers to Interrogatories the figures with respect to service to black patients were horrendous for several of the hospitals, and most especially for some in the inner City. Hotel Dieu, located in the heart of the inner City in a census tract over 80% black, a few blocks from Charity Hospital which has a 75% black patient load, has continually had less than 3% of its patients black. Not too far away Southern Baptist Hospital, on the border of two census tracts, one of which was 76% black and the other 87% black, has a patient census which is less than 1% black. Indeed the admission of Southern Baptist into the Medicare program in October 1969 is particularly aggregious from a civil rights standpoint. That 500 bed hospital serves some 18,000 to 20,000 patients a year. At the time (in October 1969) that it was permitted to sign a provider contract in the Medicare program, the records of the Office for Civil Rights indicated that it had served only 13 black patients during the previous nine months. In its answers to interrogatories served by Plaintiffs it states, with respect to the imposition of standards of performance required by the Office for Civil Rights:

"Southern Baptist Hospital qualified as a provider of Medicare services without strict compliance with each of the HEW guidelines. Principally Southern Baptist Hospital took exception to recruiting patients and physicians to achieve a racial balance. . . .

"Southern Baptist was not required by HEW to send letters to Negro physicians, or Negro Physician organizations and civil rights leaders."

Southern Baptist is located but a few blocks from Flint-Goodridge which has an all-black patient load. The staff list at Flint-Goodridge is curious. There is an enormous number of physicians with "courtesy staff privileges", which entitles them to place up to 20 patients a year in that hospital. Thus, the white physician, with a few black patients, can place his white patients in a Southern Baptist or at Hotel Dieu and his black patients in Flint-Goodridge, and never the twain shall meet.

The Office for Civil Rights has totally ignored the legal obligations that all these hospitals have assumed when they elected to participate in the Medicare program. Part of it stems from the obtuse legal reasoning which ignores the teaching of the Courts on the extent of discrimination and the affirmative action duties which follow. Part of it stems from unimaginative approaches to problems. Two-thirds of the non-profit general hospitals in the United States have been built under the Hill-Burton Act (some 2267 of the 3600). They are obligated under that Act to afford a reasonable volume of service to persons unable to pay and to be available to all persons in the territorial area of the facility. Considering the historic emergence of the "territorial service" commitment out of its "separate but equal past" before the *Simkins* decision and the subsequent amendment by Congress, it would appear that HEW (Collectively, including its component parts of the Health Care Facilities Service and the Office for Civil Rights) has an obligation, affirmatively, to assure that these obligations are being fulfilled. However, not until the Eastern District of Louisiana in May of this year in the *Cook* case found that HEW was violating its obligations to enforce the "interritorial service" commitment in acquiescing in the refusal of Hill-Burton hospitals to serve Medicaid beneficiaries, has HEW taken this matter seriously but we still are awaiting HEW action on the matter. To the extent that OCR is correct that poverty results in minority persons going to public hospitals rather than private hospitals, the refusal by private hospitals to participate in Medicaid, the health program for welfare recipients, excludes the paid-for poor. In Orleans and Jefferson Parishes, some 90% of the persons on the Aid to Dependent Children Program are black.

Thus, to refuse to participate in Medicaid (while participating in other Federal programs) has the effect of denying Federal benefits to black people by a a recipient of Federal financial assistance.

With respect to contentions of lack of private physicians for the poor and minorities, if physicians are not available in ghetto communities, or are only available in limited number to treat poor and minority persons within their territorial areas, aside from hospitals imposing the duties to serve these persons as a condition of staff privileges, there are other alternatives. These include: recruiting physicians who do serve the minority populations; hiring physicians to serve the poor and minorities; affiliation with outpatient clinics, both of the over-

crowded public hospitals and the free standing government funded ones under various HEW and OEO programs. In both Lee County, Arkansas, and Imperial Valley, California, in 1970, local Hill-Burton constructed hospitals refused staff privileges to physicians at Clinics, funded respectively by OEO and HEW, until litigation or the imminent threat of litigation resulted in reversal. In Lee County the denial of staff privileges to the Clinic physician meant that poor blacks were denied admission to a Hill-Burton hospital; in Imperial Valley it meant that poor Chicanos were denied admission. In both situations it was not HEW which brought or threatened litigation; it was legal service and civil rights attorneys.

But the non-enforcement failures of the Office of Civil Rights is not limited to its narrow perspective of legal obligations and its unimaginative approach to problems. It has failed to demonstrate any movement even where clear, overt discrimination exists. In 1969 OCR sent a questionnaire out to all hospitals, requesting certain patient data for one day. Both admission practices and room assignments were matters upon which the questionnaire ostensibly focused. In 1971 OCR sent out another questionnaire, this time to hospitals which were among the "200" hold-outs and/or had notice of noncompliance in 1966–67. Although the reports are replete with questionable practices, OCR has not taken any action against any of them.

Among the hospitals, for example, was Greenwood Le Flore, in Greenwood, Mississippi, which was one of the first hospitals listed in noncompliance on the Interagency Report in 1966. It is the only hospital in a county with a majority black population according to the 1970 census (17,500 white and 24,374 black). Its patient census for one day in 1969 showed 192 total patients, only 48 of whom were black and none of whom occupied a multi-racial room. Its 1971 census showed 185 patients, only 70 of whom were black; its room assignment information was incomplete. Nothing, or at least nothing effective, was done in the 1969–1971 period, nor is there any indication of any action since 1971.

Another example is Bryan Whitfield, in Demopolis, Alabama. It is the only hospital in a County which is majority black (10,640 white persons and 13,157 black persons). Its 1969 patient census showed 50 white patients and 26 black patients; 4 of the black patients were in single rooms and 36 in rooms with other blacks. In 1971 it did not give the total number of patients, only that there were 2 black patients in single rooms and 36 in rooms with other blacks. Again none were in rooms with whites. In November 1966 when I visited this hospital, the facility was totally segregated, with the newer wing with all private rooms and only white patients, and the older, more cramped wing with multiple beds and all black patients. I suspect that this was the picture in 1969 and 1971, but the hospital was during these later periods allowed to participate in Medicare and nothing seems to have been done about its internal segregation. How overt must segregation be to precipitate action by OCR?

Indeed, it is questionable just what the Office for Civil Rights has done in the health and welfare area during the last few years. In late 1967 these branches were combined and the efforts were directed into the activity described as the State Agency review. As documented by the GAO investigators, this has been the principle activity of the Office, but the results are highly questionable. Just why did it take until August 1971 (after the Judiciary Committee requested GAO to make this study) for OCR to be then negotiating agreements with the Alabama and Georgia Departments of Health to make Title VI reviews? What credibility can such an agreement have in Alabama, where the Justice Department has entered an appearance as *amicus*, supporting plaintiffs, against the Alabama Welfare agency and its maintenance of segregated services for beneficiaries? (*Player et al.* vs. *State of Alabama Department of Pensions and Securities et al.*, Civ. Act. No. 3835–N, M.D. Ala.)

Although the Office for Civil Rights has alluded, both to the GAO investigators and to members of the Health Task Force and the American Public Health Association, that various actions have been brought or are pending, close examination reveals that OCR has entered cases after they have been brought by private parties, represented by civil rights, legal service, or public interest attorneys. The Connecticut matter was precipitated by the Puerto Rican League Defense Fund. Over two years ago Public Advocates, a public interest law firm, brought an action against the California Welfare Agency as well as HEW for non-enforcement of Title VI. Precipitated by this action, OCR apparently investigated the cause of the complaint, discrimination practiced by the Sonoma County Depart-

ment of Social Service. This investigation occurred in September 1971; in June 1972 a letter of noncompliance was sent to the County office. (A copy of that letter is attached hereto.) To date no action has occurred to enforce Title VI or to cut the County off from Federal funds. As noted by the U.S. District Court for the District of Columbia, and affirmed by the Court of Appeals, in the case of non-enforcement of Title VI in education facilities by the Office for Civil Rights, there is a reasonable time limit to seeking voluntary compliance. A consistent failure to act constitutes a violation of the Agency's duty to enforce the law. (*Adams* v. *Richardson*, CADC June 12, 1973, No. 73–1273).

The continued funding of programs which have a discriminating effect

Ironically, the Office for Civil Rights can go no further than its sister agencies if it wants to find practices and policies which accept discriminatory and segregated systems. I shall only briefly allude to these practices. The Hill-Burton program is one with which I am familiar, largely because of the *Cook* case and its six companion cases across the country which finally forced HEW to recognize that it had some obligations to enforce the commitments of Hill-Burton hospitals to afford a reasonable volume of services to persons unable to pay and to be accessible to all persons in the territorial area of the facility. In response to interrogatories in the *Cook* case on the civil rights aspects, HEW identified areas where all private room facilities had been approved for Hill-Burton funds, the vast number of these in the South. In response to a more specific letter, the facilities were identified, and a check of these facilities with the Hill-Burton project register indicates that these facilities received the grants after Title VI was promulgated. I have attached copies of the answer to interrogatories and the letter. Although HEW takes the position that the all private room hospital is more efficient (which is a matter in dispute with health experts) how come the incidence of constructing such facilities is largely confined to the region of the country where segregated facilities were openly and actively maintained until the pressure of Title VI upon a desire to participate in the Medicare program began to be felt? What effect does this practice have upon room rates (noting that Medicare pays for semi-private rooms), and what effect does increased room rates have upon persons with low incomes, a class in which minority persons are disproportionately highly represented?

In many areas we have witnessed the flight of the hospital into the suburbs from the inner city, funded with Hill-Burton moneys under the modernization guise. If a service area is large enough, the "need" in the ghetto portion permits the far reaches of the area to obtain a facility which the ghetto residents shall never use. This is what occurred in Chicago, where two hospitals fled the inner city, to the white suburbs located at the other end of a pie shaped service area.

In 1970 Congress, recognizing the problem of lack of private physicians in urban and rural poverty areas, amended the Hill-Burton Act to give a priority for construction of outpatient facilities in such areas and to permit free-standing facilities to apply for such construction moneys. This amendment has been ignored in a substantial number of States, where the vast portion of the moneys has been awarded to hospitals not located in poverty areas and/or not serving the poor. HEW has approved such awards.

One would have hoped by 1973 that OCR would have reached the level of sophistication to analyze the operation of HEW health programs and see how these programs encouraged and aided the perpetuation of the dual, and unequal health system. The failure to proceed beyond the concept that only overt discrimination was involved doomed any such hope or expectation. It is ironic that the grand platitudes of the Department recognize the realities which the operatives in the Department ignore. We all have heard the statistics and studies which demonstrate the greater health hazards of being non-white in this society. Let me close with a quote from the HEW White Paper of 1971 in this regard:

"On nearly every index that we have, the poor and the racial minorities fare worse than their opposites. Their lives are shorter; they have more chronic and debilitating illnesses; their infant and maternal death rates are higher; their protection, through immunization, against infectious diseases, is far lower. They also have far less access to health services—and this is particularly true of poor and non-white children, millions of whom receive little or no dental or pediatric care." *Towards a Comprehensive Health Policy for the 1970's: A White Paper*, U.S. Department of Health Education and Welfare, May 1971, p. 2.

APPENDIX

1. Rose Letter to Flemming
2. Brown letter to Sonoma County
3. Excerpt from Interrogatories—*Cook* v. *Ochsner*
4. Granning letter to Rose

405 HILGARD AVENUE,
Los Angeles Calif., March 12, 1971.

Mr. BILL FLEMMING,
Office of Civil Rights, U.S. Department of HEW,
Adolphus Tower Building, Dallas, Tex.

DEAR BILL: As I promised on an earlier occasion, when I received further information concerning the admissions' practices by race of the Defendant Hospitals in my New Orleans case, I would send you the figures. In Answers to Interrogatories, the following responses have been received to date:

(1) HOTEL DIEU

	White	Negro	Yellow
Inpatients by race in prior 3 years:			
1969	8,178	225	17
1968	9,067	217	5
1967	9,346	190	23
6-1970	790	24	2

(2) OCHSNER FOUNDATION HOSPITAL

	White	Negro
Inpatients by race in prior 3 years:		
1969	11,601	426
1968	11,408	431
1967	11,472	379

(3) FLINT-GOODRIDGE [1]

	Inpatient	Outpatient	Emergency room
Year:			
1969	3,599	8,993	2,732
1968	3,718	9,615	2,292
1967	3,983	9,580	2,107
6-1970	1,446		

[1] States that it does not keep statistics by race, but believes 99 percent of its patients black.

(4) TOURO INFIRMARY

	Inpatient	Outpatient [1]	Emergency room
1968:			
White	16,450	2,534	15,873
Nonwhite	2,638	2,796	3,601
1969:			
White	16,298	2,338	14,827
Nonwhite	3,262	2,578	5,050
1970 (through July):			
White	11,346	1,222	8,587
Nonwhite	2,338	1,347	2,798

[1] Outpatient figures were based on percentages applied from previous studies according to Touro, and not actual records.

	Emergency room	Nonemergency room
1970:		
Inpatient services:		
White	343	1,081
Nonwhite	89	303
Outpatient:		
White	919	1,54
Nonwhite	409	1,53

(5) SARA MAYO

	1967	1968	1969
Number of patients:			
White	2,492	2,386	2,212
Nonwhite	2,652	2,411	2,027
Emergency room:			
White	877	1,055	879
Nonwhite	757	1,003	908

June 1970: Inpatients—159 white; 238 Negro.

(6) METHODIST HOSPITAL

	White	Negro
Inpatients served annually by race:		
September 1968 to December 1968	636	80
January 1969 to December 1969	4,750	665
January 1970 to Sept. 10, 1970	4,553	505
Emergency room patients by race:		
September 1968 to December 1968	715	103
January 1969 to December 1969	5,312	422
January 1970 to Sept. 10, 1970	4,728	329

(7) MERCY HOSPITAL

Inpatients:	
1969:	
White	10,148
Black	214
Other	6
1968:	
White	10,097
Black	118
Other	11
1967:	
White	10,967
Black	77
Other	0
June 1970:	
White	941
Black	18

(8) WEST JEFFERSON

1969:	
White	11,032
Black	886
1968:	
White	11,748
Black	868
1967:	
White	9,828
Black	630
June 1970:	
White	1,181
Black	112

(9) CHARITY HOSPITAL

July 1, 1969 through June 30, 1970:	
White	10,375
Black	33,937
July to December 1969:	
White	5,191
Black	17,922
January to June 1970:	
White	5,184
Black	16,015
June 1970:	
White	742
Black	2,506

The only major hospital in New Orelans not named originally as a Defendant was Southern Baptist. We have now moved to amend the Complaint to add Southern Baptist as a Defendant with respect to the civil rights allegations. Accordingly to the listings in the Journal of the American Hospital Association, published in 1970, Southern Baptist had a total of 18,849 inpatient admissions in 1969. I understand that for the first nine months of 1969, its Negro admissions were only 13.

The 1970 census indicates the following population figures:

Orleans Parish: White, 319,428; black, 264,930 (45 percent black); Jefferson Parish: White, 291,987; black, 41,435 (12.5 percent black).

Thus, with 45 percent of Orleans Parish and 12.5 percent of Jefferson Parish being black, the patient loads of the Defendant Hospitals (which comprise virtually all the beds in the Metropolitan area now that Southern Baptist has been added to the Complaint) the percentage of blacks in these hospitals by their own answers were:

	Percent black
Hotel Dieu	2.6
Ochsner	3.5
Flint-Goodridge	99
Touro Infirmary	16.7
Sara Mayo	45
Methodist	12
Mercy	2
West Jefferson	7.4
Charity	[1] 75
Southern Baptist	[2] Less than 0.1

[1] Although the figures we received were for a fiscal year, the 75-percent figure has been consistent since the advent of medicare I understand (when white medicare patients who used to be treated at Charity started to go to the private hospitals).

[2] I extrapolated the 13 black patients for 9 months to 17 for a year to arrive at this figure.

Sincerely yours

MARILYN G. ROSE.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
760 MARKET STREET,
San Francisco, Calif., June 16, 1972.

Mr. PAUL M. ALLEN,
Director, Sonoma County Department of Social Service, 2555 Mendocino Avenue, Santa Rosa, Calif.

DEAR MR. ALLEN: Let me express my appreciation for the courtesy and cooperation extended by the Department's personnel during our onsite review of the Department's operation and during subsequent discussions relating to the release of computer stored data.

As you are aware, the purpose of our reviews was to assess the current compliance of the Sonoma County Department of Social Service with title VI of the Civil Rights Act of 1964. This letter sets forth a summary of our findings and conclusions.

Title VI and the departmental regulation, 45 CFR part 80 (a copy of which has been provided to you), prohibits discrimination on the grounds of race, color, or national origin by recipients of Federal financial assistance.

The regulation provides that no person shall, on account of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to the provision of services in a discriminatory manner in the operation of any federally assisted program. More specifically, the regulation prohibits the operation of any such program in a manner which has "the effect of subjecting individuals to discrimination because of their race, color or national origin or [has] the effect of defeating or substantially impairing accomplishment of the objectives of the program as respect[s] individuals of a particular race, color or national origin. This Office has reviewed a substantial amount of data related to the current operations of your Department. During our onsite visits to the county during August and September 1971, members of the review team inter-

viewed several members of the Department's staff as well as clients of the Department and other interested members of the community.

In addition, the Office has reviewed data files of the Department stored with Alpha Beta Associates, questionnaires completed by nearly all of the Department's current staff, and preliminary Fourth Count Census Data relating to the language characteristics of the Spanish-surnamed population of the county and the racial and ethnic characteristics of the poverty population of the county on a county-wide basis (rather than by consus tract).

On the basis of this information, we have concluded that the Sonoma County Social Services Department is in probable noncompliance with title VI of the Civil Rights Act in that Spanish-surnamed potential and enrolled clients are frequently excluded from receiving public assistance benefits or receive inferior treatment and services not because of a lack of eligibility or legal entitlement to benefits, but solely because of their Spanish language and culture, their limited knowledge of the English language, and the county department's failure to take account of these characteristics.

With regard to the exclusion of Spanish-surnamed potential clients from receiving public assistance benefits, preliminary Fourth Count Census data reveals that based on the efficiency of the Department in enrolling non-Spanish surnamed potential clients, at least 800–950 Spanish-surnamed clients have been excluded. While Spanish-surnamed persons and families constitute 11 percent of the county's population below "75 percent Poverty Level",[1] 11–12 percent of the county's population below "Poverty Level," and 12–13 percent of the county's population below "125 percent Poverty Level," Spanish-surnamed cases constituted only 5 percent (an estimated 608) of the public assistance caseload (12,342) and 6 percent (129) of the Social Service caseload (2,024) as of January 31, 1972.

Using the efficiency of the Department in enrolling non-Spanish surnamed public assistance clients below "Poverty Level" as a base, approximately 41 percent of the Spanish-surnamed public assistance clients which this efficiency level would indicate should be enrolled are, in fact, enrolled. With regard to the population below "125 percent of Poverty Level," this percentage drops to approximately 30 percent. From our analysis of the data collected, we have concluded that the present operation of the Department has the effect of substantially impairing the accomplishment of the objectives of the program with respect to Spanish-surnamed individuals.

The barriers presented to Spanish-speaking applicants for welfare benefits are highlighted by the poor utilization of Spanish-speaking employees. During an on-site visit to the Department, a total of 7 employees were identified as Spanish-speaking. Of the 7 employees so identified, 3 were assigned in some capacity to the eligibility caseload, and 4 were assigned to the social service caseload. Of the 3 persons assigned to the eligibility caseload, one served as an eligibility supervisor, one as an intake worker, and one as a case aide. Of the 4 persons assigned to the social service caseload, one served as a social service supervisor, one as a social service caseworker, one as a foster home licensing worker, and one as a case aide. Questionnaires were completed by each of these persons and the data was incorporated in the estimate of current client service capability.

We have been informally notified that 4 more Spanish-speaking persons have been employed, that one of those previously identified—a social service case aide—has left the Department, and that one—an eligibility supervisor—appears to have been assigned to other duties. Of the 4 newly hired Spanish-speaking employees, only 3 are professionals and only one has been assigned to the eligibility caseload. Thus, a total of 3 Spanish-speaking employees (two professionals and one aide) are currently assigned to the eligibility caseload. According to data supplied to us on January 31, 1972, the Spanish-speaking public assistance caseload was distributed among a total of 87 eligibility workers. Data revealed that the highest caseload of any worker in terms of the number of Spanish-speaking cases was 13 (5% of the total caseload for that worker) and that in only one instance did a Spanish-speaking caseload for any worker exceed 20% of the caseload—the exception being 35.7% (or 10 cases) of a total caseload of 28. It appears, therefore, that little effort has been made to allocate currently available Spanish-

[1] Items in quotations are classifications used in preliminary 1970 Fourth Count Census data tables.

speaking staff so as to reduce as much as possible the number of Spanish-speaking public assistance cases unserved by bilingual staff. To the extent that Spanish-speaking personnel are not assigned to each identifiable unit within the Department, i.e., telephone, reception, eligibility intake, ongoing eligibility, and each of the categorical Social Service units, there is a denial of services to Spanish-speaking persons.

Our review also indicates that the current underenrollment of Spanish-surnamed clients is directly attributable to the failure of the County Department to utilize culturally and linguistically competent client contact staff to serve potential Spanish-speaking clients. Caseload data supplied by the Department indicate that as of January 31, 1972, approximately 75% of all Spanish-surnamed eligibility cases (and approximately 70% of currently served persons) are Spanish-speaking and approximately 65% of all Spanish-surnamed social service cases (approximately 67% of all currently served persons) were Spanish-speaking. Similarly, preliminary Fourth Count Census Data for the county shows that approximately 64% of all Spanish-surnamed persons in the county speak Spanish, not English, as the language of regular communication. The close correlation between census figures and the figures derived from computer printout data and questionnaires as to your eligibility caseload, cited above, leads to the conclusion that the term "Spanish-speaking" as used in this letter to refer actual or potential welfare clients means that such individuals use Spanish as their primary language of communication.

Computer printouts from Alpha Beta Associates and questionnaires from case workers reveal that of the 311 Spanish-speaking eligibility cases recorded as of January 31, 1972:

(*a*) Approximately 292 or 93% of Spanish-speaking public assistance cases were not served by a bilingual eligibility worker;

(*b*) approximately 239 or 76% were not served by a bilingual eligibility worker or Department-provided translator; and

(*c*) approximately 216 or 69% were completely unserved either by a bilingual eligibility worker, agency-provided translator, or bilingual friend or acquaintance. Based on the estimated caseload of 608, the number of Spanish-surnamed eligibility cases would be approximately 438. The percentages in paragraphs a, b, and c above, accordingly, would thereby increase to approximately 96%, 83%, and 78% respectively.

The failure to provide linguistically competent staff appears to be complete with regard to initial client contact. According to records of the Department supplied to our Office and questionnaires completed by Department staff, as of January 1, 1972, the Department employed no Spanish-speaking telephone operators or receptionists. Interviews with clients and caseworkers indicate that the absence of bilingual telephone operators has resulted in significantly greater burdens on Spanish-speaking potential clients as compared to other potential clients in terms of greater time delays, more required visits to the Department's office and, as a result, the additional burdens of child care, transportation time and expenses, and the like. Moreover, this breakdown of communication regarding general eligibility for benefits and enrollment procedures has led to a failure by Spanish-speaking clients to enroll for benefits to which they are entitled by law.

From interviews with caseworkers and clients, our Office has also determined that the non-existence of bilingual reception services results in Spanish-speaking potential clients receiving markedly different treatment than other potential clients. For instance, Spanish-speaking clients are often told to come back at another time, which imposes additional burdens of child care, transportation, and the like. Spanish-speaking clients are also told to come back with a child or neighbor who can translate, thereby deterring them from returning because of an understandable reluctance or refusal to have to disclose to children, neighbors and acquaintances private information which the Welfare Department, by its own criteria, rightfully regards as highly personal and confidential. Spanish-speaking clients are also asked to wait long periods of time in order for a translator to be located, thereby deterring enrollment or causing hardships not suffered by non-minority clients.

The lack of bilingual eligibility workers has also led to a breakdown of necessary communication with Spanish-speaking potential clients.

Interviews with caseworkers reveal that the lack of staff capability to communicate in Spanish often results in a failure to enroll Spanish-speaking clients. Data gathered during the review indicates that non-bilingual workers frequently

require potential clients to use translators from the non-professional staff of the agency who do not understand the basic eligibility requirements and, therefore, cannot adequately explain them, or children, neighbors, or bilingual persons who happen to be in the waiting room, and who neither understand the basic eligibility requirements nor, in any event, are appropriate persons to discuss or have knowledge of confidential information about potential clients.

Another area of concern which has arisen as a result of our review is the apparent unequal delivery of services to Spanish-speaking clients who have been enrolled despite whatever obstacles may have existed at the initial eligibility stage. For example, the inability of the Department to assist Spanish-speaking clients in communicating changing circumstances has apparently led to a failure by eligibility workers to make available upward adjustments or emergency financial allocations to such clients. From interviews with clients and caseworkers, the Office has also determined that unwarranted reductions of benefits and terminations of assistance have resulted from the inability of eligibility workers to communicate directly with the clients.

These interviews also indicate that the inability of eligibility workers to communicate with Spanish-speaking clients has resulted in the inability of Spanish-speaking clients, who are in need of social services, effectively to communicate their need. Computer printouts from Alpha Beta Associates and questionnaires from caseworkers reveal that of the 129 estimated Spanish-surnamed social service cases as of January 31, 1972, approximately 81 or 63% of such cases are primarily Spanish-speaking. With regard to these cases:

(*a*) Approximately 42 or 52% are not served by a bilingual social service worker;

(*b*) Approximately 39 or 48% are not served by either a bilingual social service worker or Department provided translator; and

(*c*) Approximately 36 or 44% of such cases are completely unserved by a bilingual social service worker, agency-provided translator, or bilingual relative, friend, or acquaintance.

Testimony of Spanish-speaking clients also indicates that important welfare-related problems of many Spanish-speaking clients are never understood by non-Spanish-speaking social service workers responsible for evaluating clients' needs. We have concluded that the failure of the Department to employ more than four Spanish-speaking social service workers, one of whom incidentally, is a superviser not in direct contact with clients, results in the discriminatory treatment of Spanish-speaking clients. Again, the use by non-Spanish speaking social service workers of children or neighbors as translators creates a barrier to communication with the Spanish-speaking client who, like the English-speaking client, seeks and is entitled to privacy. Thus, the use of translators may also have the effect of defeating or substantially impairing the objectives of the program with respect to many Spanish-surnamed clients.

From information gathered during the review, we have also concluded that the absence of any form of agency-provided cultural awareness training to client contact and supervisory personnel has resulted in a significantly lower level of understanding by the staff of the unique characteristics of Spanish-speaking clients—such as religious beliefs, family life, self-concept, and similar areas—than the level of staff understanding of such matters with regard to non-Spanish-speaking clients. As we know you will recognize, an understanding of client behavior has an important and legitimate bearing on whether and how welfare benefits should be delivered. The lack of such understanding on the part of your staff has, in our opinion, been a material factor in the current lack of delivery or differential delivery of benefits to the Spanish-speaking community.

In accordance with the findings set forth in this letter, we are requesting that you inform us within 30 days of what specific actions will be taken by the Sonoma County Department of Social Services to correct the deficiencies identified. Since we recognize that you may not have given adequate thought or planning to correct these deficiencies, we are also ready to be of immediate assistance with regard to further discussions on the problems set forth, and the preparation and design of appropriate remedies. In this connection, as you may know, our office is also currently conducting similar reviews of other county welfare departments, and is working with the California Department of Social Welfare both to provide appropriate remedies in county welfare departments, and to identify appropriate steps to be taken at the State level. We are providing the State Department with a copy of this letter, and expect that the design and implementation of appropriate remedies in your county system will be con-

sistent with those that may be identified in conjunction with our State agency review.

We would also like to inform you that, in the absence of clear and convincing rebuttal to any points we have raised, or adequate and prompt remedies for those deficiencies which we have identified, and may identify further in the course of our discussions, formal enforcement steps under Title VI of the Civil Rights Act of 1964 will be taken.

We look forward to hearing from you to begin discussions with your staff as promptly as possible. Please feel free to call me at area (415) 556-8586, or write to me as Regional Director, Office for Civil Rights, 760 Market Street, Room 700, San Francisco, California, 94102.

Sincerely,

ROBERT L. BROWN,
(For Floyd L. Pierce),
Regional Civil Rights Director.

Supplemental interrogatory (1)

No answer necessary. See response to Interrogatory 8(c).

Answer to supplemental interrogatory (2)

10(a). One application was received by the Tennessee State Hill-Burton Agency wherein the applicant had asked waiver of the subject assurance. As the application did not otherwise reach an approval stage (the applicant could not raise its share of the proposed project), no disposition was made with respect to the request to waive the subject assurance.

10(b). There are no applications for Hill-Burton assistance pending approval wherein the applicant has indicated, by marking block 10P.(2), that the facility will not furnish below cost or without charge a reasonable volume of services to persons unable to pay therefor.

Answer to supplemental interrogatory (3)

From the commencement of the program to June 30, 1971, the Hill-Burton program of the Department has assisted 5,787 general hospital projects. These were construction or modernization projects.

Thirty-four projects have been identified as constituting facilities which, upon completion of the assisted project, would be an all-private room facility. Project records are not filed on the basis of whether the projects were for "all-private bed rooms", and it has been necessary to base identifications on the recollections of regional office personnel and State agency staff. There may be others because hospitals are encouraged to design facilities with single rooms because they can operate at a higher occupancy rate and more efficiently. We require coverage by third party vendors. The list follows:

Idaho.—Project approved May 1966, for replacement construction of 107 general hospital beds, all one-patient bed rooms with exception of pediatrics and obstetrics.

Oregon.—Project approved September 1962, for new hospital, all one-patient bed rooms, 93 beds.

Washington.—Two (concurrent) projects approved May 1967 for participation in replacement construction of 128 general hospital beds in a 177 bed facility having all single patient rooms with the exception of two "semi-private" rooms.

Region VIII (Denver) reported participation in *one* general hospital project having mostly all single patient rooms. Further details with respect to this project can be obtained if needed.

Georgia.—One project involving Hill-Burton assistance for the addition of 28 all-private rooms to a hospital having semi-private rooms.

Mississippi.—In Mississippi, Hill-Burton assistance has been provided for the construction of or addition to 16 hospitals which, upon completion were "all-private room" facilities. Assistance has also been provided for the addition of "all-private rooms" to 8 hospitals which did contain some multi-bed rooms.

North Carolina.—7 hospital projects approved for all-private bed rooms.

South Carolina.—2 hospital projects approved for all-private bed rooms.

Oklahoma.—Two hospitals are in the planning stage, OKLA-336—Mercy Hospital, Oklahoma City, and OKLA-337—Presbyterian Hospital, Oklahoma City. Both hospitals are teaching hospitals for the Oklahoma University of Medical Schools and are following recommendations of the Medical School Faculty in the development of the new facilities which will replace present non-conforming structures.

Louisiana.—Two hospitals have been constructed as all-private room facilities. They are: LA-148—Richland Parish Hospital, Rayville, La., just completed. The Part 1 was approved June 16, 1969. LA-149—Bunkie General Hospital, Bunkie, La., just opened. The Part 1 was signed March 17, 1969.

Ohio.—Fulton County Medical Center under construction. Will be an all-private bed facility.

Minnesota.—Canby Hospital. A 27-bed all-private bed facility.

Dr. Harald M. Graning, Director, Health Care Facilities Service, Health Services and Mental Health Administration, being first duly sworn, deposes and states that the foregoing answers to the interrogatories and supplemental interrogatories are to the best of his knowledge and belief true, although the truth of all said answers is not known to him personally.

HARALD M. GRANING.

STATE OF MARYLAND,
County of Montgomery, ss:

This is to certify that on this 23rd day of September, 1971, Harald M. Graning personally appeared before me, a Notary Public in and for the State aforesaid, and makes oath that the above is true to the best of his knowledge, information and belief.

WAYNE F. GUSS.
Notary Public in and for Montgomery County, Md.

My commission expires July 1974.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Rockville, Md., March 22, 1972.

Miss MARILYN G. ROSE,
National Health Environmental Law Program, Suite 235, 733 Fifteenth Street NW, Washington, D.C.

DEAR MISS ROSE: Thank you for your letter of January 17, which requested certain information concerning private room general hospital projects which have been assisted with grants under the Hill-Burton program and the basis for our policy of encouraging the construction of such projects. I am sorry for the delay in processing this response.

In brief, we have been encouraging the construction of single rooms because it has been demonstrated that hospitals having a high proportion of single rooms are able to operate at a higher occupancy rate, and thus more efficiently. Enclosed are a number of excerpts from the literature which support that conclusion.

The following is a list of Hill-Burton projects, by state, which have involved all-private-room construction:

Georgia: Calhoun County Hospital, Arlington.
Idaho: Mercy Hospital, Nampa.
Lousiana:
- Richland Parish Hospital, Rayville.
- Bunkie General Hospital, Bunkie.

Minnesota: Canby Hospital, Canby.
Mississippi:
- Northeast Mississippi Hospital, Booneville.
- Cohona County Hospital, Clarksdale.
- Forest General Hospital, Hattiesburg.
- University Hospital, Jackson.
- Tishomingo County Hospital, Juka.
- Memorial Hospital, Gulfport.
- North Mississippi Medical Center, Tupolo.
- Houston Hospital, Houston.
- Pontetoc Community Hospital, Pontetoc.
- Singing River Hospital, Pascagoula.
- Simpson General Hospital, Mendan Hall.
- Hancock General Hospital, Bay St. Louis.
- Webster General Hospital, Eupora.
- Jasper General Hospital, Bay Springs.
- Vicksburg Hospital, Vicksburg.
- Union County General Hospital, New Albany.
- Perry County Hospital, Richton.
- Jefferson County Hospital, Fayette.

Mississippi—Continued
Madison County Hospital, Canton.
Granada County Hospital, Granada.
Ittawamba County Hospital, Fulton.
Ocean Springs Satellite, Ocean Springs.
Southwest Mississippi General Hospital, McComb.
Rankin County Hospital, Brandon.
Lowndes General Hospital, Columbus.
Marshall County Hospital, Holly Springs.
North Panola County Hospital, Sardis.
Smith County General Hospital, Raleigh.
Baldwin Satellite Hospital, Baldwin.
Walthall Hospital, Tylertown.
Hillcrest County Hospital, Calhoun City.
Oktibbeha County Hospital, Starkville.
North Carolina:
Nash County Hospital, Rocky Mount.
Gaston County Hospital, Gastonia.
Martin County Hospital, Williamston.
Lenior Memorial Hospital, Kingston.
Northwest District Hospital, Roanoke Rapids.
Hugh Chatham Memorial Hospital, Elkin.
Washington County Hospital, Plymouth.
Ohio: Fulton County Medical Center, Wausen.
Oklahoma:
Mercy Hospital, Oklahoma City.
Presbyterian Hospital, Oklahoma City.
Oregon: Providence Hospital, Medford.
South Carolina:
Lexington County Hospital, Lexington.
Edgefield County Hospital, Edgefield.
Washington: St. Peters Hospital, Olympia.

Copies of the application for each of these projects are maintained in the various Regional Offices of the Department. These documents are available for your inspection, or for copying at your own expense, at the Regional Offices. If this is inconvenient, we would be willing to have a sample selected by you mailed to our central office here in Rockville. After you have identified which, if any, of the applications you would be interested in inspecting, their identifying numbers and locations may be obtained by calling Mr. Ted Bechtel at 443-1960. He will order them mailed here if you so request.

We are unable to provide you with the information requested concerning per diem cost before and after construction. Even if such material were available, however, it would be of little use without a detailed analysis of each hospital's financial situation to ascertain what factors are responsible for any particular change in per diem charges. Additions, alterations and complete replacement of hospitals have, in nearly all instances, provided additional services which are reflected in per diem charges. Depreciation and debt service costs would also affect such charges. Then too, as you know, the per diem cost has been increasing in most hospitals whether they have a capital expansion program or not. In any event, no information concerning per diem costs has been obtained in the grant program, either as part of the project application or following completion of the facility.

Sincerely yours,

HARAD M. GRANING, M.D.,
Assistant Surgeon General,
Director.

CALIFORNIA RURAL LEGAL ASSISTANCE,
San Francisco, Calif., September 14, 1973.

MS. MARILYN G. ROSE,
Chairwoman, Health Task Force, Leadership Conference on Civil Rights, Washington, D.C.

DEAR MS. ROSE: Thank you very much for your recent letter. As you are no doubt aware, CRLA on behalf of its clients has a continuing and deep interest

in enforcement of Title VI of the Civil Rights Act of 1964. A substantial number of our clients are farmworkers who have a vital interest in the enforcement by HEW of its obligations under Title VI.

At the present time CRLA attorneys, myself included, are counsel for plaintiffs in a class action lawsuit charging HEW with non-enforcement of its civil rights obligations under Title VI. This case was filed on May 16th, 1972 and is entitled, *Asociacion Mixta Progresista, et al.*, v. *United States Department of Health, Education and Welfare, et al.*, (NO. C–72–882, N. Dist. Calif.). Additional defendants in the case are Caspar Weinberger, as head of HEW, Fernando E. C. de Baca, as administrator for Region IX of HEW, Peter Holmes, director of the Office of Civil Rights (OCR) in HEW, the California Department of Social Welfare, and the welfare departments in the counties of Sonoma, Tulare and San Mateo. I have taken the liberty of enclosing a copy of the amended complaint in this case for your information. As you can see from the complaint, basically the first claim for relief charges a denial of equal services and benefits to plaintiffs and their class and specifically charges the local state and federal defendants with violation and non-enforcement of Title VI.

In addition to a copy of the amended complaint I have also included a copy of the previous administrative complaint to HEW outlining the same grievances, a copy of a letter of probable non-compliance with Title VI which HEW issued against Sonoma County, and portions of discovery memoranda which relate to our efforts to discover HEW's investigation of the California welfare system. As outlined in the later documents, pursuant to the administrative complaint, HEW did conduct a thorough investigation of the allegations made. It is our contention that in fact HEW found substantial evidence of non-compliance with the requirements of Title VI., e.g., the findings evidenced in the letter of probable non-compliance issued to Sonoma county. Plaintiffs in *Asociacion Mixta* attempted to discover the results of this investigation, however, then Secretary of HEW, Elliot Richardson's claim of "executive privilege" was sustained by the federal court and to date HEW and OCR has pretty much suppressed these findings. From my perspective and experience in this case, HEW has done nothing to enforce the provision of Title VI in the California welfare system even though it has discovered substantial violations. HEW has taken no further action against Sonoma County pursuant to the letter of probable non-compliance and as far as I know has not even attempted to negotiate with the state and county agencies for the correction of these shortcomings. I believe that the findings in *Adams* v. *Richardson* are precisely in point in this case. Finally, the problems outlined in *Asociacion Mixta, et al.*, are not isolated to the counties complained of, but are in fact state-wide.

I hope this brief description adequately outlines the problems Mexican-American welfare recipients are having in California as a result of the non-enforcement by HEW of the provisions of Title VI. If I can provide additional information on this situation or be of any assistance to you, please advise.

Sincerely,

JOSE L. MARTINEZ, *Deputy Director.*

Enclosures.

Ms. ROSE. Thank you.

To date, HEW has done nothing about this picture, and we can expect no action until the day a court orders them to enforce title VI. Concentration of the parties and the court on the Hill-Burton aspects of the case has put the civil rights aspects on a back burner until recently.

The 1970 census from Orleans and Jefferson Parishes indicates the following population figures:

Orleans Parish has 319,428 white patients and 64,930 black patients, which is 45 percent black; and Jefferson Parish has 291,987 white and 41,535 black persons, that is 12.5 percent black. These are the two parishes which make up what is called Metropolitan New Orleans.

For the 3-year period covered by the answers to interrogatories the figures with respect to service to black patients were horrendous for several of the hospitals, and most especially for some in the inner city.

Hotel Dieu, located in the heart of the inner city in a census tract over 80 percent black, a few blocks from Charity Hospital which has a 75 percent black patient load, has continually had less than 3 percent of its patients black. Not too far away Southern Baptist Hospital, on the border of two census tracts, one of which has 76 percent black and the other 87 percent black, has a patient census which is less than 1 percent black. Indeed the admission of Southern Baptist into the medicare program in October 1969 is particularly egregious from a civil rights standpoint. That 500-bed hospital serves some 18,000 to 20,000 patients a year. At the time (in October 1969) that it was permitted to sign a provider contract in the medicare program, the records of the Office for Civil Rights indicated that it had served only 13 black patients during the previous 9 months, and yet it was found in compliance with the Civil Rights laws and allowed to come into this program.

At this point, I would like to say, parenthetically, in August, by telephone I was discussing the civil rights case with one of my colleague attorneys in New Orleans and he told me that just that week their domestic had been hurt in an automobile accident right in front of Southern Baptist and she happened to have some private commercial insurance. The ambulance drivers came and the man in the other car, who was white was taken to Southern Baptist. She wasn't asked where she wanted to go. She was taken to Charity Hospital. She is black. That is the pattern.

In its answers to interrogatories served by plaintiffs Southern Baptist states, with respect to the imposition of standards of performance required by the Office for Civil Rights.

> Southern Baptist Hospital qualified as a provider of Medicare services without strict compliance with each of the HEW guidelines. Principally Southern Baptist Hospital took exception to recruiting patients and physicians to achieve a racial balance . . .
>
> Southern Baptist was not required by HEW to send letters to Negro physicians, or Negro Physician organizations and civil rights leaders.

That is the most minimum thing you can imagine and they weren't even required to do that.

Mr. EDWARDS. So, Southern Baptist just said we are not going to do it and we don't have to; is that correct?

Ms. ROSE. And they let them come in.

Mr. EDWARDS. And they made no affirmative effort to integrate?

Ms. ROSE. In later interrogatories, for the full year of 1971, of approximately 19,000 or 20,000 patients, there were 90 black patients so Southern Baptist had improved but still 90 black patients out of 20,000 isn't good. Later they reached 99 black patients, but, as I said, they are in an area that is 90 percent black.

Mr. EDWARDS. And is there action in Federal courts pending on this?

Ms. ROSE. Yes, another example is Ochsner, which rates itself the Mayo Clinic of the South; of their patients, less than 3 percent are black.

Mr. EDWARDS. And in what way, if any, is the Office of Civil Rights of HEW participating in this action?

Ms. ROSE. They have been named as defendants and they have done nothing whatsoever.

Mr. EDWARDS. Thank you.

Ms. ROSE. Now, Southern Baptist is located but a few blocks from Flint-Goodridge which has an all-black patient load. The staff list at

Flint-Goodridge is curious. There is an enormous number of physicians with "courtesy staff privileges," which entitles them to place up to 20 patients a year in that hospital. Thus, the white physician, with a few black patients, can place his white patients in a Southern Baptist or at Hotel Dieu and his black patients in Flint-Goodridge, and never the twain shall meet. And that, incidentally, is a common pattern I have seen across the South. There is always one black middle-class hospital and historically, that is the only hospital where black middle-class people with insurance went.

Mr. EDWARDS. The subject of separate but equal came up in the last set of hearings we had and I believe it was stated by a witness that the services were relatively equal in the segregated hospitals that they had examined. Are you suggesting that the services offered the black patients in Flint-Goodridge are inferior to the services offered the patients at Southern Baptist?

Ms. ROSE. Let me answer this in a different way. I disagree that they really are separate and equal. First of all, the vast majority of black patients in this country don't get into the small Martin de Porres Hospitals, for instance. They get into the large overcrowded, understaffed, and underequipped public hospitals, D.C. General Hospital, New Orleans Charity Hospital, the L. A. County General-type hospitals; Boston city-type hospital; the Cook County-type hospital. I could name them across the country. All of these hospitals have deteriorated seriously in the last few years and I would refer everyone to the July 1970, issue of American Hospital Association magazine called "Hospitals." The entire issue was devoted to the plight of the public hospitals, and this is a matter of record. The hospital industry knows it. This is not to say the individuals at these hospitals are incapable men. Some of the most dedicated men I have met are the doctors at Charity General in New Orleans. I would go on record to state that, but concerning the number of patients and the size of the hospitals, the fact that they have to close down wings because they don't have the equipment and they don't have the beds, that is all a matter of record.

Charity Hospital in New Orleans, for instance, has been forced to turn away 25 to 50 patients a day from inpatient admission because they just don't have the beds. They will treat them on an ambulatory basis, but they can't take them as inpatients. The doctors there hope it is a less sick person they have turned down and the surgeons at that hospital keep a list of people, which is called the surgical wait list, hoping that will find a bed for them, and, if it isn't an emergency surgery, it may take 6 months and that suspect breast mass, which they hoped wasn't cancer might instead of being a simple operation in January, in May become a total mastectomy because of this. They gamble and they hate to gamble but they have to.

The Flint-Goodridge type hospitals, also have problems. They are middle-class hospitals but very often the black doctor and, especially, the older black doctors, couldn't get into the fancy medical schools and couldn't get into the fancy specialty training and so that even though they are good—and many of them are really excellent doctors—but the comparison of getting into a Flint-Goodridge and getting into an Ochsner is like, well, for instance, in this city I suppose it is like going to Johns Hopkins or maybe going into Suburban Hospital. The

problem is, too many of the black hospitals are suburban hospitals and they have not been, because of other kinds of discrimination, ever been able to build themselves into Johns Hopkins type institutions.

The Office for Civil Rights has totally ignored the legal obligations that all these hospitals have assumed when they elected to participate in the medicare program. Part of it stems from the obtuse legal reasoning which ignores the teaching of the courts on the extent of discrimination and the affirmative action duties which follow. Part of it stems from unimaginative approaches to problems. Two-thirds of the nonprofit general hospitals in the United States have been built under the Hill-Burton Act; some 2,267 of its 3,500 to 3,600. They are obligated under that act to afford a reasonable volume of service to persons unable to pay and to be available to all persons in the territorial area of the facility. Considering the historic emergence of the "territorial service" commitment out of its "separate but equal past" before the Simkins decision and the subsequent amendment by Congress, it would appear that HEW, collectively, including its component parts of the health care facilities service and the Office for Civil Rights, has an obligation, affirmatively, to assure that these obligations are being fulfilled. However, not until the eastern district of Louisiana in May of this year in the *Cook* case found that HEW was violating its obligations to enforce the "territorial service" commitment in its acquiescing in the refusal of Hill-Burton hospitals to serve medicaid beneficiaries, has HEW taken this matter seriously but we still are awaiting HEW action on the matter.

To the extent that OCR is correct that poverty results in minority persons going to public hospitals rather than private hospitals, the refusal by private hospitals to participate in medicaid, the health program for welfare recipients, excludes the paid-for poor. In Orleans and Jefferson Parishes, some 90 percent of the persons on the aid to dependent children program are black.

Thus, to refuse to participate in medicaid—while participating in other Federal programs—has the effect of denying Federal benefits to black people by a recipient of Federal financial assistance.

With respect to contentions of lack of private physicians for the poor and minorities, if physicians are not available in ghetto communities, or are only available in limited number to treat poor and minority persons within their territorial areas, aside from hospitals imposing the duties to serve these persons as a condition of staff privileges, there are other alternatives. These include recruiting physicians who do serve the minority populations; hiring physicians to serve the poor and minorities; affiliation with outpatient clinics, both of the overcrowded public hospitals and the free standing Government funded ones under various HEW and OEO programs.

In both Lee County, Ark., and Imperial Valley, Calif., in 1970, local Hill-Burton constructed hospitals refused staff privileges to physicians at these clinics, funded respectively by OEO and HEW, until litigation or the imminent threat of litigation, resulted in reversal. In Lee County the denial of staff privileges to the clinic physician meant that poor blacks were denied admission to a Hill-Burton hospital; in Imperial Valley it meant that poor Chicanos were denied admission. In both situations it was not HEW which brought or threatened litigation; it was legal service and civil rights attorneys.

But the nonenforcement failures of the Office for Civil Rights is not limited to its narrow perspective of legal obligations and its unimaginative approach to problems. It has failed to demonstrate any movement even where clear, overt discrimination exists. In 1969 OCR sent questionnaires out to all hospitals, requesting certain patient data for 1 day. Both admission practices and room assignments were matters upon which the questionnaire ostensibly focused. In 1971 OCR sent out another questionnaire, this time to hospitals which were among the "200" holdouts and/or had notice of noncompliance in 1966–67. Although the reports are replete with questionable practices, OCR has not taken any action against any of them.

Among the hospitals, for example, was Greenwood Le Flore, in Greenwood, Miss., which was one of the first hospitals listed in noncompliance on the interagency report in 1966. It is the only hospital in a county with a majority black population according to the 1970 census of 17,500 white people and 24,374 black people. Its patients census for one day in 1969 showed 192 total patients, only 48 of whom were black and none of whom occupied a multiracial room. Its 1971 census showed 185 patients, only 70 of whom were black; its room assignment information was incomplete in 1971. Nothing, or at least nothing effective, was done in 1969–71 period, nor is there any indication of any action since 1971.

Mr. EDWARDS. Ms. Rose, would you happen to know if there is another hospital in Greenwood?

Ms. ROSE. Well, according to my records that I use, which is the American Hospitals Association listing of hospitals in the United States, unfortunately, there is no other hospital listed. Now, it is conceivable that there is one that did not send a report in, which is so small it can't be considered a hospital by the AHA; something small like a nursing home.

Another example is Bryan Whitfield, in Demopolis, Ala. It is the only hospital in a county which is majority black (10,640 white persons and 13,157 black persons). Its 1969 patient census showed 50 white patients and 26 black patients; 4 of the black patients were in single rooms and 36 in rooms with other blacks. In 1971 it did not give the total number of patients, only that there were 2 black patients in single rooms and 36 in rooms with other blacks. Again none were in rooms with whites. In November 1966, when I visited this hospital, the facility was totally segregated, with the newer wing with all private rooms, and only white patients ,and the older, more cramped wing with multiple beds and all black patients. I suspect that this was the picture in 1969 and 1971, but the hospital was during these later periods allowed to participate in medicare and nothing seems to have been done about its internal segregation. How overt must segregation be to precipitate action by OCR?

Indeed, it is questionable just what the Office for Civil Rights has done in the health and welfare area during the last few years. In late 1967 these branches were combined and the efforts were directed into the activity described as the State agency review. As documented by the GAO investigators, this has been the principal activity of the Office, but the results are highly questionable. Just why did it take until August 1971 (after the Judiciary Committee requested GAO to make this study) for OCR to be then negotiating agreements with the

Alabama and Georgia Departments of Health to make title VI reviews? What credibility can such an agreement have in Alabama, where the Justice Department has entered an appearance as amicus, supporting plaintiffs, against the Alabama welfare agency and its maintenance of segregated services for beneficiaries? [That is *Player, et al.* v. *State of Alabama Department of Pensions and Securities, et al.*, Civ. Act. No. 3835-N, M.D. Ala.]

I have furnished a copy of it to Ms. Chavez and it should be made a part of the record here.

Mr. EDWARDS. Without objection, it will be made a part of the record at this point.

[The document referred to follows:]

In the United States District Court for the Middle District of Alabama
(Northern Division)

Civil Action No. 3835-N

EMMETT PLAYER; PRICE DWAYNE COEFIELD; CHARLES SCOTT; minors, by and through their next friend, C. D. (DENNY) ABBOTT, for themselves and for all others similarly situated, PLAINTIFFS,

vs.

STATE OF ALABAMA DEPARTMENT OF PENSIONS AND SECURITY; REUBEN KING, individually and in his official capacity as Commissioner of the State of Alabama Department of Pensions and Security; BRANTWOOD CHILDREN'S HOME; SALLY BABB, individually and in her official capacity as Superintendent of Brantwood Children's Home; ALABAMA BAPTIST CHILDREN'S HOME; R. H. SHIREY, individually and in his official capacity as Superintendent of the Alabama Baptist Children's Home; ALABAMA SHERIFF'S BOYS RANCH; DON ACTION, individually and in his official capacity as Administrator of Alabama Sheriffs Boys Ranch; PRESBYTERIAN HOME FOR CHILDREN; JAMES GABBIE, individually and in his official capacity as President of the Presbyterian Home for Children; UNITED METHODIST CHILDREN'S HOME; RICHARD I. KIRKLAND, individually and in his official capacity as Executive Director of the United Methodist Children's Home; GATEWAY, INC.,; MARY EDNA PORTER, individually and in her official capacity as Executive Director of Gateway, Inc., DEFENDANTS.

COMPLAINT

I. Jurisdiction

1. This action arises under the First, Fifth, Thirteenth, and Fourteenth Amendments to the United States Constitution and the following provisions of the United States Code Annotated: Title 42, Sections 1981, 1983, 1985(3) et seq. Jurisdiction of the Court is conferred pursuant to Title 28, Sections 1331, 1343(3) and 1343(4), and 2201 and 2202 of the United States Code. The amount in controversy exceeds, exclusive of interests and costs, the sum of ten thousand ($10,000.00) dollars.

II. Parties

2. Plaintiff Emmett Player, Jr., a fifteen year old Negro youth, is a citizen of the State of Alabama and of the United States. Emmett has been institutionalized at the Alabama Industrial School for Negro Children in Mt. Meigs, Alabama since June 14, 1968. His mother is either dead or missing and his father is presently incarcerated in Atmore State Prison, Atmore, Alabama.

3. Plaintiff Price Dwayne Coefield, a twelve (12) year old Negro youth, is a citizen of the State of Alabama and of the United States. The whereabouts of Price's father are unknown, and his mother is physically and emotionally unable to care for him. He is presently residing with his seventy (70) year old grandparents in Montgomery County, Alabama.

4. Plaintiff Charles Scott, a fifteen (15) year old Negro youth, is a citizen of the State of Alabama and of the United States. Charles' father is deceased and

his mother is retarded and unable to care for herself or Charles. He is presently residing with his retarded mother and a 73-year-old woman who cares for his mother.

5. Plaintiffs bring this action on their own behalf and on behalf of all other black children similarly situated pursuant to Rule 23 of the Federal Rules of Civil Procedure. The prerequisites of subsections (a), (b)(1), (b)(2), and (b)(3) of that rule are satisfied. There are common questions of law and fact affecting the members of the class, and these common questions predominate over any questions affecting only individual members. The claims of the plaintiffs are typical of the claims of the class. The members of the class are so numerous as to make it impracticable to bring them all before the Court, and the interests of the class are adequately represented by the individual plaintiffs. Finally, a class action will provide for fair and efficient adjudication of the controversy.

6. Plaintiff C. D. (Denny) Abbott, who is over the age of twenty-one (21) years, is a citizen of the State of Alabama and of the United States. As Chief Probation Officer of the Circuit Court of Montgomery County, Alabama, Domestic Relations Division, plaintiff Abbott has a direct and deep interest in and concern for the quality of care offered neglected, dependent, and delinquent black children. He also serves in the capacity of guardian and next friend for each of the named minor plaintiffs.

7. Defendant State of Alabama Department of Pensions and Security [hereinafter "State D.P.S."] is the State agency responsible for administering and supervising public assistance and social welfare programs for the State of Alabama. *Ala. Code*, T. 49 Sec. 17(7) and 17(36). The State D.P.S. overseas and prescribes rules and regulations for the various county departments of pensions and security in the State of Alabama. *Ala. Code* T. 49 Sec. 17(7), 17(9), and 17(39).

8. Defendant Reuben King, who is sued both individually and in his official capacity as Commissioner of the State D.P.S., is, upon information and belief, a citizen of the State of Alabama and of the United States. As Commissioner, defendant King is the top executive and administrative officer of the State D.P.S. *Ala. Code*. T. 49 Sec. 17(5) and 17(37).

9. Defendant Brantwood Children's Home hereinafter ["Brantwood"] is a non-profit child caring institution organized and incorporated under the laws of the State of Alabama. Brantwood is located in Montgomery, Alabama.

10. Defendant Sally Babb, who is sued both individually and in her official capacity as Superintendent of Brantwood, is, upon information and belief, a citizen of the State of Alabama and of the United States. As Superintendent, she is the person primarily responsible for overseeing the day-to-day operations at Brantwood.

11. Defendant Alabama Baptist Children's Home [hereinafter "Baptist Home"] is a non-profit child-care institution organized and incorporated under the laws of the State of Alabama. The Baptist Home has its central office in Troy, Alabama.

12. Defendant R. H. Shirey, who is sued both individually and in his official capacity as Superintendent of the Baptist Home, is, upon, information and belief, a citizen of the State of Alabama and of the United States. As Superintendent, he is the person primarily responsible for over seeing the day-to-day operations at the Baptist Home.

13. Defendant Alabama Sheriffs Boys Ranch [hereinafter "Boys Ranch"] is a non-profit child care organization incorporated under the laws of the State of Alabama. The Boys Ranch is located in Dallas County, Alabama.

14. Defendant Don Acton, who is sued both individually and in his official capacity as Administrator of the Boys Ranch, is, upon information and belief, a citizen of the State of Alabama and of the United States.

15. Defendant Presbyterian Home for Children [hereinafter "Presbyterian Home"] is a non-profit child care institution organized under the laws of the State of Alabama. Presbyterian Home has its home in Talladega, Alabama.

16. Defendant James Gabbie, who is sued both individually and in his official capacity as President of the Presbyterian Home, is, upon information and belief, a citizen of the State of Alabama and of the United States.

17. Defendant United Methodist Children's Home [hereinafter "Methodist Home"] is a non-profit child care institution incorporated under the laws of the State' of Alabama. Methodist Home is located in Selma, Alabama.

18. Defendant Richard I. Kirkland, who is sued both individually and in his official capacity as Executive Director of the Methodist Home, is upon

information and belief, a citizen of the State of Alabama and of the United States.

19. Defendant Gateway, Inc. is a non-profit child care institution incorporated under the laws of the State of Alabama. Gateway is located in Birmingham, Alabama.

20. Defendant Mary Edna Porter, who is sued both individually and in her official capacity as Executive Director of Gateway, Inc., is upon information and belief, a citizen of the State of Alabama and of the United States.

III. Nature of the Action

21. The State D.P.S. has the duty and responsibility to protect and guarantee the welfare of all dependent, neglected, and delinquent children in the State of Alabama. The State D.P.S. is authorized to "[s]eek out, through investigation, complaints from citizens, or otherwise, the minor children in the state who are in need of its care and protection and shall, as far as may be possible, through existing agencies, public or private, or through such other resources, aid such children to a fair opportunity in life." *Ala. Code* T. 49 Sec. 17(7). Once the State D.P.S. has ascertained which minor children are "in need of its care and protection," the agency is then to [e]stablish and maintain homes or other agencies for the care of [such] minor children or contract with any approved agency or institution for the care of such children . . ." *Ala. Code* T. 49 Sec. 17(7).

22. To ensure that all child care institutions and facilities in the State of Alabama were of a high quality and were operated by reliable, competent persons or groups, the State Legislature enacted, in 1951, a comprehensive code governing the licensing and responsibilities of child care institutons in Alabama. *Ala. Code* T. 49 Sections 62–84. The State D.P.S. was given the responsibility for "[l]icensing all institutions and agencies, except those under state ownership and control, caring for, receiving, or placing minor children and to revoke such license for cause." *Ala. Code* T. 49 Sec. 17(7).

23. On January 21, 1972, the State Legislature enacted the "Child Care Act of 1971," which act repeals and supercedes sections 62–84 of the Code of Alabama. *Ala. Code* T.49 Sections 84(1)–84(17) (1971 Supp.). Under this new act, no person or group may operate a child care facility or institution in the State without first having been licensed by the State D.P.S. *Ala Code* T.49 Sec. 84(3). [The "Child Care Act" authorizes the state D.P.S., in determining which persons or groups to license, to "prescribe and publish minimum standards for licensing and for approving all child care facilities." *Ala. Code* T. 49 Sec. 84 (7).] The New Act does not apply, however, to child care institutions or juvenile detention homes operated by the State of Alabama.

24. There are not, at the present time in the State of Alabama, any State owned and operated child care facilities or institutions for dependent or neglected minors. The State D.P.S., along with the local county departments of pensions and security is thus required to contract with various child care institutions[1] to provide shelter and care for the State's dependent and neglected children.

25. It is alleged, upon information and belief, that the following child care institutions have been licensed by the State D.P.S.:

---

[1] Not every dependent or neglected child is placed in a child care institution by the State D.P.S. The State often places such a child with relatives or contracts with nonrelatives to care for the child at home.

A. STATEWIDE CHILD CARE INSTITUTIONS

1. Alabama Baptist Children's Home ..... Troy, Ala.
2. Alabama Sheriffs' Boys Ranch ..... Selma, Ala.
3. Childhaven, Inc ..... Curllman, Ala.
4. Freewill Baptist Children's Home ..... Eldridge, Ala.
5. Presbyterian Home for Children ..... Talledega, Ala.
6. Salvation Army Shelter Care Facility ..... Tuscaloosa, Ala.
7. St. Mary's Home ..... Mobile, Ala.
8. United Methodist Children's Home ..... Selma, Ala.
9. Wilmer Hall (Episcopal) ..... Mobile, Ala.
10. Alexander City Children's Home ..... Alex City, Ala.

B. COUNTYWIDE CHILD CARE INSTITUTIONS

1. Brantwood Children's Home ..... Montgomery, Ala.
2. Children's Village ..... Birmingham, Ala.
3. Gateway, Inc ..... Birmingham, Ala.
4. Harris' Home for Childen ..... Huntsville, Ala.
5. Linnie Oden Voluntary Effort, Inc ..... Brookwood, Ala.
6. Chi-Ho Mansion ..... E. Huntsville, Ala.
7. Tuscoba Friendship Home (all girls) ..... Northport, Ala.

26. It is alleged, upon information and belief, that four of the above child care institutions—1) Alabama Baptist Children's Home, 2) Childhaven, Inc., 3) Presbyterian Home for Children, and 4) Brantwood Children's Home—have not as yet signed statements of compliance with the Civil Rights Act of 1964. It is alleged, upon information and belief, that each of these institutions has had, and continues to have, a policy of accepting and admitting only white children.

27. It is further alleged, upon information and belief, that 1) Alabama Sheriffs' Boys Ranch, 2) Freewill Baptist Children's Home, 3) United Methodist Children's Home, 4) Wilmer Hall, 5) Alexander City Children's Home, 6) Gateway, 7) Linnie Oden, 8) Chi-Ho Mansion, and 9) Tuscoba Friendship Home, while having signed forms expressing compliance with the Civil Rights Act of 1964, have all continued their previous policy, pattern and practice of accepting and admitting only white children. None of these institutions has, at the present time, any black children.

28. The only child care institutions in the State of Alabama which accept, and have accepted black children, are 1) Salvation Army Shelter Care Facility, 2) St. Mary's Home, 3) Children's Village, and 4) Harris' Home for Children. The former two institutions are integrated, the latter two are all-black.

29. Plaintiff Emmett Player was illegally committed [2] on June 14, 1968, at the age of ten, to the Alabama Industrial School for Negro Children. While the average confinement at the Industrial School is between six months and a year, and despite the fact that he has been in the School's pre-release program for over two years, Emmett, who is now fifteen (15) years of age is still confined at the School. His mother is dead or missing and his father is incarcerated at Atmore State Prison, Atmore, Alabama. It is alleged, upon information and belief, that plaintiff's cruel and excessive confinement has resulted from 1) the State D.P.S.' failure and/or refusal to attempt to place plaintiff in a licensed child care institution or foster home and 2) the racially discriminatory admissions policies of the licensed child care institutions in the State of Alabama.

30. Plaintiff Price Dwayne Coefield was admitted to Our Lady of Fatima School on September 21, 1971, after his mother had been arrested several times for child neglect. Price was placed at the School by a county D.P.S. The School, which was operated by a Catholic Priest, was a child care institution in Montgomery, Alabama, comprised exclusively of Negro boys. On January 24, 1972, plaintiff Coefield was removed from Our Lady of Fatima School [3] by D.P.S. and placed with his 72 year old great-grandmother who lived by herself. In June of 1972, when his great-grandmother became partially incapacitated, plaintiff was placed by D.P.S. with his seventy year old grandfather and grandmother, who share a small apartment with Price's aunt (divorced) and a first cousin. While his grandparents have made every effort to care for Price, they are financially unable to properly feed and clothe him. They receive no money from D.P.S. for housing, feeding, or caring for him. It is alleged, upon information and belief, that no effort has been made by the State D.P.S. to place plaintiff in a licensed child care institution or foster or boarding home.

31. Plaintiff Charles Scott was admitted on March 2, 1969, at the age of 12, to Our Lady of Fatima School by D.P.S. Charles mother is severely retarded and his father is deceased. When Our Lady of Fatima School was closed in May of 1972, Charles was placed with his retarded mother and a 73 year old lady who cares for his mother. This lady, who is herself quite physically ill, receives $29.00 a month from D.P.S. to house, feed, clothe, and otherwise care for plaintiff. She

---

[2] Under Alabama law, a youth cannot be committed to the Alabama Industrial School until he has attained his twelfth (12) birthday. *Ala. Code* T.52 Sec. 613(5) et seq. It is alleged, upon information and belief, that no valid commitment papers were ever filed for plaintiff Player.

[3] Our Lady of Fatima School was closed in May of 1972, after its founder and director, Father Michael Caswell, was killed.

cannot afford to properly feed or clothe plaintiff, nor can she give the guidance and supervision he needs. It is alleged, upon information and belief that neither the State nor county D.P.S. has ever referred plaintiff Scott to one of the all-white child care institutions licensed by the State D.P.S.

IV. First Cause of Action

32. The State of Alabama has empowered the State D.P.S. to exercise substantial control over the operation and policies of all child care facilities and institutions in the State. *Ala. Code* T. 49 Sec. 84(1) et seq. Despite this grant of power, the State D.P.S. has made no effort to ensure that any person or organization granted a license has a non-discriminatory admissions policy.

33. It is alleged, upon information and belief, that the United States Department of Health, Education and Welfare, which supplies the State D.P.S. with a substantial portion of its operating budget, has ordered the State D.P.S. 1) to stop making referrals to and 2) to stop making payments to any child care institution or facility which refuse or fail to sign statements of compliance with the Civil Rights Act of 1964. It is further alleged that the State D.P.S. continues to contract with and make referrals and payments to these institutions in violation of HEW guidelines.

34. It is alleged, upon information and belief, that the State D.P.S. continues to 1) make approximately seventy-five percent (75%) of the referrals to, 2) make sizeable child payments to, 3) license private social workers at, and 4) render technical assistance to those all-white child care institutions and facilities which have signed statements of compliance with the Civil Rights Act of 1964. It is further alleged, upon information and belief, that the State D.P.S. has made no investigation, nor has taken any other steps, to determine whether these institutions are, in fact, admitting children on a racially non-discriminatory basis.

35. It is alleged, upon information and belief, that the State D.P.S. has actively conspired with those child care institutions and facilities with racially discriminatory admissions policies to exclude black dependent and neglected children by:

1. Making no effort to ensure that all persons and organizations granted licenses maintain racially non-discriminatory admissions policies;
2. Referring only white dependent and neglected children to the all-white child care facilities and institutions;
3. Referring only black dependent and neglected children to the all-black child care facilities and institutions;
4. Referring only white dependent and neglected children to those child placing agencies affiliated with all-white child care facilities and institutions; and
5. Failing and/or refusing to establish any state owned and/or operated child care facilities or institutions for dependent and neglected children.

V. Second Cause of Action

36. Defendant Baptist Home is a child care institution licensed by the State of Alabama. Dependent and neglected children are referred to the Baptist Home by its own child placing agency, by the State D.P.S. and local county departments of pensions and security, by members of and clergy in the Baptist Church, and by various public and private social service agencies and organizations. A contract is then entered into between the Baptist Home and the State D.P.S., the child's parent or guardian, etc. It is alleged, upon information and belief, that the Baptist Home has refused to sign a statement of compliance with the Civil Rights Act of 1964 and admits and contracts with only white persons.

37. Defendant Brantwood Children's Home is a child care institution licensed by the State of Alabama. Dependent and neglected children are referred to Brantwood by the State D.P.S., the Montgomery County Department of Pensions and Security, the Circuit Court of Montgomery County, and various public and private social service agencies and organizations. Brantwood, if it accepts a child, enters into a contract with D.P.S., the social service agency, etc. It is alleged, upon information and belief, that Brantwood has failed and/or refused to sign a statement of compliance with the Civil Rights Act of 1964 and accepts and contracts with only white persons.

38. Defendant Presbyterian Home for Children is a child care institution licensed by the State of Alabama. The Presbyterian Home, after screening a

child, decides whether or not to enter into an agreement or contract with the referring agency, the child's parent, etc. It is alleged, upon information and belief, that the Presbyterian Home has failed and/or refused to sign a statement of compliance with the Civil Rights Act of 1964 and accepts and contracts with only white persons.

39. Defendants Boys Ranch, Methodist Home, and Gateway, Inc. are all child care institutions licensed by the State D.P.S. In admitting children, each of these institutions enters into agreements or contracts with the referring party, parent, etc. While all three institutions have signed forms evidencing compliance with the Civil Rights Act of 1964, it is alleged, upon information and belief, that they accept only white children.

40. Plaintiffs allege that Baptist Home's, Brantwood's, Presbyterian Home's, Methodist Home's, Boys Ranch's, and Gateway's failure and/or refusal to accept black children on an equal basis with white children violates their statutory rights under T. 42, Section 1981 of the United States Code Annotated and their constitutional rights under the Thirteenth Amendment.

VI. Third Cause of Action

41. The defendant child care institutions are subject to an elaborate licensing system imposed by the State of Alabama. These institutions are required to comply with a number of rules and regulations promulgated by the State D.P.S. to obtain and/or retain their licenses. [Social workers hired by these institutions must be licensed by the State D.P.S.]

42. The defendant child care institutions are all nonprofit organizations incorporated under the laws of the State of Alabama. All contributions and donations to these non-profit organizations are tax-deductible.

43. It is alleged upon information and belief, that the defendant child care institutions receive substantial sums of money from the state and federal governments. Each of these institutions receives Social Security and V.A. payments for those children entitled to them. The State D.P.S., through its county agencies, makes monthly payments to these institutions to cover the cost of caring for those children referred by D.P.S. These institutions also receive funds from such organizations as the United Appeal, etc.

44. The defendant child care institutions are closely tied to and involved with the operations of the State D.P.S. and the State of Alabama. In addition, defendant child care institutions are providing a public function by offering child care services to the State's dependent, neglected, and delinquent (white) children. The State D.P.S. is statutorily required to "[e]stablish and maintain homes or other agencies for the care of dependent, neglected, or delinquent minor children." *Ala. Code* T. 49 Sec. 17(7). Rather than establishing and maintaining child care institutions, the State D.P.S. has selected to contract with other agencies and institutions.

45. The defendant child care institutions are thus inextricably intertwined with the State D.P.S. and are providing a public function. Plaintiffs allege that defendants' refusal to accept black children violates their statutory rights under T. 42, Sections 1983 and 1985(3) of the United States Code, and their constitutional rights under the Thirteenth and Fourteenth Amendments to the United States Constitution.

Wherefore, premises considered, plaintiffs respectfully pray that this Court take jurisdiction of this case, and grant the following relief:

1. A Judgment declaring defendant State D.P.S.' failure and/or refusal to require all child care institutions and facilities to have racially non-discriminatory admissions policies before licensing them to be violative of plaintiffs' Thirteenth and Fourteenth Amendment rights;

2. A Judgment declaring defendant State D.P.S.' failure and/or refusal to ascertain whether those all-white child care institutions which signed the statements of compliance with the Civil Rights Act of 1964 are, in fact, maintaining racially non-discriminatory admissions policies to be violative of plaintiffs' rights under the Thirteenth and Fourteenth Amendments;

3. A Judgment declaring defendant State D.P.S.' failure and/or refusal to refer black neglected, dependent, and delinquent children to the all-white child care institutions and white dependent, neglected, and delinquent children to the all-black child care institutions to be violative of plaintiffs' rights under the Thirteenth and Fourteenth Amendments to the United States Constitution;

4. A Judgment declaring defendant State D.P.S.' practice and policy of licensing, referring children to, paying monthly payments to, and rendering technical assistance to child care institutions which have racially discriminatory admissions policies to be violative of plaintiffs' rights under the Thirteenth and Fourteenth Amendments to the United States Constitution;

5. A Judgment declaring the defendant child care facilities and institutions' failure and/or refusal to accept, admit, and contract with blacks to be violative of plaintiffs' statutory rights under T. 42, Sections 1981, 1983, and 1985(3) of the United States Code Annotated and their constitutional rights under the Thirteenth and Fourteenth Amendments;

6. A permanent injunction against defendant State D.P.S., its officers, agents, servants, employees, or attorneys, and those persons in active concert or participation with them:

(*a*) Restraining them from referring only white children to the all-white child care institutions and only black children to the all-black child care institutions;

(*b*) restraining them from licensing or approving any person or organization to operate or conduct a facility for child care unless such person or group demonstrates, by clear and convincing evidence, that it maintains a racially non-discriminatory admissions policy;

(*c*) restraining them from referring any children, making any payments, or providing any assistance to any child care institution or facility which has not signed the statement of compliance with the 1964 Civil Rights Act and which has not shown, by clear and convincing evidence, that it maintains a racially non-discriminatory admissions policy;

(*d*) restraining them from in any way assisting or encouraging the continuation or development of segregated child care institutions or facilities;

(*e*) requiring them to develop and use objective, non-racial criterion for determining to which child care institution a child is to be referred;

(*f*) requiring them to take affirmative steps to overcome the effects of the past discrimination;

(*g*) requiring them to find plaintiffs Player, Coefield, and Scott clean, healthy, and suitable homes where they will be properly clothed and fed and will receive adequate guidance and supervision.

(*h*) requiring them to plan and build a sufficient number of state owned and operated child care facilities for neglected, dependent, and delinquent children in Alabama.

7. A permanent injunction against the defendant child care facilities and institutions, their officers, agents, servants, employees, or attorneys, and those persons in active concert or participation with them:

(*a*) Restraining them from continuing to maintain their racially discriminatory admissions policies;

(*b*) restraining them from refusing to accept, admit, and contract with blacks solely on account of their race;

(*c*) requiring them to develop an objective, non-racial admissions policy and to apply such policy to all persons equally.

8. An award of costs to the Plaintiffs.

9. Such other and further relief as this Court may deem appropriate and necessary.

HOWARD A. MANDELL,
Montgomery, Ala., Attorney for Plaintiffs.

STATE OF ALABAMA,
Montgomery County, ss:

Before me, a Notary Public in and for the State of Alabama at Large, personally appeared C.D. (Denny) Abbott, who being duly sworn, deposes and says that the foregoing is true and correct to the best of his knowledge, information and belief.

C.D. (DENNY) ABBOTT.

Sworn to and subscribed before me on this the 11th day of November 1972.

HOWARD A. MANDELL,
Notary Public.

Mr. McCLORY. Could I inquire at this point? I would just like to be informed on this. Is there some regulation or is there some decision that makes this a violation of the civil rights law to not have the patients integrated in the hospital?

Ms. ROSE. To have internal segregation would be like internal segregation in a school, by having one room all black and all white in another room.

Mr. MCCLORY. I see. But is there some regulation?

Ms. ROSE. Well, the HEW guidelines so provide and, also, there is some court cases, for instance, *Cycruse* v. *Newport News Hospital*, 375 F. 2d, and I don't remember the page cite, but that was a 1968 case, the fourth circuit for——

Mr. MCCLORY. And that was you should integrate the patients inside the hospital?

Ms. ROSE. That normal assignment without regard to race would result in some integration; yes. And I think if any of us have been in Washington's hospitals we have seen integration. If you don't consider race, but statistical probability, if you find all white patients in one wing and all black in another wing, you know there has to be segregation.

Mr. MITCHELL. I would like to comment just there.

Mr. MCCLORY. Your statement, of course, said it is segregation, but I just wanted to know whether that violates some court decision or some regulation.

Mr. MITCHELL. I would certainly think, Mr. McClory, in addition to violating some court decision, that it would be contrary to the intent of Congress, when you and others, who are interested in this, made title VI a part of the 1964 act because, at that time, Congress had before it a lot of information about how the separation of people in various wings or wards resulted in the exclusion of blacks simply because the facility, which was assigned to them, would be filled. This came up in connection with the Veterans' Hospital at Tuskegee, Ala. And it came up in connection with the hospital at Fort Howard here in this area, also.

Mr. MCCLORY. Well, does your study indicate that the poorer rooms are given to the blacks? For instance, rooms in the basement in contrast to sunny, open windowed rooms?

Mr. MITCHELL. Well, that certainly was the case when we presented the testimony to Congress.

Mr. MCCLORY. I know, but how about now?

Ms. ROSE. In 1967, when I was an attorney for HEW, that is what we found and we found literally wings in the basement for blacks.

Mr. MCCLORY. Yes, and in this more recent study that you made, did that indicate that that practice was being continued, or is it just the element of segregation that seems to be persisting?

Ms. ROSE. Well, I am not in a position to make a study. I only know in specific instances where I have been involved in litigation within the Government, so I can't say. But, I don't think that is the point, Mr. McClory. In fact, Mr. Mitchell made a very good point. Say you have a 50-bed hospital in a rural area and you decide, well, you don't have as many black people as white and they are poorer and you have 15 rooms at one end of the hospital. Say it is an equal hospital in terms of all of the rooms, with 15 decent black rooms of the 50, and the others white, and you get an epidemic and you have the 15 black beds filled. Then the thinking comes in: well, I have to keep the other beds for the whites. That is what we found in 1966 and 1967——

Mr. MCCLORY. But I am more interested in this later period.

Ms. ROSE. Yes.

Mr. MCCLORY. Did this information indicate any discrimination insofar as quality of services?

Ms. ROSE. Well, these, of course, are just one page paper reports at HEW. HEW didn't inquire into that. I think, as you came in, Mr. McClory, Mr. Edwards had asked me questions and I was discussing that in the system as a whole, there is inequality of services. The more sophisticated and the more complicated machinery are in the hospitals that are very largely white in many areas of the country.

Mr. MITCHELL. I would like to comment on that, too, Mr. McClory, because, while I am not an expert on hospital matters, as Ms. Rose is, I am aware, on the basis of personal contact with many institutions around this country, of what the picture is and I would say in every instance where I have seen a hospital, which is identified as a black hospital or a hospital which is identified as one giving the major part of its services to the black community, in every instance the facilities are not equal to the institution which serves the greater community. So that the mere fact that the separateness is a handicap. But added to that, as Ms. Rose said in her testimony, is the tendency when anything happens to a black person, to just send him to that black hospital. So, some years ago, we had a big blowup in Washington about the Methodist Hospital, I think it was, where a lady was expecting a baby and the story was she didn't get in and almost had to have the baby on the sidewalk. Well, that doesn't happen now, but Ms. Rose in her testimony pointed out that in a situation where there was an automobile accident in front of one of these hospitals, which caters largely to the white people, the white victim of the accident was taken across the street or to the front door, whichever was the case, while the black victim was sent some distance away. That is the standard practice.

Mr. MCCLORY. Well, I take it from your testimony, that you feel that there is a positive duty to effect integration in addition to eliminating discrimination?

Ms. ROSE. I don't see how those concepts can be separated and I think the courts have said that.

Mr. MCCLORY. Going back, you did start your testimony on page 10, referring to the "Obtuse legal reasoning which ignores the teachings of the courts," and is that what you had in mind? In other words, is this obtuse legal reasoning on the part of the Justice Department or the Office of Civil Rights? Is it within HEW?

Ms. ROSE. Well, I think it is the Office of Civil Rights. I am not saying the Justice Department, because when the Justice Department has gotten involved in these cases, often as amicus, their position has been largely the position we are talking about——

Mr. MCCLORY. In other words, they have a clear sense of legal reasoning?

Ms. ROSE. Well, they have a clearer one. When I discussed earlier the obtuse legal reasoning, that is not getting beyond the context of overt discrimination. The Office for Civil Rights seems to think that once they remove the signs from the entrance doors, they can't do anything else, and that is what I was talking about, more than what you are saying.

Mr. MITCHELL. One of my favorite quotes from a Supreme Court decision, Mr. McClory, is that the Constitution prohibits sophisticated

as well as simple-minded attempts to deprive people of their constitutional rights. The simple-minded attempts are when they put a sign over the door and say, this is the colored ward, or whatever it is, and the sophisticated method is what Ms. Rose is talking about. And I don't think there is any question, speaking as a lawyer, that that is also prohibited by the law. We can draw fine distinctions, but the facts of life are that, if you have a ward in which you concentrate the black patients or if you have a system of administration which says, we will put you in a certain room with a black person, even though it might not be available at the moment, and you might have to put an extra bed in there, at the same time there is a bed available where a white patient is. There isn't any question in my mind that that is the type of discrimination which is forbidden by law and I think that is what we have got here.

It isn't only on the nice academic level of saying, well, the law requires that people be admitted, but if you let them come to the door and put them in a separate room, then maybe the law doesn't reach that. There isn't any question in my mind that the law does reach it, and those who practice that are violating the law.

Mr. McCLORY. Well, I have some more questions but I will save them until later.

Ms. ROSE. OK. Although the Office for Civil Rights has alluded, both to the GAO investigators, which I think was alluded to, and to members of the health task force and the American Public Health Association, that various actions have been brought or are pending, close examination reveals that OCR has entered cases after they have been brought by private parties, represented by civil rights, legal service, or public interest attorneys. The Connecticut matter was precipiated by the Puerto Rico League Defense Fund. Over 2 years ago, Public Advocates, a public interest law firm, brought an action against the California Welfare Agency as well as HEW for nonenforcement of title VI. In fact, I have gotten this morning some of the papers in that case. That case was in January 1971, and a detailed, very thick complaint was filed with HEW. That is almost running on 3 years now.

Precipitated by this action, OCR apparently investigated the cause of the complaint, discrimination practiced by the Sonoma County Department of Social Service. This investigation occurred in September 1971; in June 1972 a letter of noncompliance was sent to the county office.

That should be made a part of the record, too.

Mr. EDWARDS. Without objection, it will be made a part of the record. [See p. 50.]

Ms. ROSE. To date no action has occurred to enforce title VI or to cut the county off from Federal funds. As noted by the U.S. District Court for the District of Columbia, and affirmed by the court of appeals, in the case of nonenforcement of title VI in education facilities by the Office for Civil Rights, there is a reasonable time limit to seeking voluntary compliance. A consistent failure to act constitutes a violation of the agency's duty to enforce the law [*Adams* v. *Richardson*, CADC June 12, 1973, No. 73-1273].

I would like to also submit for the record a copy of the letter I received this morning from the California Rural Legal Assistance,

which actually is handling the case as a lawsuit which gives a summary of their problems in trying to get the welfare agency to act.

Mr. EDWARDS. Without objection, it will be received and made a part of the record. [See p. 56.]

Ms. ROSE. Thank you.

Ironically, the Office for Civil Rights can go no further than its sister agencies if it wants to find practices and policies which accept discriminatory and segregated systems. I shall only briefly allude to these practices. The Hill-Burton program is one with which I am quite familiar, largely because of the *Cook* case and its six companion cases across the country which finally forced HEW to recognize that it had some obligations to enforce the commitments of Hill-Burton hospitals to afford a reasonable volume of services to persons unable to pay and to be accessible to all persons in the territorial area of the facility. In response to interrogatories in the *Cook* case on the civil rights aspects, HEW identified areas of the country where all private room facilities had been approved for Hill-Burton funds, the vast number of these in the South. In response to a more specific letter, the facilities were identified, and a check of these facilities with the Hill-Burton project register indicates that these facilities received the grants after title VI was promulgated. I have attached copies of the answer to the interrogatories and the letter.

I would like to have this made a part of the record.

Mr. EDWARDS. Without objection, that will be made a part of the record. [See p. 54.]

Ms. ROSE. Although HEW takes the position that the all private room hospital is more efficient—which is a matter in dispute with health experts, I would like to state—how come the incidence of constructing such facilities is largely confined to the region of the country where segregated facilities were openly and actively maintained until the pressure of title VI upon a desire to participate in the medicare program began to be felt? What effect does this practice have upon room rates and we note that medicare pays for semi-private rooms, and what effect does increased room rates have upon persons with low incomes, a class in which minority persons are disproportionately highly represented?

In many areas we have witnessed the flight of the hospital into the suburbs from the inner city, funded with Hill-Burton moneys under the modernization guise. If a service area is large enough, the "need" in the ghetto portion permits the far reaches of the area to obtain a facility which the ghetto residents shall never use. This is what occurred in Chicago, I think it was last year or 2 years ago, where two hospitals fled the inner city, to the white suburbs located at the other end of a pie-shaped service area.

In 1970 Congress, recognizing the problem of lack of private physicians in urban and rural poverty areas, amended the Hill-Burton Act to give a priority for construction of outpatient facilities in such areas and to permit freestanding facilities to apply for such construction moneys. This amendment has been ignored in a substantial number of States, where the vast portion of the moneys has been

awarded to hospitals not located in poverty areas and/or not serving the poor and also not given to outpatient facilities. HEW has approved such awards.

As I recall, the statistics in 24 states for fiscal 1971, the money was so transferred, totally or partly, and it was 16 States for 1972 moneys and, of course, the 1973 money has been impounded.

One would have hoped by 1973 that OCR would have reached the level of sophistication to analyze the operation of HEW health programs and see how these programs encouraged and aided the perpetuation of the dual, and unequal, health system. The failure to proceed beyond the concept that only overt discrimination was involved doomed any such hope or expectation. It is ironic that the grand platitudes of the Department recognize the realities which the operatives in the Department ignore. We all have heard the statistics and studies which demonstrate the greater health hazards of being both nonwhite and poor in this society. Let me close with a quote from the HEW White Paper of 1971 in this regard:

> On nearly every index that we have, the poor and the racial minorities fare worse than their opposites. Their lives are shorter; they have more chronic and debilitating illnesses; their infant and maternal death rates are higher; their protection, through immunization, against infectious diseases, is far lower. They also have far less access to health services—and this is particularly true of poor and nonwhite children, millions of whom receive little or no dental or pediatric care. [Toward a Comprehensive Health Policy for the 1970's: A White Paper, U.S. Department of Health, Education and Welfare, May 1971, p. 2.]

Thank you.

Mr. EDWARDS. Thank you very much, Ms. Rose. That is a most helpful statement and one that has been, obviously, carefully prepared. We appreciate it very much.

Most of your testimony had to do with hospitals. Would the same facts apply to nursing homes that participated in medicare?

Ms. ROSE. Oh, absolutely. It is both medicare and medicaid that you would have with your nursing homes and, in fact, the referral practice that I talk about in hospitals when we talk about staff position—well, when we are talking about the nursing homes, we are talking about the State welfare agencies because a large portion of them are responsible for the referrals. These are the agencies, of course, to whom the HEW has given jurisdiction with its so-called State agency review.

Mr. EDWARDS. As I recall the testimony by the General Accounting Office, where they found a number of the same facts that you did with regard to patient load being practically all black in one hospital and all white in another. As I recall that, the GAO investigation reflected that one of the reasons was that white doctors were attached to these particular hospitals and had all-white patients and, second, that the black patients were accustomed to going to public hospitals and, therefore, apparently would have no reason to seek out a private hospital, even though they would be entitled to such care under medicare.

Ms. ROSE. Well, of course, this gets into the affirmative action concepts I discussed. I think a hospital that has an all-white patient load

has the guideline No. 1 obligations and, if its staff doctors, only treat white patients, then that hospital has to make efforts to be accessible to the minority population and, that is, especially so in hospitals that are located near minority populations. Unlike what GAO said, a significant portion of the hospitals are so located and they are in inner cities. Their former white patients may have gone out to the suburbs and their doctors went with them, but these hospitals have obligations, I think, to serve that immediate community.

Mr. MITCHELL. I would like to make an amplification here and these things sometimes are so fantastic, that it is hard for a rational person to believe that they actually occur.

In the South, for example, I know there are times when undertakers refuse to comb the hair of black persons and make the family do it. Well, this kind of thing carries over into medical practices also. We have stacks and stacks of complaints from people in our office from people who say that when they go to a white doctor's office—he is a specialty doctor of some kind and has staff privileges at these hospitals—but they are forced to go into separate entrances and forced to sit in separate waiting rooms. So, I think if you were in the position of some of these people—and I would never voluntarily submit to going through the back door even if I were dying—but I think that is really what seems to decrease the use of these facilities, this discouragement, and I think Congress ought to do something about it.

I think that if these doctors are going to have the advantages of these beautiful hospitals where they can take their patients in—and I think they are really lovely—then they better not have any segregated waiting lists and back doors that people go through. I think we need to amend the law to make it crystal clear that if anybody does that, he cannot participate in the Federal tax benefits that are collected from everybody.

Mr. EDWARDS. Then, well, the doctors don't have to treat medicare and medicaid patients if they don't want to, is that correct?

Mr. MITCHELL. That is true.

Ms. ROSE. Well, a physician or a hospital doesn't have to participate in medicare and medicaid, but, if you look at the incomes of many doctors, you will find a large percentage of their income is going to be from medicare and medicaid. Especially, medicare. If you are treating a nice comfortable middle-class family, and grandma is 70 years old and she has medicare, well, then you better be participating in that medicare because that family will find another doctor. So, it is an incentive, definitely. That doctor is going to be participating in medicare. It is a societal pressure. The question is—and I know Mr. Mitchell raised it and I think it is very important—HEW has drawn a distinction in the years between part A and part B of medicare. Part A provides for a contract with the hospital; the hospital is then a recipient of Federal financial assistance when it signs that contract for medicare and medicaid payments.

And I have always had difficulty trying to conceptualize philosophically the difference between that and part B, which administratively does not provide that the doctor sign a contract; the bureaucracy decided that he isn't a recipient. That strikes me as a strange distinction, but that is the distinction that HEW took earlier. I wonder if there

shouldn't be a second look at this. Mr. Mitchell talked about Congress amending the law and I think you people know how hard it is to get amendments, but I think there should be some look at the question again of whether or not under the current law, there is an obligation.

Mr. EDWARDS. Well, it is your position that the law is not being enforced?

Ms. ROSE. The law is not being enforced and there are a lot of people who won't want to go to a doctor who really doesn't want to treat them, but since hospitals are built with public money and they are tax exempt and the contributions to them are tax deductible, I feel they should follow guideline No. 1. They do get medicare and medicaid money. I think in some statistics I have seen that 50 percent or 60 percent of the money, directly or indirectly, of the hospitals' operational moneys really comes from the Federal dollar. So these hospitals do have a public obligation. And if their staff doctors only treat whites, that hospital has an obligation to find alternative means by which the people of their community get served, whether we are talking about blacks, Chicanos, or whoever; any minority people who get discriminated against in that community.

Mr. EDWARDS. Have you seen any effective programs that have been initiated and followed through by hospitals to solve this?

Ms. ROSE. Well, I think the very fact that a mobile infirmary got up to 3 percent in 1967 was because of the threat that we were going to litigate and it stayed at the same percentage of black patients, even when the suit was dropped. It didn't fall back. So, it did open up to that extent, anyway.

We have seen situations—actually, they relate more to the Hill-Burton obligations where the hospital first said, well, we don't get medicaid patients or we don't get poor people because our doctors don't treat them, and the hospitals have, under community pressure, opened up outpatient clinics and started to serve the immediate community and so they are getting more poor people.

Now, I referred to Hotel Dieu, and Hotel Dieu's bad record in the inner city of New Orleans, but Hotel Dieu as a result of the Hill-Burton litigation, opened an outpatient clinic for its immediate community. It had never served medicaid patients before but in the first 6 months of the consent order it suddenly has treated 200 or 300 medicaid patients on an inpatient basis referred from that clinic. And I think the next time we get statistics from Hotel Dieu, they will have improved somewhat over their previous record as to service to black people because of their increased service to medicaid patients from their immediate area.

Mr. MITCHELL. You know, I can't help but say I think I remember that the word "Dieu" in French means God. Apparently they had to take God into court down there to stop segregation and I don't think He would like that because I don't believe He would want anything in His name to be separated on the basis of race.

Mr. EDWARDS. Is the situation in Washington considered satisfactory?

Mr. MITCHELL. I would not be in a position to answer that, Mr. Chairman. I would say, offhand, that there does seem to be an extensive interchange of patients in all hospital facilities but it does seem

to me, as I look at Freedman's Hospital, as contrasted with the other institutions, that even with the very best of intentions, Freedman's Hospital does not have the kind of facilities and equipment that is available to other hospitals and, unfortunately, there is a heavy concentration of blacks in Freedman's.

Ms. ROSE. Well, along that line, during the more active period in HEW when it was the Office of Equal Health Opportunity in 1966 and 1967, during that time, Washington was one of the cities where there was some pressure and I recall the compliance officer, who was a very capable man, working with Washington Hospital Center which had very few black physicians and they increased the number of black physicians at that hospital and that increased dramatically the black patient load.

I also remember a story that happened late in the 1960's and some of you gentlemen may recall it from the Washington Post, which carried the story of an integrated group of kids who had graduated from the Woodrow Wilson School and were celebrating in Georgetown and some toughs picked a fight with them and one of the toughs had a gun and shot two of the kids. The white kid was taken by ambulance to Georgetown Hospital and the black was taken across town to District of Columbia General where he was dead on arrival. It was in 1968 or 1969 that that occurred. So these things still occur here, too.

Mr. EDWARDS. Thank you.

Mr. MCCLORY. It seems to me you are testifying about two different subjects. One is the predominance of whites and blacks in hospitals, and the other is the lack of integration of black and white patients in the hospitals. Now with respect to the affirmative action that you feel that hospitals should take to integrate patients in the hospitals, for instance, dividing up more equally the single rooms and to mingle people in the wards and that sort of thing, now, do you have some recommendations as to how that should be done?

I mean, I have an idea that it is the admissions clerk that says, "All right, I am going to assign you to the third floor in ward B," and it is kind of an arbitrary decision and it is made by an admissions clerk with rather broad authority. Now, should there be some kind of a system by which people are assigned by lot or should we intentionally put blacks and whites in the same ward in order to achieve integration? What is your recommendation?

Ms. ROSE. Well, if I were the administrator of a hospital and I walked through my hospital and found all of the black patients in one ward or one wing, and all of the whites in the other, I would know that my admissions clerk was violating the law and I would do something about it. That is the easiest way to check. Statistical probability just doesn't come out that way. If a hopsital is assigning people to rooms and beds without regard to race, the statistics just wouldn't come out that way. Actually, hospitals should be doing that. Of course, there is segregation; for instance, there is medical and surgical segregation, there are age segregations, there is sex segregation. There are other factors that have justifiable medical reasons and within each group you should find that there will be some people in rooms with a number of the same race and some of the other race, so you just look at statistics over a representative period of time. If your admissions

personnel is separating people because of race, or if you find that the statistics don't support the separations, you get your admissions clerk to do something about it, or you get yourself a new admissions clerk.

Mr. McCLORY. Well, there is no specific plan then that you have? The result would be the most important factor and any kind of a variety of plans would be all right?

Mr. MITCHELL. Could I just clarify our position a little bit?

We are not so much talking about positive programs to mingle whites and blacks. We are talking about eliminating a program that separates them on the basis of race and then let the normal operations of the laws of chance come into play. I don't know whether you have ever noticed this but in hotels, for example, somehow or other, the clerk, when a black person comes in, looks all around behind the counter and all over the place and somehow or other the blacks wind up by the elevator shaft or in a back place where they don't get a good view of whatever there is to be seen.

Now, I know enough about the hotel industry to know that this is purposeful discrimination on the part of the industry. I also know enough about hospitals because it so happens that I have some rather intimate connections with hospitals in this country. I don't want to embarrass anybody by mentioning that because the people I am connected with might not appreciate my saying it. But the fact of life is that these hospitals conscientiously try to avoid putting blacks and whites together, even under some of the very best of circumstances.

Ordinarily, the policy is so entrenched that in many instances when you have a black person on the admissions desk, for instance, you somehow or other wind up with segregated arrangements also. So this is not a low level decision. This is a high level decision and it seems to me that it ought to be required that when people are presented for admission to the hospital they get into the first available space and nobody should go down behind the counter and look around and find out who is white and who is black. It should just be that room A has a vacant bed in it and put the patient in it, and if by the laws of chance it turns out that the other patient is white, that is OK; that is all we are talking about.

Mr. McCLORY. You and I are integrationists, but I think we have a lot of segregationists, both among whites and blacks, from what you tell me and——

Mr. MITCHELL. I don't agree with any of them, Mr. McClory. I think this is America. I don't believe in black segregation or white segregation. I don't think that if you and I, for instance, were in an accident—good friends as we are—and I happened to have some black friends who wanted to put me in a nice room with a beautiful view and all and first-class medical care, I still don't think they ought to put me up there and put you in the basement because they don't happen to like white people. I think it ought to be the same for everybody.

Ms. ROSE. We brought up the example of discrimination to show that HEW doesn't even act when they find overt discrimination. The major point of the testimony was the disparity of treatment in the hospitals and segregated hospitals, you know, you don't get to talk about same rooms and all because the blacks are over across town in the black hospital.

27-401—74——6

Mr. McCLORY. We are not going to get into the busing of patients, though, I mean, you made the comparison of the school integration and that has caused us enough headaches, but——

Mr. MITCHELL. Now, you really opened up a can of worms, and the reason I say that, you would be amazed Mr. McClory, because you are a high-minded individual and I don't believe you know that things like this occur but——

Mr. McCLORY. I am glad that is down on the record.

Mr. MITCHELL. But really in many, many communities of this country, blacks are not given ambulance services. The undertakers supply the ambulance services. Now, even if they had nice looking rooms and that kind of thing. I don't suppose you would feel like you were going to get out of the hospital if you go there under the auspices of an undertaker in the first place.

Mr. McCLORY. No, I don't think so.

Mr. MITCHELL. So, you really put your finger on something important. We think of this as just beds and wards and that kind of thing, but the collateral services including transportation to the place where you are going to get the medicare, that is also important.

Ms. ROSE. May I mention when you say busing, Mr. McClory, we have done some kidding about busing but if you look at the big cities in the north, like Chicago or Los Angeles—where I have lived for 2 years—you will find that the minorities will travel long distances on public transportation. Chicago, for instance, is abysmal. When blacks take public transportation across town to go to Los Angeles general, they travel by one after another virtually all white hospitals that are built with Hill-Burton money but do not serve the minority communities.

I remember a quote in a study that was done in Chicago about Chicago's apartheid health system and this quote was by one woman who had to travel 20 miles to get to Cook County, which is outside the city and far from the ghetto, and she said she would have to be $12 worth sick to be able to get to that hospital.

Mr. EDWARDS. Is she a medicare patient?

Ms. ROSE. I don't know.

Mr. EDWARDS. I wondered why she would have to go across town——

Ms. ROSE. Because she was a black patient.

Mr. EDWARDS. Right.

Ms. ROSE. And she felt that she could not get into the nearby white hospitals, but that Cook County would treat her and the quote was that she would have to have $12 worth of sickness before she would pay the $12 to get a cab out there.

Mr. McCLORY. Was that a false notion she had, though?

Ms. ROSE. I don't know whether it was a false notion. It is like the notion when we have the freedom of choice in schools that all of these black kids and black parents could have chosen a white school, but chose the black schools. The onus was put on them. I think the onus should never be put upon the discriminated person to change the system and in the health system it is even more grievous.

One of the witnesses we had in one of the South Carolina cases in 1967 was a leader of the NAACP in his county in South Carolina and he was talking about the internal segregation in this particular hos-

pital and he said it had a freedom of choice system. There was a white wing and a black wing, so supposedly the blacks could choose the white wing if they wanted. He had his 12-year-old daughter in the hospital and was asked by the counsel why he chose the black wing—she was in the black wing—and he said: "I don't know what those people in that hospital would do to her if I put her in the white wing and I wasn't going to gamble with her life."

Mr. McCLORY. Are there records kept with respect to the color of patients in the admissions department?

Ms. ROSE. HEW has required it since 1965.

Mr. McCLORY. And, of course, if those records were not kept, it would be very difficult to determine whether or not statistically the degree of integration or separation. Now, you mentioned two hospitals in Chicago and the Chicago area. I am interested in the two hospitals that moved from Chicago into the suburbs.

Ms. ROSE. I would have to supply that to you. I must say I thought this morning I should get that because Mr. McClory is from Illinois and is going to ask me that. I will get the information. The lawyers committee for civil rights under law in Chicago were handling the matter and I can't remember the names but I will get it. [See app. 2 at p. 265.]

Mr. McCLORY. Is it fair to say that one of the related problems that could be resolved or that would help resolve this problem is the shortage of black doctors and nurses?

Ms. ROSE. Well, I would think, of course, if there is an increase of black doctors, they are going to have black patients. A lot of the younger black doctors now are in cities and have integrated patient loads like everybody else, like white doctors, but the older doctors have black patients.

Mr. McCLORY. But, in general, the population is not quite used to a general supply of black doctors?

Ms. ROSE. That is correct. In New Orleans, for instance, I think it is now 36 or 38 black doctors. That is a very small number of black doctors but white doctors serve black people in New Orleans, of course. Some of them do and some of them don't.

Mr. MITCHELL. I think, Mr. McClory, that in addition to having the doctors available that we must have also access to these hospitals, which, as Ms. Rose's testimony points out, have such a small number of people and give them hospital privileges. Now the Medical Association, as I understand it, requires that every 3 years in order to keep a license, a doctor must show that he has a certain amount of training and exposure to more modern treatment, and, if these are not available in some institutions, which the black doctors may use, even though they have had the training it is still a possibility that they might not be able to qualify for the regular licensing requirements. So, it is a broad-gaged problem we are talking about.

Mr. McCLORY. Now you made reference, Ms. Rose, or Mr. Mitchell did, to the separate entrances and the back doors and that sort of thing. Are there any entrances that are marked "colored only" or "white only" that you know of in these hospitals?

Ms. ROSE. We have not seen such in recent months.

Mr. MITCHELL. May I answer that? We have not seen any in recent months where they actually have a sign up, but I have a number of

complaints where people indicate that they are required to go through a certain kind of door, or sit in a separate waiting room in a doctor's office and we have been all up and down the road with HEW and everybody else trying to correct that problem.

Ms. ROSE. The reports that I get are that you still find very overt instances in some doctors' offices but the hospitals have moved away from having the signs up, even in the Deep South.

Mr. MCCLORY. But do some of the hospitals still have the separate waiting rooms even though they do not have them separately designated? Are you aware of anything like that?

Mr. MITCHELL. I would not be aware of anywhere where they have a distinct room. I am aware somewhere, where they have an arrangement where somehow or other the blacks get in one section and the whites get in another and it is hard to say whether that is entirely by choice. I think you know, there is always a way to steer people in a certain direction but that problem, Mr. McClory, as far as I know, is not as acute as the one to which I referred, where people are required to sit in separate waiting rooms if they want to get treated.

Mr. MCCLORY. Do you have any view along this line that, for instance, in a city where they have 10 hospitals and the racial population is 50 percent black and 50 percent white, to make this a simple illustration, do you have any views that all of those 10 hospitals should accommodate 50 percent patients in each of the 10 hospitals?

Mr. MITCHELL. Fifty percent of what? Fifty percent of the black population?

Mr. MCCLORY. And the white population.

Mr. MITCHELL. No, I think as I said before, the best way to be sure that everybody is treated right is where, if an accident occurs—as Ms. Rose indicated—right on the front steps of the hospital they ought to pick the black man up and take him through the door and treat him and not send him all of the way across town. And by the same token, I think that if the physician knows there is available a hospital which specializes in a certain kind of treatment, he ought not have to question whether a black patient could get in there or find a bed. It seems to me he ought to just send him on over there.

Mr. MCCLORY. Well, in contrast to the school integration cases, then, we do support the neighborhood hospital principle.

Mr. MITCHELL. No, I wouldn't say that because, well, for example, they are building a beautiful hospital out in Los Angeles called The Martin Luther King Memorial Hospital. I have been all through that. It is a magnificent place but I could see from looking at it that there would be services there which would be available to that community, yes, but maybe better services—and this is no reflection on Martin Luther King Memorial Hospital—but there would be services in other institutions. And I think that you can't in a hospital arrangement rely on neighborhood concepts.

A beautiful example is: Who would want to rely on a neighborhood concept, a neighborhood hospital, if you had a chance to go to the Mayo Clinic or Johns Hopkins as opposed to the hospital that is right next door to him?

Ms. ROSE. May I quote another thing? At a pretrial conference involving the hospitals in New Orleans—and this is from the Hill-Bur-

ton aspect—you mentioned the Mayo Clinic and that reminded me of Ochsner. Ochsner is considered the Mayo Clinic of the South and we had these stipulations at this pretrial conference and the judge started to read the stipulation about what a great hospital it was, and the judge read this paragraph and he turned to the lawyer from Ochsner and said: "That is why Rosella Cook wants to go there."

Mr. McClory. Thank you very much.

Mr. Butler?

Mr. Butler. No questions.

I would also apologize for being late.

Mr. Edwards. The committee would like to have these two witnesses stay here for a considerable length of time more than they have been here this morning, but today we are rather pressed for time and certainly you have made a very good case, Ms. Rose, but in any event, I have no more questions. Perhaps we will submit any questions, if we do have some, to you by writing. With that, we thank you very much for your appearance here this morning. It has been very helpful.

Ms. Rose. Thank you. I will submit the information Mr. McClory asked for.

Mr. Edwards. Thank you. We also have with us this morning two witnesses from Aiken, S.C. Would Mrs. Barbara Paige and Mrs. Tolar Lee Gibbs step forward?

TESTIMONY OF BARBARA PAIGE AND TOLAR LEE GIBBS, AIKEN, S.C.

Mrs. Paige. Thank you.

Mr. Edwards. Mrs. Paige is with the Community Service Organization of Aiken, S.C., and Mrs. Gibbs is with the National Welfare Rights Organization in Aiken, S.C.

We welcome you both and if you have a prepared statement, you may proceed.

Mrs. Paige. Well, I would like to say we haven't a written statement to give, but if this is necessary, within the next 30 days you can have it for your records.

Mrs. Williams, which is the young lady who was actually involved, she was one of the women that were sterilized, was supposed to be here to testify herself but instead I came and thought perhaps I could give you really what is going on down there.

Her reason for not coming was when she informed her supervisor where she was going, he let her know that if she missed work she wouldn't have a job when she came back. So this is why I am here instead of Mrs. Williams.

Our problem——

Mr. McClory. Where does she work?

Mrs. Paige. She is working at one of the mills. Let me let it stay right there. I don't want to be liable for anything.

Mr. Butler. Mr. Chairman, if I may, I think we ought to explore that. This is a committee and we have asked these people to testify and if this sort of coercion exists, I think we ought to put that in the record. I think we ought to be more specific and I don't think we ought to let it stand on generalities.

Mrs. Paige. The reason I made the statement like I did, this is what she said to me is what he had said. Now, I don't know if it is the reason that she didn't have any leave time or he didn't fully understand what this was about and so I can't assume that this was personal because I didn't talk with the man myself but this is what he told her, that if she did go and wasn't here to report to work she didn't have a job when she came back.

Mr. Edwards. Our problem, of course, is that we don't want to be responsible for her losing her job. If we go into it in much detail she might——

Mr. McClory. Mr. Chairman, if I may? Did we invite her?

Mr. Edwards. Yes; she was going to travel at the committee's expense, I understand, and she accepted several weeks ago.

Mrs. Paige. Yes; and she informed me just on Saturday that she couldn't come.

Mr. McClory. What is her first name?

Mrs. Paige. Bertha Williams.

Mr. McClory. Well, I would like to get the information and have counsel for the committee get this information. I agree with Mr. Butler, I think we should pursue the subject further and my own feeling is that she should insist that she appear and that, if she does not appear, issue a subpena and have her appear.

Mr. Edwards. Shall we proceed in executive session on this subject at a later date?

Mr. McClory. All right.

Mr. Edwards. You may proceed.

Mrs. Paige. Speaking from just off the top of my head of what I know that is going on now in Aiken County as far as sterilization is concerned, it is not a thing by choice. It is being done to our women that are on medicaid. The reason I say that it is not being done by choice is because we have only one doctor down there which will have medicaid patients or even three medicaid patients and this one doctor is the one that insists that, if they have at least three children, that with the third child they will have to sign a paper for him to sterilize them. I don't know but it seems to me to be a type of thing that—well, let me sort of get myself together here.

This is being done against their wishes. Now, it is not that the women mind so much being stopped from having children but it has been rumored from some of the other ladies and statements they have been making, they say that he has been telling you when you sign this paper that it is a regular tubal ligation, which is the tying of tubes and when you wake up it might be a total hysterectomy, and this is the fear that these women have.

We have been trying to get them to see another doctor but the other doctors in the county will not see them. And let me tell you of an incident that happened only a short time ago with one of our ladies. She called me and told me that he had presented her with this paper that either you have the sterilization operation or I will refuse to deliver the baby and, well, you would say she should go somewhere else; am I right? But if there is not another doctor that would see you, and you are on medicaid and the State of Georgia is the only place that has the closest hospital and if welfare had told you that they wouldn't

pay the bill, well, what are you supposed to do then? So this is the reason they have to consent to letting him do what he wants to do.

There was one in particular that he told he was going to give a D. & C. to and after she woke up from the operation she found out that he had given her a hysterectomy. This upset her to the point where she is now in the State hospital. She was another one who could have been a witness today.

But now let me, at this point, add that talking off the top of my head, gentlemen, it is not helping too much, but if you would tell me exactly what it is you want to know, I am better at answering questions than I am just sitting here talking at random.

Mr. EDWARDS. Is there just one hospital in Aiken County?

Mrs. PAIGE. There is one hospital in Aiken. At the time it is a county hospital but they are working very diligently trying to make it a private hospital.

Mrs. GIBBS. That is right.

Mr. EDWARDS. And is that Aiken County Hospital?

Mrs. PAIGE. That is right, Aiken County. It is really not equipped to take care of the people of the county, though.

Mr. EDWARDS. There are no clinics, no neighborhood clinics, at Aiken?

Mrs. PAIGE. You have your health department and the only other clinic is the planned parenthood clinic. These are the only two.

Mrs. GIBBS. And may I add to our statement about the Aiken County? Medicare and medicaid patients, if they go to the hospital they are being turned down and they say they don't have any staff doctors and that is the situation they are left with. If a medicare patient gets sick the first time—I don't care how sick he is—they say, where is your doctor and, if you don't have any doctor, they are turning you down.

Mrs. PAIGE. What she is saying is in the case of an emergency situation where you go to the hospital, and you don't have a family doctor they will refuse to see you.

Mrs. GIBBS. They will refuse to see you.

Mr. EDWARDS. How many doctors are there in Aiken County?

Mrs. PAIGE. That is pretty rough.

Mrs. GIBBS. Well, we have about 39 doctors according to the survey we have taken in Aiken County.

Mr. EDWARDS. Are they black and white doctors?

Mrs. PAIGE. There is only one black doctor in Aiken County and he has had a stroke and is not practicing now, but we do have three black doctors right in Georgia. They live in South Carolina and have offered their help, but since they practice in another State, they were not really sure they would get their money.

Mr. EDWARDS. How many of these doctors in Aiken County have a certain part of their income coming from medicare and medicaid funds? Is it practically all of them?

Mrs. PAIGE. Well, it has narrowed down since there has been so much confusion to the point where quite a few of the doctors will not receive medicaid patients now. This one doctor, in particular, is about the only one. The other doctors say they will continue with the few patients they have but, as new patients come in and they find out you are on medicaid, they just won't bother.

Mr. EDWARDS. What kind of improvements would you like to see made in Aiken County to serve the black population?

Mrs. PAIGE. Well, at this time I feel like increasing perhaps our planned parenthood program and getting other programs of educational benefit into this area to educate these women. It sounds silly at this day and time that a woman wouldn't know what sterilization means but until this issue came out in the papers, there were many women that knew they had signed for this type of operation who didn't really know until a month or so ago what had actually been done because they weren't educated to the fact and they just signed the paper because the man said, this is the way it must be done.

Now, I don't feel like any person has the right to set himself up as God to say who should and who should not come into this world. Now, I am definitely against any doctor that says this. I am not saying that I go along with women on medicaid continuously having babies and this type of thing but who are we to say how many children people should have; this should be a choice of the individual. When we get to the point that we are saying, how many children you are going to have, and how many this one is going to have, because he is poor, well, none of us are here—none of us poor people, I mean—because we wanted to be poor, because if somebody had asked me before I got here, what do you want to be, I would have said rich, too, but I wasn't that lucky.

Mr. EDWARDS. Thank you.

Mr. MCCLORY. Mrs. Paige, do you know of other women in addition to Mrs. Bertha Williams, who claim that they had been sterilized?

Mrs. PAIGE. It is not claimed, sir, these are facts. Oh, I could really just off the top of my hat tell you of at least 20 right in Aiken proper.

Mr. MCCLORY. And they have had the same experience as you say Mrs. Williams had?

Mrs. PAIGE. Well, I don't know. Let me tell you about the incident that happened not too long ago.

I had a young woman call me—and this was before she had delivered—and when she called me I said, don't bother to go back to that doctor: I believe I can get you another doctor. I called the planned parenthood program and the director there, working along with me, we both tried to secure doctors for these women, so that they wouldn't have to go to this particular doctor. Anyway, after my conversation with her—and we had assured her that we could have another doctor—but the next morning I received a call from her saying: "I have changed my mind."

I made the mistake of calling the welfare department and saying to them:

> I thought you people here had instructed your Case Workers that if you received any complaints from any of your clients that that doctor said he would only deliver the baby if they consented to be sterilized, that you would help them find another doctor or you would refer them to us.

And she said: "Well, we do."

So that was that situation.

Anyway, the next morning this young lady decided to go along with Dr. Pierce and take her chances as she said. I thought it was so strange when she was so eager just the night before to go to someone else but, anyway, I can't say that these women are being threat-

ened. You can't get them to talk freely. All I know is what is going on and it must stop.

Mr. McClory. Well, from what you tell me and this other incident that you have related, apparently, the women consented knowing what they were doing; is that correct?

Mrs. Paige. Well, if you have no choice and there is a baby inside of you, Mister, and it is time for it to come out and there is nobody else to get it out, you know you are not going to do too much bargaining. You know, that is the wrong time to do any bargaining. These women are afraid when there is no one else to handle you.

Maybe someone says: "Well, when you come out here there might not be any finances either" so that, you know, you really don't know what is really being said to the people because these women are afraid; they are frightened and they won't talk. That is why they ran me up here today because I think they are actually afraid.

Mr. McClory. Now, do they sign this statement——

Mrs. Paige. They are afraid.

Mr. McClory. Do they sign this statement before the delivery?

Mrs. Paige. No, sometimes it is after delivery. We were able to get one through just the week before last. I told her that to go in there and have your baby and stall signing anything and, after the baby is born, let's see, when you tell him, no, what is going to happen. So this was done the Sunday before last, and then he approached her for her to sign the forms, she said, no, but the baby was already here so she was dismissed right then and was told not to come back for her 6-week checkup because she wouldn't let him sterilize her.

Mr. McClory. So that what you are telling me is that the condition upon which either a baby is delivered or there is postnatal care provided is that the mother sign the statement that they consent to be sterilized?

Mrs. Paige. To be sterilized, yes.

Mr. McClory. Are these all black women?

Mrs. Paige. There is only one white that contacted me but she was lucky. We were able to get her out of it. She called me ahead of time and I got a doctor to deliver the baby, but after the paper came out showing the doctor that delivered the baby was black, and she was a white woman, so now in the town where she has to live her people are looking down on her. They refuse her credit in stores where she has been getting it all along and she has been harassed because she wouldn't let this doctor sterilize her.

Mr. McClory. And are all those patients on medicaid?

Mrs. Paige. Yes, these patients are on medicaid. And I would like to add one thing: You were talking to Mr. Mitchell about signs being down in separate waiting rooms. We still have them in Aiken County. Several of our doctors still have them. They have a new technique now, where it doesn't say black and white. They have numbers and you know who No. 2 is.

Mr. McClory. They have a waiting room No. 1 and waiting room No. 2?

Mrs. Paige. And you know who No. 2 is?

Mr. McClory. As I understand it, you have one white doctor there and one black doctor.

Mrs. PAIGE. One black doctor and he is not even practicing now because he has had a stroke.

Mr. MCCLORY. So you only have one doctor and that is a white doctor?

Mrs. PAIGE. No, they have several doctors but there is only one doctor now who will see medicaid patients.

Mr. MCCLORY. And what is his name?

Mrs. PAIGE. Let me give it to you. The first name is—well, the last name is Pierce and I was trying to give you the first name.

Mr. EDWARDS. C. H. Pierce?

Mrs. GIBBS. Yes. He is C. H. Pierce.

Mrs. PAIGE. Yes, his name is Clovis.

Mr. MCCLORY. Now, you say there are 20 women that you know of that have given you evidence at this time and have told you about these sterilizations?

Mrs. PAIGE. Yes, well, you see there is a few that had called me before; then after the story came out in the paper and the people are talking about it so much, others called. The women really didn't know what sterilized meant at the time. So now that everybody is talking about those two girls, they are coming up and they are saying: "Hey, he did that to me, too." So, it is just really coming to light what has been happening.

Mr. MCCLORY. This all fits a particular pattern he has and, that is, he doesn't make you sign the statement if you are having your first baby or the second baby?

Mrs. PAIGE. No, it is the third one. Now, how can he set himself up as a god to do this type of thing. I thought his job was to bring life into the world and to keep us here a little bit longer, but now he is going to say who is coming.

Mr. MCCLORY. Now with respect to the planned parenthood organization, do they advise as to other means of birth control?

Mrs. PAIGE. Yes, they do, but with a county that large and they being understaffed and working their fingers down to the bone——

Mr. MCCLORY. You mean they can't accommodate everybody?

Mrs. PAIGE. They just can't get around and they have to serve two counties.

Mr. MCCLORY. Thank you.

Mr. EDWARDS. I think we ought to include in the record at this point articles from the American Medical News regarding the situation you are describing. It is entitled "18 Well Mothers Have been Sterilized at the Aiken Hospital in the First 6 Months of 1973."

[The article referred to follows:]

[From the American Medical News, Aug. 13, 1973]

STERILIZATION CASES STIR CONTROVERSY

Sterilization procedures have been halted at an Alabama facility for the mentally retarded, pending a federal court hearing, and in South Carolina, the state department of social services is investigating the sterilization of welfare patients in Aiken. A $1-million suit has been filed in a second Alabama case involving two young girls.

These are the latest developments in a continuing controversy over involuntary sterilization and the role of government in it.

In mid-July the Dept. of Health, Education, and Welfare hurriedly issued guidelines to be used in drafting regulations, following disclosure that two girls,

aged 12 and 14, had been sterilized in a Montgomery, Ala., clinic funded by the Office of Economic Opportunity.

The father of the girls, both of whom are retarded, filed a $1-million damage suit against the government.

OEO claimed that if its own guidelines had been followed, the girls would not have been sterilized. It developed, however, that several thousand copies of the OEO guidelines were locked up prior to the 1972 election, and were never issued.

The physician primarily responsible for preparing the OEO guidelines, Warren Hern, MD, resigned in frustration last year after repeated attempts to get them distributed.

The South Carolina situation is a little different. Three Aiken obstetricians are involved in charges that they limited obstetrical care to welfare mothers. The allegation is that one agreed to deliver a mother's third or later child only if she agreed to sterilization, and that the other two obstetricians concurred in this policy.

The three physicians are MDs C. H. Pierce, Niles A. Borop Jr., and Kenneth N. Owens.

The South Carolina Medical Assn. executive committee has met with Dr. Owens, and is continuing an investigation.

Hospital records indicate that 18 women of about 50 welfare mothers who had babies at Medicaid expense this year in Aiken County, have been sterilized. In South Carolina, only welfare recipients are eligible for Medicaid assistance.

Archie Ellis, commissioner of the state social services department, said the investigation may take several weeks, and that findings will be made public.

A U.S. Justice Dept. lawyer in Washington, Robert Murphy, said FBI agents will interview four Aiken County women whose names were supplied by the Aiken Welfare Rights Organization.

The new guidelines issued by HEW have four main points:

Local review committees must be established to approve or disapprove sterilization of those under the age of 21 or legally incapable of consenting to sterilization.

Federal funds are to be withheld from any agency or department if sterilizations it sponsors are not approved by such a review committee.

A "court of competent jurisdiction" must review the committee's decision to sterilize a person.

Annual reports on sterilization programs must be filed by local agencies.

The earlier, undistributed OEO guidelines were based on similar guidelines for voluntary sterilization, issued last September by the American Public Health Assn. Dr. Hern was a member of the committee which drafted the APHA guide, and incorporated major points into his final OEO instructions.

"Since the OEO guidelines remain locked up, no one has seen them. But it's my understanding they are very similar to our guidelines," said Ben Terry, APHA director of population studies.

"Freedom from coercion to be sterilized is as essential in protecting the rights of an individual as the acquisition of informed consent," the APHA guide says. "Coercion in any form with regard to sterilization cannot be condoned.

"Consenting to sterilization should never be a condition for receiving any form of public assistance. Likewise, consenting to sterilization should never be a prerequisite for abortion or any other health or social service," APHA's statement said.

APHA's executive board rejected an early draft of the guidelines last year, partly because the group felt that provisions for informed consent were not strong enough, Terry said.

The final version contains this statement:

"If . . . the person seeking sterilization cannot understand or comprehend the nature and consequences of the operation, he may not be competent to sign the consent. In all such instances, it is incumbent upon the health worker to seek further assistance in identifying the barriers to understanding. If there still remains substantial doubt that the person understands the nature and consequences of the operation, the sterilization should not be performed."

In all, eight federally funded agencies offer sterilization programs in Alabama similar to that of the Montgomery clinic. Under federal law, family planning must be provided in state Medicaid programs to all eligible persons, including "sexually active minors" when such services are requested.

Alabama officials also said 82 persons have been sterilized within the past year under state family planning programs, not related to the federally funded activities.

A second suit in Alabama, not involving the two young girls, concerns procedures at Partlow State School and Hospital, a facility for the mentally retarded.

The complaint, added to a two-year-old suit against the hospital, alleges that Partlow officials "have caused numerous inmates . . . to be surgically sterilized." It claims patients were sterilized without informed consent, and without submission of the cases to the hospital's sterilization committee.

The complaint also claims the hospital's assistant medical director suggested that several patients could be sterilized by cobalt treatment, rather than by tubal ligation. The physician referred to in the complaint, Charles M. VanDuyne, MD, has resigned.

Dr. Pierce Backed by Colleagues

American Medical News talked with two of the three obstetricians involved in the sterilization controversy in Aiken, S.C. The third, C. H. Pierce, MD, was out of town and unavailable for comment.

The three men are the only obstetricians in Aiken, a town of about 15,000 near the Georgia border.

Kenneth N. Owens, MD, has been practicing in Aiken for the past 14 years. A native of Colorado, he came to Aiken after 11 years of service in the Army Medical Corps.

Dr. Owens says he has performed none of the sterilizations on Medicaid patients. On philosophical grounds, he has refused to bill for Medicaid services for the past year and a half.

"The story has been blown all out of proportion, we feel," he said. "I took the facts to the South Carolina Medical Assn. executive committee. The committee was in a position not to do anything—because there has been no complaint, except from the newspapers."

Representatives of the state department of social services came to Aiken, "and went over certain information with Dr. Pierce in his office. Now, what was gone over, or what was done, no one knows."

"I question, and others question: was this a violation of Dr. Pierce's constitutional rights? Does the department of welfare have the legal right to do this?"

"I am not involved in this, other than (my) public pronouncements," said Dr. Owens. "I do not see Medicaid patients; I do not accept them. If I have a Medicaid patient in my practice, I treat that individual free.

"I made this decision about a year and a half ago. I disagree with the basic principles of the program, and think it is being abused. I think the problem of illegitimacy, and the continuing payment to individuals who keep on having illegitimate children is wrong. I see no reason why the taxpayers should have to be subjected to this.

"I feel very strongly about sterilizing them. I agree wholeheartedly with what Dr. Pierce has been trying to do," Dr. Owens said.

Dr. Pierce has been the center of attention, because he treats the majority of Medicaid obstetrical cases in Aiken. It was allegedly Dr. Pierce's policy to encourage welfare mothers with three or more children to undergo sterilization.

Both Dr. Owens and Niles Borop, MD, the other Aiken obstetrician, say that if this is Dr. Pierce's policy, they agree with it.

"I urge them (welfare mothers) to consider sterilization," said Dr. Owens. "Now, there is a difference in the way an obstetrician or gynecologist should approach this when the individual is on public assistance. I have publicly stated that after they had two children, they should be sterilized. I feel that this should be the policy.

"I don't feel (Dr. Pierce) has done anything wrong," said Dr. Owens. "There has been no charge brought against him."

Of the first three women on a list of those sterilized in Aiken this year, the first was separated, and had nine children, Dr. Owens said. The second had eight children, and was single. The third was also single, and had seven children.

In all, 18 welfare mothers were sterilized at the Aiken hospital in the first six months of 1973. Two of these were sterilized by court order, following requests

by the mothers. In the same period, 50 welfare mothers were delivered of children, Dr. Owens said.

Dr. Borop, 57, has been practicing in Aiken for 20 years. He occasionally treats Medicaid patients, he said, but the majority are treated by Dr. Pierce.

"Dr. Pierce has reasoned that after these patients have had, I think, three or more children, they ought to be sterilized. So, he just told them that if they did not want to be sterilized, they could just go somewhere else. Unfortunately, they don't have much else place to go," said Dr. Borop.

"Dr. Owens is jammed with patients, and I am, too. We just can't take many more," he said. "We take our turn on staff service at the hospital, but we (Dr. Owens and Dr. Borop) don't feel like we can take that much more in Medicaid patients."

What Dr. Borop regards as a probable "test case" of the policy involves a woman who was pregnant with her fifth child, and who refused sterilization as a condition of treatment by Dr. Pierce.

"She called Dr. Owens, and he told her he couldn't take her, and then with me, it was the same way. I did say that I thought Dr. Pierce was right about it, that she probably ought to be sterilized."

"No, I don't tell my patients they have to be sterilized," said Dr. Borop, "but I would encourage them, just like I would anybody. I think no one should have more children than they can take care of."

Dr. Borop said he had done two or three sterilizations of Medicaid recipients, "but those were for medical reasons, mostly."

Neither officials of the state department of social services nor the state medical society has contacted him, Dr. Borop said.

"Most of the letters and calls I have had from obstetricians over the state agree that the situation is basically right, that these people should be encouraged to be sterilized," he said.

Dr. Owens also said he had received a heavy volume of mail, most of it agreeing with his position.

The net results of the controversy may be positive: a better understanding of the need for voluntary sterilization, Dr. Owens said. There has been no immediate effect on his practice, but the controversy had badly damaged a long-term effort to build a new hospital in Aiken, Dr. Owens said.

Mr. Butler?

Mrs. PAIGE. I have a breakdown on that, sir, of age level, if that would be helpful to you.

Mr. EDWARDS. I believe it appropriate to place it in the record at this point. Are you finished?

Mr. MCCLORY. Yes. I have someone waiting in my office, if you will excuse me, but as I understand it, we will have an executive session on this subject?

Mr. EDWARDS. Yes, we will.

Mr. BUTLER. I have a few questions if I may?

Mr. EDWARDS. Yes.

Mr. BUTLER. You are Mrs. Paige?

Mrs. PAIGE. Yes.

Mr. BUTLER. In what capacity are you here today? As a private citizen or are you representing an organization?

Mrs. PAIGE. I am here as a private citizen today although I am working with the Community Action Agency. They are in Aiken and I think maybe that is the reason I am getting calls all times of the day and all times of the night about this.

Mr. BUTLER. You are employed with the Community Action Agency in South Carolina?

Mrs. PAIGE. Yes, as an out-reach worker, yes.

Mr. BUTLER. And how long have you lived there? Are you a native of Aiken?

Mrs. PAIGE. No, I have been in Aiken, though, for 21 years.

Mr. BUTLER. Well, that is pretty close. Tell me how large is Aiken County?

Mrs. PAIGE. Aiken County is a fairly large county. Well, you have got me stumped here but it is fairly a large county.

Mr. BUTLER. Large geographically or populationwise.

Mrs. PAIGE. No, geographically.

Mr. EDWARDS. If the gentleman will yield?

Aiken is a town of 15,000, near the Georgia border.

Mr. BUTLER. Well, I am embarrassed to tell you I have never been to Aiken.

Mrs. PAIGE. You haven't missed anything.

Mrs. GIBBS. That is true.

Mr. BUTLER. Well, I am interested in just exactly how this situation is developing from the way you have presented it. Do you consider there is a shortage of physicians there generally?

Mrs. PAIGE. No, I don't think it is that, but I feel like more or less they are together; you know, since this is what he has set about to do, his brothers are just going to go along with him. I mean they have to be condoning what he is doing or why do they refuse the patients when they come to them?

Mr. BUTLER. I understand that. But what I am trying to determine in my own mind is exactly how these people feel about sterilizations once they are informed. Do they feel like they have really been misled on this thing? What are you told is wrong about the presentation that is made, assuming it is voluntary?

Mrs. PAIGE. All right. These are young women; some of them are married. The one that was coming with me today, she was married and her husband and her had had a dispute and she left him to come to Aiken. She was already pregnant and she had six children. When she went to this doctor, although this was the first time she had been to him and this would have been her first delivery, as far as he was concerned but because of the six other children that she did have, he told her the same thing that you must be sterilized or I won't deliver this baby. So she consented to it because she didn't want any more babies either but when the husband found out about it, you know, not knowing about it really—some men think that this is it; that, well, you are finished, Chick—so he left her and now she is without a husband because of his lack of knowledge about what the operation was all about. This is why welfare has to take care of her now, but she had a husband until this happened.

Mr. BUTLER. Well, let's go back one more time.

First, then, what is the law of South Carolina with reference to its sterilization? Does the doctor have to have the written permission of the husband or not under the law of South Carolina?

Mrs. PAIGE. No, it must not be that way, but now a lot of these women don't have husbands, I will admit that. In the case of Mr. Brown though——

Mr. BUTLER. No, just answer my question. If you don't know the law, I will accept that. What I am trying to figure out whether or not the doctor has done anything illegal if this was a voluntary sterilization. It is not clear to me yet whether that is true.

Mrs. PAIGE. Well, now after you have signed a form to do a thing, that let's the doctor off the hook. But when you only have one doctor and nowhere else to go what choice do you have?

Mr. BUTLER. I recognize what you are saying. What I am searching for is how this develops and exactly what the facts are.

Mrs. GIBBS. Well, may I add to what Mrs. Paige said? We are talking about the doctor forcing the sterilization without their knowledge about what it is. That is what is being done in Aiken County.

Mr. BUTLER. If I could ask my question and get a response to my question, I think we could find this out. You are saying it is legal if it is voluntary?

Mrs. PAIGE. Yes, sterilizations are legal.

Mr. BUTLER. My next question is, are you satisfied that in each of these instances that the doctor actually presented it, not as an attractive alternative for a lady who has too many children? I should think it would be very appealing. If you have got six children and you are having trouble feeding them—and if you have got six children, you are bound to have trouble feeding them—isn't this a pretty attractive alternative if properly presented; that is, sterilization?

Mrs. PAIGE. If you want it, but why should you be made to do it?

Mr. BUTLER. Now wait a minute, don't argue with me. I am trying to find out, is the doctor saying to them—in order to make this an attractive alternative—that there is nothing wrong with this and this is not going to affect your sexual life at all except that you won't have any more children?

Mrs. PAIGE. He is not saying that. He is saying you must have one before I wait on you, so if you don't want it you have no choice; you still have to go to him.

Mr. BUTLER. All right. In each one of these instances, these 20-some cases you have investigated, did you go and sit down with the lady and satisfy yourself that it was presented to her in exactly that fashion?

Mrs. PAIGE. I found out that several of them really didn't understand what they were signing. This is what I said. They didn't even understand fully what it meant.

Mr. BUTLER. All right. Next question.

Did you keep a record of your interviews with each one of these women?

Mrs. PAIGE. No, not really.

Mr. BUTLER. So what—and I am not being critical, but simply from my point of view I want to verify the accuracy of all of this and I am not satisfied that we have anything more than your impressions, from a series of interviews. Have you made an effort to keep a record with reference to each individual or have you simply compiled this, and this is sort of a summary.

Mrs. PAIGE. I can get statements from the young ladies if this is what you are saying. No. 1, I wasn't even supposed to be a witness here today. The young lady herself was the witness.

Mr. BUTLER. Yes, ma'am. Well, I think it would be helpful to the committee if you would go back and get written statements from these ladies as to exactly what took place.

Mrs. PAIGE. Well, this is what I think I said when I first started here.

Mr. BUTLER. Yes; I know.

Mrs. PAIGE. That I would do this so you would have it for your records.

Mr. BUTLER. Mr. Chairman, I would like to have that in order to make the record clear as to exactly what has taken place.

I would appreciate it if you would interview these ladies again and get an accurate record of how it was presented to them and their response to it. And, if you feel that there was an element of coercion in it, or an element of misrepresentation or both, then I think we ought to know it. And then the committee would be in a better position to assess what its responsibilities are and how we can proceed.

Mr. EDWARDS. Yes; the committee would be pleased to receive this additional information. I do understand that a lawsuit has been filed with the attorneys being ACLU attorneys; is that correct?

Mrs. PAIGE. This was just with the two young ladies. I haven't worked as closely with them as someone else has, but this is true.

Mr. EDWARDS. Well, this is the two young women who were in the facility for the mentally retarded, is that correct?

Mrs. PAIGE. No.

Mr. EDWARDS. I am reading from this paper which says a million dollar lawsuit has been filed. This is the case involving the two youngsters?

Mrs. PAIGE. This, I suppose, is the two youngsters but the same firm, if I am not mistaken, will be handling the case of the two young ladies. This is a joint type of thing with the two young women from Aiken. The other ones haven't joined in on this and I have nothing to do with that.

Mr. EDWARDS. Well, I believe it is entirely appropriate to get further information as was suggested by the gentleman from Virginia. You were talking about Federal funds being involved here. These operations are being paid for with medicaid funds; is that correct?

Mrs. PAIGE. Since January, you paid $60,826 to this one doctor.

Mr. EDWARDS. That is a substantial sum. You may proceed.

Mr. BUTLER. I think if it is a voluntary process, a voluntary sterilization, that many of these women should be pleased with the results. What offends me in this instance is that they are not given a choice and that it is not presented fairly.

Mrs. PAIGE. This is what I am saying. It should be a choice for the individual to say what happens to their body. Now because you are poor, I don't think nobody should go around and tell you how many children you should have.

Mr. BUTLER. I couldn't agree with you more. Now, going back to the planned parenthood organization; is that what it is?

Mrs. PAIGE. Yes.

Mr. BUTLER. That is giving them education in that area?

Mrs. PAIGE. Yes.

Mr. BUTLER. Are they encouraging this alternative, this voluntary sterilization?

Mrs. PAIGE. No; because there are other means of birth control and this is what planned parenthood offers. But with a county as large as

Aiken and with the fact there is no public transportation, there is just one planned parenthood clinic. They can't do all of it. They do go out to the rural areas and try to reach as many people as possible, but, you know, if you have to work for a living—for instance, this young lady couldn't even come up here and testify. It is just not that easy. It is easy in a small southern town where everybody is together to keep the poor man down.

Mr. BUTLER. I recognize that. Thank you, Mr. Chairman.

Mr. EDWARDS. Ms. Chavez?

Ms. CHAVEZ. Just one question, Mr. Chairman.

Most of the publicity on the sterilization cases broke in about mid-July of this year, both in South Carolina and in the Alabama cases. Now, at that time, the Department of Health, Education, and Welfare, issued some guidelines covering the use of medicaid funds and sterilizations, which had been held up for some time. Do we take it from your testimony that these funds are still being used at this time since those HEW guidelines have been issued and that sterilizations are being performed liberally today in Aiken County?

Mrs. PAIGE. Yes; if you go to him this afternoon, he will present you with the same proposition.

Ms. CHAVEZ. That is all.

Mr. EDWARDS. Mr. Blommer?

Mr. BLOMMER. No questions.

Mr. EDWARDS. Mr. Parker?

Mr. PARKER. No questions.

Mr. EDWARDS. Well, thank you very much, Mrs. Gibbs, and Mrs. Paige, for coming all of the way up here and giving us this important information. We will meet in executive session and discuss the matter further, and the committee will make the decision as to what further action might be taken at a later date.

That concludes the hearing.

[Whereupon, at 12 noon the subcommittee recessed subject to the call of the Chair.]

27-401—74——7

TITLE VI ENFORCEMENT IN MEDICARE AND MEDICAID PROGRAMS

MONDAY, SEPTEMBER 24, 1973

House of Representatives,
Civil Rights and Constitutional Rights Subcommittee
of the Committee on the Judiciary,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:05 a.m., in room 2226, Rayburn House Office Building, Hon. Don Edwards [chairman of the subcommittee] presiding.

Present: Representatives Edwards, Waldie, Drinan, and Lott.

Also present: Alan A. Parker, counsel; Michael W. Blommer, associate counsel; and Linda Chavez, staff analyst.

Mr. Edwards. The committee will come to order.

The Civil Rights and Constitutional Rights Subcommittee of the House Committee on the Judiciary meets this morning to continue its hearings on the enforcement of title VI in medicare and medicaid programs.

We are pleased to have with us today two witnesses and associates from the American Public Health Association, Dr. Paul B. Cornely and Dr. Allen N. Koplin.

Dr. Cornely is a past president of the American Public Health Association and is currently a member of the action board which formulates policy for APHA. Dr. Cornely's distinguished career includes past positions as professor of preventive medicine and public health at Howard University College of Medicine; chairman of the Department of Community Health Practice, Howard University and Freedman's Hospital. Dr. Cornely received his bachelor of arts, doctor of medicine, and doctor of public health degrees from the University of Michigan.

Accompanying Dr. Cornely this morning is Dr. Allen Koplin, chairman of the Equal Health Opportunity Committee of the APHA.

Dr. Koplin has served as senior assistant surgeon of the U.S. Public Health Service and has been a consultant to the National Institute of Mental Health, the Office of Economic Opportunity, the Group Health Association of America, and the East Tennessee regional medical program. Dr. Koplin now serves as the deputy executive medical officer of the United Mine Workers of America, welfare and retirement fund. He is a graduate of New York University and received his M.D. from Middlesex University School of Medicine in Boston, and his master of public health degree from the University of Minnesota School of Public Health.

I believe that accompanying you this morning is Mr. Jeffrey Merrill, coordinator of the action board of the American Public Health Association.

Thank you all for coming here this morning. We are—the committee is most interested in this particular subject. I believe this is the third series of hearings we have had on the subject. We plan to continue our work here and we look forward to your presentation and the opportunity to hear from such distinguished witnesses. Would you please go ahead with your statement?

TESTIMONY OF DR. PAUL B. CORNELY, PAST PRESIDENT, AMERICAN PUBLIC HEALTH ASSOCIATION; AND DR. ALLEN N. KOPLIN, CHAIRMAN, EQUAL HEALTH OPPORTUNITY COMMITTEE, AMERICAN PUBLIC HEALTH ASSOCIATION, ACCOMPANIED BY JEFFREY MERRILL, COORDINATOR, ACTION BOARD, AMERICAN PUBLIC HEALTH ASSOCIATION

Dr. KOPLIN. Mr. Chairman, on behalf of the American Public Health Association I will begin. We represent the Committee on Equal Health Opportunity, as you indicated, which contains members from throughout the country, West Virginia, New York, California, Oregon, and so on. Our committee attempts to be as representative as possible of the ethnic minorities in our association.

I have a prepared statement that provides you with copies of what I am about to read. Our procedure this morning is for this to be read by me, and then for Dr. Cornely to continue the presentation from his point of view, and from the point of view of the American Public Health Association.

Our association is an organization which, including affiliate associations, represents over 50,000 members with a wide variety of disciplines and interest. Our concerns include not only personal health services but, also, environmental health, health education, and occupational health, and a number of other areas encompassing the total public health field. We have long been an advocate of equal health opportunity for all health services and, thus, were very encouraged by this subcommittee's request of the General Accounting Office to look into questions of title VI compliance in facilities receiving medicare or medicaid funds. We were pleased that, during the study, we could assist the GAO in their efforts and, further, congratulate the subcommittee for holding these important hearings.

We are confident that the testimony already given at these hearings has provided the subcommittee with sufficient evidence of the fact that discrimination is still widespread where Federal medicaid or medicare moneys are being used to pay for services. APHA does not want to dwell further on the excellent case that has already been made; rather, we would like to address our comments to some causes of this problem and to some possible solutions to it, particularly in relation to the HEW Office for Civil Rights and other mechanisms on the State and local level that do, presently, or could, in the future, play a role in efforts to eliminate discriminatory practices.

A great deal of discussion has taken place in this Nation in regard to overt discrimination. That is, where an individual has been directly

denied access to a health service because of his race or economic status. Yet, other forms of discrimination exist which, though more subtle or indirect in nature, are equally invidious. Deposits required to gain admission to a hospital; a doctor's admitting patterns where a white patient is sent to one institution while a minority individual is referred to another; placement of facilities in a locale not easily accessible to minority residents; and the practice of "dumping" certain emergency patients at municipal hospitals are all examples of more covert, less easily identifiable forms of discriminatory practices on the part of health facilities. I believe examples of these kinds of discrimination have already been presented to the committee. They are seldom reported in the same way as acts of overt discrimination can be and, thus, may not be brought to the attention of an enforcement agency such as OCR or their local surrogate.

One reason given by the Office for Civil Rights for its inability to develop a more effective action program is a lack of sufficient funds and, consequently, of adequate staff. APHA takes exception to this. Although we acknowledge that an increase in funding would be desirable, we feel that more could be accomplished with available resources. The example of the National Health and Environmental Law project serves to point out how impact can be made in advancing civil rights with very modest resources. This law program, despite its limited staff, has been able to pursue, and win, an important and far-reaching case requiring hospitals receiving Hill-Burton funds to accept medicaid patients. Their success required a commitment to action, the establishment of priorities, and a focus of the efforts of the agency on those priorities. We would certainly support increased funding for the Office for Civil Rights, but feel those funds, as well as existing moneys, should be better spent through an affirmative action policy and a commitment to the priorities that are set.

Without dwelling on either past accomplishments or failures of the Office for Civil Rights, both overt and covert discrimination still exist. Reliance on questionnaires or on State agencies to uncover problems has not been an adequate vehicle to identify discriminatory acts, nor, as Congressman Rangel stated earlier in these hearings, could sick patients be expected to march to Washington to voice their complaints. To identify problems, action is necessary on two fronts: (1) to develop mechanisms on the local level through which complaints can be lodged; and (2) to make the public aware that it is their right, and, indeed, their responsibility, to bring discriminatory practices to the attention of the authorities. We recommend that local efforts be expanded by requiring the establishment of patient complaint offices within hospitals that could relay problems to the national Office for Civil Rights or to their local representatives. These local OCR surrogates could be a social security office, the State medicaid bureau, or the department of human rights of the municipality. Regardless of what the actual vehicle is, it is imperative that each community be required to establish some mechanism accessible to the population of the area in order to discover where discriminatory practices exist, and that this mechanism be in continual communication with the Office for Civil Rights, either through its national or regional offices. These various mechanisms, however, cannot be totally effective if the public is

not aware of their existence or of the means of redress they have when discrimination occurs.

Presently there has been little effort on the part of the Office for Civil Rights or of local groups (including local Social Security or Medicaid offices) to publicize either the existence of the mechanism to correct discriminatory practices, or to inform recipients of these funds (particularly minority groups) that they have the right to choose any participating provider or facility, rather than being limited to a municipal hospital in their locale and to its medical staff. It is our opinion that a publicity campaign would be very helpful, both to inform recipients of their rights to obtain care where they choose and of the mechanisms that exist to correct situations where these rights have been denied. As part of an affirmative action program of the hospital and nursing homes in an area that receive medicare and medicaid funds, the institutions should be required to publicize that fact through the media or through an outreach program so that people are made aware of the facility and their right to use it. Through similar publicity, local complaint offices should make the public cognizant of their existence and location, as well as their willingness to help.

As part of the information provided in a publicity campaign, there should be an attempt to apprise the public of the kinds of discriminatory practice that could prevent them from entering a specific facility or that would discourage them from wanting to return to that institution. Hospital practice, for example, that requires a patient to pay a large deposit prior to admission, even though the individual is covered by medicare and medicaid, is one means that is used to exclude poor and minority patients from utilizing that institution.

The practice of "dumping," which I have already mentioned, whereby a patient is transferred from a community hospital to a "municipal" facility is another method of implementing a discriminatory policy. This practice is often used with patients who enter on an emergency basis and who are in no physical condition to complain or refuse transfer, and serves as an effective form of "triage," relegating the poor or minority patient to a public institution. A third technique is that of intentionally isolating minority patients in a "poor" ward—hospitals sometimes claim that because of the level of medicaid reimbursement, those patients can only be placed in a certain type of room—coincidentally, no white patients are placed in those rooms—or giving generally offhanded attention to those patients to discourage their choosing that facility on another occasion. This latter practice would not necessarily appear in census data, nor would one complaint suffice as conclusive evidence of discrimination.

If the public, however, were better educated about their rights, the types of possible discriminatory practices, and the redress mechanisms available, a number of complaints of this type lodged against one facility could lead to an indepth investigation of that institution and might uncover these practices.

Another means by which action might be initiated to prevent covert discrimination requires an affirmative action policy as part of the enforcement process. Where continual monitoring of the minority census of facilities is maintained, the proportion of minority patients can be compared with the minority population of the region, and if signifi-

cant disparities exist, further investigative action can be taken to determine whether some form of discrimination is actually being practiced. We want to emphasize that these comparisons should be made on the regional level, as opposed to simply basing them on data for the service or catchment area, for, as was already stated, the geographical location of the institution and the lack of accessibility to a significant proportion of the minority population can, in itself, constitute a form of discrimination.

In regard to the data that is presently used by the Office for Civil Rights, APHA is of the opinion that a wide variety of information is needed. More is involved than simply identifying blatant cases of discrimination, and in order to uncover more covert forms, it is vital that the Office for Civil Rights look to different sources to expand their data base. For example, although not an overt form of discrimination, the geographical placement of facilities can affect minority admissions. Information regarding hospital distribution in comparison to distribution of the minority population of the region could be obtained through State or local comprehensive health planning agencies. The use of this type of data would help to avoid situations such as presently exists in San Francisco, where almost all hospitals are located in the white, middle- and upper-income sections of the city, with the exception of the public hospital which is situated in the lower-income, minority community. The availability of this type of data to the Office for Civil Rights could give them leads to possible discriminatory practices on the part of the institution or institutions located in more affluent communities.

Other arrangements might be developed between the Office for Civil Rights and comprehensive health planning agencies. Under the review and approval powers recently granted to these agencies through Public Law 92–603 (H.R. 1), consideration might be given to the construction and expansion of health facilities in terms of guaranteeing an equitable distribution of institutions accessible to minority populations. Similar powers might also be used by those agencies through certification of need legislation, now in operation in many States. Thus, hospitals could be prevented from locating in areas where they cannot serve the needs of all citizens.

Also, as part of the review process under Public Law 92–603, whether through the powers presently granted by this law, or through additional legislative action, these planning agencies might require affirmative action plans for assuring use by a reasonable proportion of minority patients on the part of the group applying for permission to construct, modernize, or relocate a facility. I think the key word there is "use." A hospital, then, would not be approved by the regional or State health planning agency unless this plan had been submitted and was acceptable to that agency and the Office for Civil Rights.

Another area where comprehensive health planning agencies might now, or in the future, be helpful to Office for Civil Rights would be in providing information about physician distribution and admitting patterns of these physicians. Most hospital admissions are dependent on the patient's doctor and his hospital privileges. Thus, hospital admissions of minority patients can be determined in this way. Although complete data is not available, planning agencies might be able to give

some indication as to where physicians are sending medicaid patients and where minority physicians have privileges. The former information might help identify a form of discrimination that, although not entirely within the hospital's control, plays an important role in that hospital's minority census. Also in this connection, no effort has been made to date to assess whether federally supported ambulatory services, particularly a physician's office care, are provided in compliance with the law.

The question of admitting privileges could represent discrimination against minority physicians which, in turn, would directly affect minority admissions at those hospitals. Claims of hospitals that they have offered privileges to minority doctors who have refused to accept them must not be taken at face value. It must be recognized that the reluctance of physicians may, in part, be due to the uncomfortable environment they might face in those institutions, or to the inferior treatment their minority patients may receive.

We realize that this problem is not easily resolved by the Office for Civil Rights, but we feel it is serious enough to be mentioned since it can be the basis for a hospital's lack of minority medical staff and may lead to violations of title VI. In general, admitting patterns of physicians, in our opinion, requires a great deal more effort on the part of the Office for Civil Rights. Through data provided by a local comprehensive health planning agency or through the medicaid office in the region, some determinations could be made concerning this question.

We acknowledge that this is not an easy problem to uncover, but through this data and an improved complaint system, cases of discrimination might be identified. Also, if study of the minority census is carried out, as previously suggested, investigation of disproportionate nonminority admissions could lead to the pinpointing of such discrimination. All this requires a commitment on the part of the Office for Civil Rights to pursue, completely, a potential case of discrimination and depends on its ability to work through objective local mechanisms to carry out a thorough investigation.

Another important factor determining the source of patients referred to specific institutions is the growing number of neighborhood health centers and other clinics that primarily serve the poor. All of these facilities require some affiliation with a backup hospital and can serve as a major provider of minority patients to an inpatient institution. Community hospitals should be encouraged to cooperate with these clinics in providing speciality staff, laboratory services, and other programs that would benefit the clinic. In turn, these programs would absorb some of the load of the hospitals' already overworked outpatient departments and the clinics would also utilize the inpatient services of that institution, thus providing a further source of more minority patients. Presently, many of these clinics are referring only to municipal hospitals or to large teaching centers where, often, the minority patient serves as research or teaching material or gets lost in the shuffle of an academically oriented institution. A community hospital is a better environment for the average patient, and this kind of relationship would help to improve the distribution of minority and poor patients throughout the region.

It appears to us that the Office for Civil Rights has need for assistance on a continuing basis from professional health organizations to guide them in their actions. This could be achieved through a creation of an advisory group that could consider the various questions relating to medical practice patterns, health center liaison, hospital responsibilities, and health planning agencies. A committee representing, for example, APHA, the American Medical Association, the NMA, the American Hospital Association, and others of course, would be useful in assisting to develop policies for improvement of implementation of title VI. This group could be advisory to OCR or to this subcommittee with a view, in either case, to increasing professional and technical resources. It is interesting to note that, as far as we can ascertain, there is, presently, no full-time health expert among the personnel of OCR.

In summary, the Office for Civil Rights should not take a passive role in assuring that medicare and medicaid recipients receive their right to access of quality medical services. By waiting for complaints to reach their Office, or by basing their action on information provided solely through questionnaires, only extreme cases of discrimination will be brought to their attention. It is the responsibility of this Office to insure that facilities are being continually inspected by OCR or their surrogate, that the data they receive is reliable, and that mechanisms exist locally to receive and follow up on complaints. These require a policy of affirmative action on the part of the Office for Civil Rights and their local equivalents.

We are also of the opinion that as well as enforcing the law, the Office for Civil Rights should take an active role in cooperating with other Federal and local agencies in order to catalyze changes necessary to obviate the need for those enforcement procedures. By working, for example, with comprehensive health planning agencies to improve the placement of hospitals to guarantee better access for minorities, and by cooperating with those same agencies to assure affirmative action plans on the part of facilities, great strides could be made in improving some of the covert discrimination that presently exists. Also, by assisting communities in publicizing the rights of medicare and medicaid recipients to equal access, and apprising them of the existence of complaint mechanisms, they can also contribute to the goal of equal opportunity.

The challenge to the Office for Civil Rights is great, and we do not want to mitigate the difficulties it faces. Yet, the magnitude of their charge and the seriousness of the issue make it imperative that they do not delay, but focus their priorities and commit themselves to carrying them out now. The American Public Health Association stands ready to help them in any way we can to meet this challenge.

Now, with your permission, I want to pass the microphone to Dr. Cornely with one more final word. The American Public Health Association has worked with this problem for many years and we have actually seen, in our view, a diminution of enthusiasm or activity in title VI enforcement for many reasons and we came here with some ambivalence and trepidation, wondering about what is possible at the present time. We are very seriously concerned that this law is not being enforced, that the law is adequate, but that perhaps with further

commitment more can be accomplished, and this is our plea. And we hope that your committee can have some impact in assuring that those things that should have been done, and in fact, were being done at one time will again be given serious consideration.

And with that, I would like with your permission, to pass the microphone to Dr. Cornely.

Mr. EDWARDS. Yes, Doctor.

Dr. CORNELY. Mr. Chairman and members of the committee, let me first of all join with Dr. Koplin in thanking you and the committee for holding these hearings and providing the opportunity for the American Public Health Association to present its views.

What I would like to do would be just to make one or two comments, and then to emphasize possibly three facets in the presentation.

As Dr. Koplin has indicated, there has been a deterioration of the Office for Civil Rights, beginning possibly around 1968, so that presently it is at its lowest ebb. As a matter of fact, now this Office is like a police department or a police station where the officers are there, all sitting down, waiting for people who have been assaulted, robbed, or battered to come in and present their complaints, rather than for its members to go out and really get the facts. And, therefore, it appears to me that there are three facets of our presentation that must continue to be emphasized. First, the Office for Civil Rights, with the resources that it has at the present time, even though they are not as large as we would like for them to be, can do a better job by setting priorities and then picking up specific areas for investigation. It does not have this kind of commitment at the present time.

Second, it appears to me that the matter of public education is an important facet in this whole story so that everyone can be well aware of their rights and privileges, and not only patients, but also agencies working in the communities. For instance, it would be highly desirable to have every hospital facility, nursing home, and other health care facility, display a sign that would say right at the front door and on every floor that this is an equal health facility and that it is open to everyone, irrespective of race, creed, color or any other kind of persuasion. Now, our Government puts out a great deal of literature, and here is an area where it could certainly use its talents. It appears to me that in this educational process the Office for Civil Rights could also take advantage of agencies such as the National Urban League which has about 85 chapters throughout the United States. They could become a part of the network in this particular activity.

And then lastly, I like the advisory committee concept that has been presented in this statement. And I thought last night as I read through it that I would prefer to have an advisory committee that would serve this committee rather than the Office for Civil Rights. I do not look forward to any great enthusiasm for civil rights in the next 3 years and therefore, I would much prefer to have such a committee to be advisory to this group. I remember the committee that was set up by Senator Yarborough through resolution of the Senate, the Committee of Consultants on Cancer on which I served, and this committee was quite effective in doing the kind of job that they did for cancer, which resulted in a movement forward.

Mr. Chairman, these are just the three or four comments that I would like to make about our presentation.

Dr. KOPLIN. We, of course, as Dr. Cornely has said, appreciate the opportunity to be of assistance to this committee in answering any questions that you might have.

Mr. EDWARDS. Thank you very much for both statements. And I commend you and your association on them, and in particular we are grateful that you have some affirmative suggestions in your statements for actions to be taken by the overseer, which is the Office for Civil Rights of HEW. They will be here in a short time to testify. We have already had some communication with them. One of their people came up to see me the other day, concerned about the work of the subcommittee in this area. And I hope that I do not, Doctor, have to share your lack of hope of what might happen, and this subcommittee is very, very interested, and I might say determined to see that the laws of this country in the civil rights area are enforced. We are specifically given the responsibility by the full committee and by Congress to pursue this work and as far as we are concerned we do not think that there is any excuse for any agency not enforcing the law. Certainly it would not be true in the FBI or anything else, nor in the police departments of this country.

This is a very important part of the law. It has very much to do with the health of the country, whether or not we are going to have a decent country, and a country with some sort of equality in it. So, your remarks are very well received.

Now, with regard to these excellent suggestions that you both have made as to how the Office for Civil Rights of HEW could improve its performance, have they been informed by you of some of these suggestions in the past?

Dr. KOPLIN. We have offered the aid of the American Public Health Association in a rather limited discussion we had with the Office for Civil Rights director on June 26, 1973. The personnel we were dealing with were new to us. They have had many changes, as you probably know, several changes in the directorship, so that the thing we emphasized in our first discussion was the seriousness of their commitment. Frankly, we needed to know this before we asked our members in the association throughout the country to participate in any activity. We were not entirely satisfied with their response. They had indicated a new policy was being developed, and we kind of ended on the note, well, we would like to see what you are intending to do to pursue affirmative action. You see, the word affirmative is really the most important word in this whole statement. By affirmative we do not mean that someone signs a piece of paper or says the door is open. We mean that the provider accepts responsibility to see that his institution has been used in an equal way in relationship to the surrounding community. And we were hoping for a policy statement or a commitment statement from them to that effect, but we have not seen it yet.

One reason for our cynicism is OCR's description of instances investigated in California in the welfare area, which is also their area. You know, at one time there was an Office of Equal Health Opportunity. I am sure you are aware of that. It was in the Public Health Service. Now there is an Office for Civil Rights, which has both health and welfare surveillance functions and we feel that there has been a diminution of interest in health. At any rate a staff member was

describing a welfare department the OCR had investigated and found a language barrier to service. They concluded it would be important to have Spanish-American individuals dealing with Spanish-American or Spanish-speaking clients. In finding this to be the case in a county in California—Sonora, I believe—the OCR decided that the next thing to do would be an extensive analysis of welfare cases in the whole State of California.

Now, we were critical of this. We felt that it seemed as though they were on the trail of something in one area where some enforcement measures might be brought to bear. Certainly that would have some impact on the whole State of California, and the whole country. But they were diverted in their efforts, in our view, toward abandoning the individual case as an example of their enforcement capability to make another study of the whole State.

And as you well know, California has a lot of people and a lot of welfare cases, and this seemed like a delaying effort that might take a long period of time, maybe years, before they would ever get to the enforcement stage. We were critical of this. That is why we did not go any further in suggesting a working relationship. We wanted to see a statement from them.

They subsequently made some efforts to contact us and I had a discussion with one of their staff and again asked for their statement of commitment. A statement was eventually given to us but as we read it, it does not contain anything about affirmative action. It refers to more reviews and analyses which I just described in California and elsewhere, and so we are still negative about how far they will go on this basis. And it may be that through these hearings and the spotlight they are turning on the program, you gentlemen can have a little greater impact than we have been able to have.

Mr. EDWARDS. We asked the General Accounting Office to make a study of this, and the first part was completed and delivered to us in July 1972. And then they brought their work up to date again as you know, Doctor, and I think that as I recall, and I will stand corrected, that they pointed out that the general thrust of the efforts of the Office for Civil Rights was No. 1, in a certain number of inspections, which I believe has fallen off, in the number of inspections, actually onsite inspections; and No. 2, by a widespread use of questionnaries, which you feel has some problems. I suppose the questionnaires can be self-serving, is that correct?

Dr. CORNELY. There is no doubt about it, Mr. Chairman. One just cannot depend upon the kind of questionnaires that would attempt to provide information on discrimination. One has to make site visits. One has to investigate and see what the problems really are. And therefore, I would certainly be very cynical about the questionnaire method of trying to get some valid indication of what is happening.

It also seems to me that the matter of inspections has gone downward. My cynicism is really deep about what this office is going to accomplish. We went to them, and chatted with them, and they kept on repeating the same kinds of things that they had been saying, namely that they are going to do it in this united fashion, showing that they had really no commitment to any kind of priority that would be very effective for this kind of problem.

Mr. EDWARDS. In other words, they have, as yet, not outlined an affirmative action program to make certain that the law is being enforced?

Dr. CORNELY. Exactly.

Mr. EDWARDS. And I think one of the suggestions was that you use the local medicare or local social security office as some sort of place for complaints and monitoring, is that correct, Doctor?

Dr. KOPLIN. Yes. We feel that 19 million people are involved in that program and certainly many billions of dollars, so that it could be an arm of the Government for receiving information and working with the Office for Civil Rights. In fact, in 1965, prior to medicare, as you know, there was a tremendous effort on the part of the Office of Equal Health Opportunity in the Public Health Service to bring hospitals into line. At that time a high proportion of the OEHO personnel were Social Security Administration employees who were assigned to that office on a temporary basis. I think that they had as many as 500 or 600 people working for them in the health area alone when I was a consultant, so there are people in the Social Security Administration field offices who understand the act because they were in on its initial enforcement and they are, therefore, capable perhaps of being brought back into it again on some basis.

Mr. EDWARDS. I have more questions, but I would like to yield at this time to Mr. Drinan from Massachusetts.

Mr. DRINAN. Thank you very much, Mr. Chairman.

Doctors, I appreciate your coming. Let me ask some questions first for clarification.

Dr. Koplin, would you have any hard information on deposits? This was relatively new to me. On page 4 you say that the deposits are large. On page 1 you mention deposits as a technique to block out minorities. Has there been a survey of this or is there any hard fact on what is the deposit and why it is, how widespread it is?

Dr. KOPLIN. I do not know whether this was presented by former witnesses or not. But, in general I am aware, because of my own involvement in a medical care program that deposits are very common. I imagine there are hardly any cities in the United States whose hospitals do not require deposits. And if you are required to place a deposit of several hundred dollars down or even $100, which seems minimal because that is almost less than a day's hospital cost, this can be a handicap. And I do not know how the deposits are requested—if you walk in looking well dressed so on, then you may go right on in. You are accepted without any questions. If you are not well dressed you may be asked for a deposit. I do not have any hard statistical information on this. We have not prepared ourselves with this kind of information. We could certainly try to get it but I think it pretty self evident that this can be a mechanism, and probably is.

Mr. DRINAN. I would appreciate it if you could get it and then the committee would I am sure, too, because it seems to me that that is a specific way in which affirmative action could be utilized to eliminate that.

A second question, Doctor. Maybe once again you people are not charged with this information, but in the Office for Civil Rights they claim a lack of staff and funds. And, Mr. Chairman, I think that we

ought to have a record in the hearings as to the history of this. It is my information that they do not lack staff, that the staff actually has increased over the past few years. I could be wrong on that. In any event, in order to be fully prepared for these poor gentleman from the Office for Civil Rights who will be here next Monday, I think we ought to have the record of this so that they will not be able to use that.

Doctor, I was intrigued by your suggestion that we have a local patient complaint office, and that they report to OCR. I wonder if that has been attempted through civil rights groups anyplace in the country; would you know?

Dr. KOPLIN. In the initial period of medicare certification of hospitals when there were these 500 or 600 staff members available to OEHO it was part of their training program, which I underwent, to help them understand who to contact in the community. Thus, when you came in to talk to a hospital about the Medicare Act and the Civil Rights Act, you did not stop there. You went to the NAACP chapters locally or if there were medical committees for human rights groups that were active at the time, or the Urban League, Dr. Cornely mentioned, and a number of other minority member organizations representing blacks and others, visits with them were very helpful because it gave people an opportunity to speak up that might have had some hesitation doing so inside the walls of the hospital. That has been done. The technique is a very simple one.

Mr. DRINAN. Dr. Cornely?

Dr. CORNELY. Yes. I just want to mention the fact that I have had experience with the Urban League because I have worked with them as a consultant. And throughout their 85 chapters they have health committees and in many areas these health committees have been extremely active, particularly in terms of hospital and nursing home care. And I dare say that one could contact these chapters to get information in reference to discriminatory practices that have taken place. And I do not see any reason why the Office for Civil Rights has not done this regularly because it can be done very easily without any great expenditure of money.

Mr. DRINAN. I share that conviction with you, and this subcommittee of nine members have all types of other problems and it is frightening, frankly, to think that these nine members have exclusive oversight function of civil rights in the Federal Government and that we can assume so much obligation away from OCR.

Mr. EDWARDS. Would the gentleman yield at that point?

Mr. DRINAN. Yes, sir.

Mr. EDWARDS. The gentleman from Massachusetts brought up the budget and the personnel of the Office for Civil Rights. According to this book, Budget for Fiscal Year 1974, and some preceding information that is included therein, in 1972 there were 596 permanent positions. In 1973 there were 823, and the 1974 estimate brings the total up to 871 permanent positions in the Office for Civil Rights, with a budget of approximately $19 million in 1974, up from $16 million, up $3 million from 1973. However, I believe I note a $1.2 million impoundment of funds for fiscal year 1973 which we will ask the witnesses about on Monday.

Thank you.

Mr. DRINAN. Well, thank you for that. That confirms all of my intuitions that the OCR has no justification in saying they lack staff. But, they have gone from 596 to 871 over a very short period of time, and that impoundment, I suppose it is $1.2 million, but they still have roughly $18 million and I do not see, you know, where that money is going to and what these people do all day.

Doctor, a small point. I am also intrigued by new words. On page four you speak of triages.

Dr. KOPLIN. I'm sorry. We probably should have explained it.

Mr. DRINAN. Do not be sorry. I love new words. But what does it mean?

Dr. KOPLIN. This refers to a method popularized in recent years by a late colleague of mine, Dr. Richard Weinerman who received postgraduate training in Massachusetts. Are you familiar with Dr. Weinerman?

Mr. DRINAN. Yes.

Dr. KOPLIN. Triage is used in busy overworked hospital outpatient departments or emergency rooms where no one knew what to do with the mass of people coming in; whether they needed to see a doctor of one kind or another, or enter the hospital and so on. Triage therefore refers to a form of scientific screening to place the person in the right spot for his particular or her particular needs. We use it in a little different sense by adding another component, and that is that if you are black or poor there is another kind of screening guideline used for you. I think that is the sense in which we have prepared this.

Mr. DRINAN. Very interesting, because that goes to the question of affirmative action, whether or not it is the key thing. And I am wondering if the American Hospital Association could send to us some information on the distribution of physicians and I am sure there is evidence since they have had surveys and maybe even the OCR would have one but I would like to ask both of you doctors whether this is relevant, the distribution of foreign-born physicians? I am not suggesting they are inferior, although some people have trouble communicating with them. But, I am wondering whether there is a pattern there, too, in foreign-born interns and the number is very substantial, whether there is a pattern where they are also given more readily to the poor and the black?

Dr. KOPLIN. Well, I have some personal experience in Appalachia where we provide services for mining families. And when you get into East Kentucky, West Virginia areas where there are great shortages it seems that there is an almost exclusive entry of foreign-born physicians, because these are not the most desirable communities from the point of view of the American physician, and their particular economic or cultural interests, so that by that process, the least desirable positions I think are going to foreign-born physicians. I have nothing against them either and some of them have language handicaps and they cannot be choosy about where they work and so they take these positions. Unfortunately as they achieve status and citizenship and other things they tend to leave and go to the more desirable location from their point of view.

Now, I do not know how this works in the inner city. I have not had too much experience with that.

Do you have some experience in that regard?

Dr. CORNELY. Mr. Drinan, let me make one small correction. You said the American Hospital Association might be able to get the distribution of physicians. I think that you meant the American Medical Association.

Mr. DRINAN. All right. Yes, sir.

Dr. CORNELY. The American Hospital Association could give you the hospital distribution in this country and do it very effectively.

Mr. DRINAN. All right. The AMA.

Dr. CORNELY. The AMA would do it.

But, in terms of foreign graduates, you know there are about 65,000 of these professionals in our country, and this is quite a sizeable group. And these individuals are scattered all throughout our hospital facilities. It is stated that if you travel from Boston to Arlington, Va., that your chances of being treated by a foreign-born or foreign-graduate physician would be about one in three actually. This country, unfortunately, has been taking advantage of foreign-born physicians to make up for its inadequacies in terms of medical personnel. And this is one of the really important problems in our country today so that even though I think foreign-born physicians would be found in municipal hospitals and in Appalachia and other places like that, you would also find them scattered throughout a greater portion of our hospitals.

Mr. DRINAN. I think it is something that you could follow up on though. And I am inclined to think that the poor and the blacks have a greater chance than one in three.

Dr. CORNELY. Yes. Yes. I would agree with that.

Mr. DRINAN. On the key question of affirmative action. I note, Doctor, on your last page that you are overkind to the Office of Civil Rights and you say in summary the Office of Civil Rights should not take a passive role. Well, the opposite of affirmative would be negative. I assume and not passive. And would you substitute negative in that case?

Dr. KOPLIN. That will be all right I think.

Mr. DRINAN. All right. I am not putting words in your mouth.

All right, on the affirmative role we had evidence just last Monday from the leadership conference from a Marilyn Rose and Mr. Clarence Mitchell indicating the negative attitude, if you will, of the Office for Civil Rights. Aside from the suggestions here, moving into the law and to lawsuits, I assume you are familiar with the way in which they have been reluctant, shall we say, to advance in lawsuits. Would you people have made any recommendations to them concerning the use of existing machinery under title VI to affirmatively assert the rights of minorities?

Dr. KOPLIN. You mean in relation to possible legal action?

Mr. DRINAN. That is right.

Dr. KOPLIN. Although we have been living in hope that this negative activity will end someday, I am not an advocate of lawsuits. I think it is unfortunate that Marilyn Rose and others, who have done an excellent job, have had to resort to this technique. I think that it seems to me that we ought to be able to prevent lawsuits. I do not hold any great brief for bringing these hospitals and others into court and

going that route. But, it has been necessary, unfortunately, and I think more and more of this has been going on.

I have a feeling that if the Office for Civil Rights was doing its job it would prevent this sort of thing, and that is what I would like to see happen.

Now, do you have any comment on that?

Dr. CORNELY. Well, I would disagree with Allen Koplin in that. I would go all the way with lawsuits. And I think this is important. I think this is the only way that we can get at some of these problems. And some of these hospitals and health care facilities are going to have to be hauled into court in class action suits or other kinds. I think we should do it as much as possible because there are some people who will not act until they are forced to act by law or by court action.

Mr. DRINAN. Court action sometimes, too, has been a way of fact-finding to develop what is the covert or hidden or nonovert patterns of discrimination. And I suppose that whole distinction between overt and covert goes back to affirmative action. This is not overt discrimination in most cases and the Office for Civil Rights takes the position, as I understand their position, that unless it is overt, unless there is an affirmative act of discrimination, they cannot act. Well, that obviously means that they would act practically not at all and to repeat, I do not know what these 800 people do every day, 871 to be exact, if they take that position on only covert action.

Well, I want to thank both of you and I hope that you will feel free to supplement this with anything, particularly about that pattern of deposits and other areas. I know the telephone company for example, rightly or wrongly, exacts a deposit, but they at least check out, as I understand, the credit rating of the individual before they set or require a deposit.

Thank you again. I yield back to the chairman.

Mr. EDWARDS. I might make a personal observation, that if on the matter of lawsuits, which I am certainly not in favor of, but that if Congress and the various congressional committees would do their job and oversight that a lot of lawsuits would not be necessary, or at least we could cut down on the amounts, although as I say I have no objection to lawsuits, and, in indeed, have been a plaintiff in some of them. When you have got to do it you have got to do it.

Mr. Blommer.

Mr. BLOMMER. Thank you Mr. Chairman.

Doctor, I would like to refer to page 5 of your statement where you discuss physician distribution and admitting practices. The last sentence of the second paragraph on that page says:

> Also in this connection no effort has been made to date to assess whether federally supported ambulatory services, particularly a physician's office care, are provided in compliance with the law.

And I do not understand that sentence, and I do not understand what practice would come under what law exactly. Would you expand?

Dr. KOPLIN. Well, as I understand the Civil Rights Act, it relates to the way in which Federal dollars are spent in terms of discrimination. Now, there are many physicians, as you know, who receive Federal dollars for care at the present moment, from the medicare

and medicaid program. I am sure you are aware of that. At the present time I know of only one very fleeting, minor effort and I think this was in the State of Louisiana, to determine whether physicians who are paid by medicare make any effort to treat their patients on a nondiscriminatory basis. By that I mean do they use segregated waiting rooms, refer minority patients in different directions, and possibly do other things that are a little more subtle. And I do not think that the Office for Civil Rights has ever really pursued this. We are really concentrating on institutional Federal dollars more than on ambulatory facilities of that nature, particularly physician's offices.

Mr. BLOMMER. Well, let me ask you this, Doctor. If a private physician was a racist and refused to take a black patient, and 50 percent of his white patients were eligible for medicaid, what would you have the Office for Civil Rights do to that physician?

Dr. KOPLIN. Well, I think they would have to develop some kind of criteria for judgment. I think that if the physician is a racist, and his racism leads him to discriminating against patients, some way, it seems to me, he should be in violation of this law if he is receiving any Federal dollars. If he receives Federal dollars only for white patients, how would he be any different from a hospital which accepts only white patients under medicare and refuses to accept any blacks? Is there a distinction in your mind between those two?

Mr. BLOMMER. Well, the legal problems aside, I am more interested in what you think is right for the Federal Government to do? What should the Federal Government do?

Dr. KOPLIN. I think the Federal Government ought to give some kind of leadership in this whole question. I am not—as I indicated, Dr. Cornely and I were not in complete agreement about this business of lawsuits. I happen to feel that there are thousands and thousands of people who do not pursue their own rights. As a matter of fact that is basis for our suggestions of an office where individuals might bring their complaints, because they do not want to get involved in lawsuits, and therefore, they are discriminated against. But, I think that the Federal Government in that situation could certainly make known their concern through the Office for Civil Rights about this. They could begin to make analyses, use some of these personnel referred to to discuss this with medical groups. It does not have to be done by walking into a doctor's office and just padlocking the door or hauling him into court. I think it can be done by working with the AMA. Why not ask the AMA about this question and let them react. What do they know about it?

Mr. BLOMMER. I certainly agree it might be an ethical question, but I am hung up, Doctor, on the practical way that the Federal Government can act, the practical way.

Dr. KOPLIN. I do not mean to ask the AMA the ethical question. Say to the AMA that these practices have been discovered and do you have any interest in this, is there any way in which we can begin to move in on individual situations? In other words, get the physicians groups themselves at a national and State level aware of the fact that these practices are going on. That is the first step. Then develop with them, if possible, and maybe this is too ideal, a way of counting this sort of thing, of looking, of looking affirmatively at this sort of thing,

getting feedback from physicians. As you start to do this you get an awful lot of conversation going on and an awful lot of people rethinking this. And if that is all that happens, and no changes or action happens, there may have to be some individual enforcement cases brought to court.

Dr. CORNELY. Let me just make a contribution to this. In the District of Columbia, when medicaid came into practice here, the number of white physicians who signed up for medicaid, was extremely small. I think there were about 4 or 5 out of a large group of some 2,000 physicians in the District of Columbia. But, when this was brought to the attention of the District Medical Society and through a lot of discussions, talks, and presentations, many more physicians signed up to provide care for medicaid patients. So, the point that Dr. Koplin is making is that there could be some community activities, some community pressure that would make the physician who is a racist change his ways, although of course this is conjectural.

Mr. BLOMMER. Doctor, let me ask you this. If title VI would not apply to that physician as the state of law is now, would you favor an amendment to title VI to make it apply to private physicians in their practice?

Dr. CORNELY. This is a question which gets at the problem of ethics. There has been this concept in medical practice that the physician has the responsibility and the privilege to refuse to treat a patient. He makes this known and this has been accepted at all times. So, to bring this to legislative act, to force every physician to do this would be questionable.

Now, I do not have any constraints about that because I think that a physician's license is a social contract with the community in terms of treating people. This is the only way that health professionals can treat individuals; by the fact that society gives them this privilege as a contractual relationship. If this is valid, then there would be nothing wrong in trying to put a clause in this particular license statement to that effect. But, I think that you would be exposing yourself to greater difficulties in enforcing the present regulation.

Mr. WALDIE. Would the gentleman yield at that moment?

Mr. BLOMMER. Yes.

Mr. WALDIE. Did I hear you correctly, Doctor? You mean if the law said that a physician, a professional man, cannot discriminate on the basis of race, we would run into great resistance from the profession with a simple proposition of that nature?

Dr. CORNELY. No, no; if I said that I did not——

Mr. WALDIE. You said we would run into a lot of flak that may not make it worth it. Now, what kind of flak from whom?

Dr. CORNELY. No, no; let me just reply. I said at the very beginning, that if the concept is adhered to whereby physicians have been given the privilege of refusing to treat patients then he can exercise this in relationship to any patient.

Mr. WALDIE. Well, he cannot do it if we tell him he cannot under law.

Dr. CORNELY. No, no; I am just saying what the practice is today.

Mr. WALDIE. The practice that is today are some of the problems we are dealing with in these committee hearings. We are trying to

overcome the practices of today that are destructive of the problems that the people in this country are confronting, and many of those practices have been instituted by the profession. And we are seeking to eliminate those practices that are damaging so that there is no justification for a practice that is bad by the fact that it has been in existence by the profession.

Dr. CORNELY. Well, I said that the physician had a social contract and, therefore, we should have a legislative act that could be passed for that purpose.

Mr. WALDIE. But the question I asked you was should we? I know we can pass it. That is a matter of constitutional law. But, we are asking you as a doctor should we?

Dr. CORNELY. And I said very frankly that I think at this stage of our activities that it might be much more helpful to try to take a look at the Civil Rights Act in terms of doing some of the things that we are saying must be done before we add a legislative act in which we would make it mandatory for all physicians to see or to treat all patients irrespective of race or color.

Mr. WALDIE. What you are saying is that we should go slow. Yes, you are saying we should go slow, and we have been saying that in civil rights all along.

Dr. KOPLIN. One question we are here to discuss, as you know, is the way in which these institutional problems have occurred for the Office for Civil Rights, and their lack of enforcement of the act. Now, I think if this committee recommends legislation as a result of these hearings to zero in on medical practices as a result of everything we have discussed, this would be very poor strategy. I think this is a question which has to be taken as you indicated a lot more slowly than that.

Mr. WALDIE. I did not indicate.

Dr. CORNELY. He did not, I did.

Mr. WALDIE. In fact, I resisted that and I still resist it.

Dr. KOPLIN. I think we should have the present law——

Mr. WALDIE. Of course, that is the common call that we have heard for ages on civil rights law is that we are going too fast, to slow up.

Dr. KOPLIN. What is the purpose of passing a law if you have no mechanism to enforce it?

Mr. WALDIE. Why do you say we have no mechanism?

Dr. KOPLIN. We are here today to bring testimony on the fact that the Civil Rights Act, even in an institutional setting as is not being adequately enforced. If you pass another law with respect to physicians' services, what guarantee do you have that it will be enforced any better than the present law you have got?

Mr. WALDIE. It might very well be that if we direct our resources to enforcing the law involving physicians' practices that the other would fall into line more readily. My own personal conviction is that almost every decision in health and medicine is the decision of a physician. So, we can talk about the institutions' discriminatory practices, but the physicians run the institutions. The physicians themselves are free from any compunction to end discriminatory practices. They themselves are free in their private practice from any discriminatory practices, how can we insist that they in their institutions end discriminatory practices?

Mr. DRINAN. Would the gentleman yield?

Mr. WALDIE. Yes.

Mr. DRINAN. I think Guideline 1 of HEW clarifies this. And Guideline 1 of HEW Guidelines for Health Facilities says this: "The hospital insures that staff physicians do not consider race, color, or national origin as a factor in selecting hospitals for their patients." Then it goes on to say that where there is significant variation between the racial composition of the patient census and available population census data, the hospital has the responsibility to determine the reason for such variation. So, I would ask the witnesses and Mr. Waldie, do they think that there should be some change in the guidelines, that this states it rather clearly but perhaps the guidelines rather than the law need to be clarified or strengthened?

Dr. KOPLIN. I would second that, Congressman. I have the feeling that maybe the law is already adequate in terms of the comment just made. And maybe the Office for Civil Rights can enforce it in this area without additional laws.

Mr. DRINAN. But, Doctor, do you want to strengthen the guidelines?

Dr. KOPLIN. Yes.

Mr. DRINAN. How?

Dr. KOPLIN. Well, you started out by stating it is a guideline relating to facilities. Maybe there needs to be a guideline relating to professional personnel.

Mr. DRINAN. I would assume there is. I do not have it right here but I would welcome any suggestions from you two people and from the association as to how specifically the guidelines are weak. That is, OCR falls back and says, oh, we do this, here is guideline 14A, and it sounds beautiful. So, then we fall back and you are not enforcing it. So, if there is some weakness inherent in the guidelines singly or collectively, I think this would be very relevant.

I yield back.

Thank you.

Mr. WALDIE. Well, my recollection of our last committee hearing was that the practice of physicians in their private practice is not monitored by any law relative to discrimination. Am I correct in that?

Dr. CORNELY. That is right.

Mr. WALDIE. So that guidelines would not be the problem. The problem is there is no law under which guidelines could be implemented.

Mr. EDWARDS. Will the gentleman yield at that point, Mr. Waldie?

Mr. WALDIE. Yes.

Mr. EDWARDS. I would think that the law is very clear with regard to private physicians accepting Federal funds.

Mr. DRINAN. It is.

Mr. EDWARDS. And there is just no doubt about that.

Mr. WALDIE. That is not true for medicare. There is no prohibition. They can accept private Federal funds for medicare and discriminate. Is that not correct?

Dr. KOPLIN. I do not know how.

Dr. CORNELY. I believe this is true.

Mr. WALDIE. Now, medicaid, they cannot discriminate.

Dr. CORNELY. On medicare they can.

Mr. WALDIE. Medicare they can be the most racist physician in the room and still draw medicare. Now, that is outrageous.

Mr. EDWARDS. It would seem to me that it is not lawful.

Mr. WALDIE. But it is.

Dr. KOPLIN. Is there no statement that a physician has to sign to participate in medicare that he will not discriminate?

Mr. WALDIE. I was told last committee hearing that there was not. Is that correct?

Mr. BLOMMER. That is correct.

Dr. KOPLIN. Well, then maybe you are right.

Dr. CORNELY. No. No.

Dr. KOPLIN. I did not realize that. Is that true?

Dr. CORNELY. In medicare that is quite correct. In medicaid it is not but in medicare it is. This is the reason why we had such difficulty at first here in the District with the Medicaid Act. We did not have any difficulty about medicare.

Mr. WALDIE. They all signed up for that because they could discriminate. But, when they cannot discriminate they do not sign up for medicaid, is that correct? That says an awful lot about the profession, does it not, in the District?

Dr. CORNELY. It says a lot about the profession all over the United States.

Mr. WALDIE. I suspect that is true. I really suspect that is true. We only have the testimony you have given about the District.

But, that would be fascinating, Mr. Chairman, for the committee to acquire statistics as to the experience of signing up for medicare versus medicaid. Do you have many more under medicare, many more physicians who participate in the medicare program than the medicaid program, and is it because of the fact that they are not permitted to discriminate under medicaid but they can under medicare? You see if you can discriminate under medicare and that is the law, Doctor, it seems to me that this nonsense about trying to correct discrimination in the institution—well, not nonsense, but we are beating our heads against a wall because the doctors run the institutions. And if you have the very same doctors discriminating in medicare running the institutions, how in the world do we expect to get any understanding on their part of the sensitivity of this problem and this sort of quiet, let alone overt, discrimination can take place and will take place, and we do nothing to penalize them for it.

Dr. CORNELY. Mr. Waldie, you know I would agree with you, and I take back what I said about the difficulties that such change would cause. I would agree with you about going forward with your approach, provided there would be the kinds of guidelines and regulations that would make it possible to make this law effective, and enforceable. Now, if there is some legislative clause or statement that can be put on that basis, then I would agree.

Mr. WALDIE. Well, Doctor, you have got to take the first step before you move to the second and we have not even taken the first step, placing official sanctions against discrimination. We, in fact, have acceded to the medical profession, when medicare was enacted, in their insistence that they be permitted to discriminate. That is why they were left out and that is not tolerable from my point of view.

Dr. CORNELY. I would support that. I take back what I said about going slow. I would support it, but I would like to see it enforced.

Mr. WALDIE. Sure. We have got to go much beyond passing the law, I agree. But, we had better get the law passed first.

Mr. EDWARDS. Do you have some other questions, Mr. Waldie?

Mr. WALDIE. No, Mr. Chairman, I do not.

Mr. EDWARDS. Now, in parts of the country where they do have these activist legal aid groups, patients in public hospitals receive a statement of their rights. A written statement. It is called a patients' bill of rights. We suggest that this be made a universal practice under guidelines published by the Office for Civil Rights in all rest homes and hospitals.

Dr. CORNELY. Yes. I would accept that. I also have some constraints about the AHA bill of rights for patients. You know, the American Hospital Association came out with the bill of rights just a year and a half ago, and they were forced to do so by the fact that community representatives forced them to do so when they became part of boards of trustees. But, really, this is a misnomer because whatever hospitals or physicians do to patients is done by virtue of the fact that patients give their consent for it to be done. I would like to have that term changed to something else. I mean, the fact that a hospital tells a patient he is able to receive care in any facility, at any time, or that you are giving him something is wrong. No one can give a patient a right that actually belongs to him. We should not fool ourselves about saying that we are giving him something. This belongs to him. He has always had it.

Mr. EDWARDS. He is also getting the information a little bit late if he is already in the hospital. He could be out in the community, in the local office of the Social Security Administration, or it could be posted in the post office. It could be in literature that is furnished by the Office for Civil Rights and distributed by the community health organizations and things like that.

Dr. CORNELY. Surely.

Mr. EDWARDS. You were interrupted, Mr. Blommer.

Mr. BLOMMER. Thank you Mr. Chairman.

Dr. KOPLIN. Excuse me. And the Social Security Administration mailing of its red, white, and blue cards sends out some information. It seems to me that a strong statement to the beneficiary when the card is mailed might also be of help in interpreting what this card means to him.

Dr. CORNELY. You could also put a little statement in there, you know, like you do in cigarette labels: Caution: You are entitled to health care anywhere.

Mr. EDWARDS. It could be a public service in drug advertisements too. I notice in the Washington papers especially that all real estate ads have a decal on them now that all of the offers for sale are made with equal opportunity for all persons.

Go ahead, Mr. Blommer.

Mr. BLOMMER. Let me refer you to a part of our report from the General Accounting Office, Doctor. I know you do not have it, but on page 59 it talks about practices of admissions to nursing homes in Los Angeles County. Let me just read to you a very short paragraph and in there they talk about facility B that has a total white population, and then they talk about C which is the same and D which is the same and then they give institutions B, C, and D were established to

serve special religious or ethnic groups or had policies which restricted admissions to people of means. And then skipping down to facility E they say that 80 minority group patients at facility E were Japanese and I assume they mean Japanese Americans. The nursing home was constructed through contributions from the Japanese community and was geared to meet the language, dietary and social needs of the Japanese patients. The administrator would not refuse admission to anyone, he said, but might try to discourage a nonoriental by showing him the oriental atmosphere.

Now, it strikes me that these segregated facilities might be violating title VI of the Civil Rights Act and are they? With these few facts does that sound to you like they would be violating the law by discriminating?

Dr. KOPLIN. Well, yes they are except that we cannot look at this that superficially. There is a historical antecedent to that.

Mr. BLOMMER. This is my problem, Doctor. It seems to me if there is a Japanese-American nursing home that serves Japanese-American people, and albeit in violation of title VI, that it might be wise, or prudent, or good for the health of the patients even to allow that to continue. Do you agree?

Dr. KOPLIN. No.

Dr. CORNELY. No.

Dr. KOPLIN. Historically those institutions were not established when the Japanese-Americans had any alternatives. For example, there is a black hospital in Mound Bayou, Miss., which is established because black people could not be admitted to any other hospital. It is not a good hospital. It suffers the problems of all segregated hospitals. There is something bad for your health about segregation no matter who you are. And if you look back historically at the reason for the formation of those hospitals, this law, this Civil Rights Act, is supposed to have eliminated that reason. There is no reason why a Japanese-American cannot go to any hospital at all.

Mr. BLOMMER. Doctor, let me just say that there is nothing in this section, nothing in this discussion or this problem having to do with, at least from our point of discussion, the fact that the Japanese-Americans cannot go anywhere else or that they are poor Japanese-Americans. They just happened to want to, apparently want to go to this Japanese-American nursing home. Now, what would you advise the Department of Health, Education, and Welfare to do with this facility that has 80 Japanese-American patients? Practically now, what should they do?

Dr. KOPLIN. Well, they did, in 1956, face problems like that. I do not know about this particular facility. But, for example, in Memphis, there was a hospital that was a black hospital. Now, those people went there because they needed to go there, that was good for them at the time. However, in terms of the quality of care that the title VI enforcement was intended to remedy, that needed to be changed and they changed it. They enriched the institution with a rehabilitation ward and they used a lot of ingenious techniques to change that hospital so that it became a part of the total community picture. In other words, they used the Civil Rights Act to overcome the basic reasons for segregated hospitals. And I do not know what can be done in the

Japanese situation. I am not sure that I understand that this is a voluntary decision on the part of everyone in that institution which is best for them. It may be they are forced into that decision.

Dr. CORNELY. Let me just——

Mr. BLOMMER. That is an element that I do not want to talk about. I have problems—HEW is going to be here and I have this evidence right in front of us. Here it is in Los Angeles, this nursing home, and it has all Japanese-Americans. Now, we have an oversight function. What should we do?

Dr. KOPLIN. They should ask these people something about this.

Mr. BLOMMER. Let me say that they all volunteered, they all want to be there. Should that be broken up as a pattern of discrimination?

Dr. KOPLIN. I do not know.

Dr. CORNELY. This is very clear to me. I think that in this country we should only have a single system of health care and we need not have Jewish hospitals, or Japanese-American hospitals, or black hospitals, or any other kinds of hospitals. All we want is an open opportunity for people to go into whatever hospital they want. If they want to go to a Japanese-American hospital because it happens to be located in that area, or because they adhere to certain diet practices or whatever, then this is all right. All hospitals have the responsibility to open their doors to everybody, and they should be forced to do so.

Mr. BLOMMER. Now, there you believe then that the nursing home should adopt some affirmative plan to bring non-Japanese Americans in; is that correct?

Dr. CORNELY. I would think that if they are receiving money from the Federal Government it appears to me that they have a responsibility to be integrated with all sorts of ethnic and class groups.

Mr. BLOMMER. All right. In other words, then, they should take affirmative action to change the situation?

Dr. CORNELY. Well, this would be the requirement and it should be carried out. No, I just do not see how one could say let us do it for these hospitals over here and not do it for these hospitals over on the other side. Again, I repeat there should be just one single system of health care for all.

Dr. KOPLIN. Now, those patients might object to this if, as you are suggesting, they had no other alternative. You cannot just take that one institution and put the pressure on there. It has to be done as a community pattern. That is why we have suggested the comprehensive health planning agencies get into that perhaps with an overview of this situation. I do not think you or I can speak for those patients saying that they prefer to be segregated. I do not believe that given an opportunity most people would prefer that unless there is some very unusual older group where they are fearful for some other reason. But, generally speaking, with proper opportunities to express their views, and proper understanding of what is being made available to them, I think these segregated hospitals will disappear. But nobody is doing that kind of a job.

Mr. BLOMMER. I see. I have no more questions, Mr. Chairman.

Mr. EDWARDS. Mr. Drinan?

Mr. DRINAN. No. I want to thank them again and I look forward to their continued communication with this committee. As was suggested,

groups like this can be advisory to this particular subcommittee and we can do what we can on oversight.

One last question though, Doctor. I wonder if in your capacity, Dr. Koplin, in your capacity as chairman of the Equality of Facilities Committee, Equal Health Opportunity Committee of the APHA, has the HEW really affirmatively consulted you?

Dr. KOPLIN. Not really, no. I tend to be more moderate. After all, we have a large membership and we need their support for this kind of activity and I do not know whether they would all agree 100 percent but I think in the vast majority they would agree.

Mr. DRINAN. Well, going back to their own guidelines, I recall something vaguely to the effect that they have an obligation of consulting with the people in the field. Is there something to that effect? I do not think they established formally an advisory committee but as I recall it is indicated that people should consult with the professionals in the area.

Dr. KOPLIN. Yes. And as a matter of fact, the American Public Health Association has met with various secretaries of HEW on this issue, but not the last one. And I am not using that as a criticism particularly, but, maybe it is timely for that to happen too. In all cases it has been a matter of offering our support, the resources of our membership and so on and so forth. We, however, do not feel that we should be the enforcement agency. We cannot do that. Civil rights groups have been consulted and have participated in some of these HEW staff discussions. It may be that the Office for Civil Rights has that information. I think if they went back about 4 or 5 years to the conferences with Secretary Finch and Secretary Gardner they might find some suggestions there and an indication of our willingness to work with them. I do not know whether they have that information, but it has been done before.

Mr. DRINAN. Would it help you, Doctor, and your associates and similar organizations if the Congress, either by statute or by requiring a guideline, had a fixed organizational institutional way by which you can communicate with HEW?

Dr. KOPLIN. Yes; I think so.

Mr. DRINAN. Mr. Chairman, we have made that a part of the record, and I do feel that we should try to do that either by legislation or by a new guideline. Thank you very much.

Dr. KOPLIN. I appreciate that.

Mr. EDWARDS. Mr. Waldie and I represent quite a number of Spanish-speaking people in California, and, of course, also in the Southwest generally there is a great group of people and a number of them have a language problem. And I would presume that it would be more convenient and comfortable for Spanish-speaking people to have Spanish-speaking nurses and doctors. How do we handle that and not have it result in unsatisfactory segregation?

Dr. CORNELY. Well, we have done something, for instance, specifically here. We have the Cardozo Health Center which is near the Mount Pleasant area where about 15 percent of the population is Spanish speaking and what we have done is to employ a number of Spanish-speaking personnel. In addition we have also instituted classes in Spanish so that others would learn enough of the language and be able

to communicate to some extent with them. Also, the little newspaper we publish quarterly, is done in both English and Spanish. These are the kinds of things that we have to do. The outreach people that would go out should be of a kind to reflect the composition of the population so that they can get the information.

Dr. KOPLIN. I worked, Mr. Edwards, in California as a physician for Mexican-Americans back in the farm labor program days and I had some Spanish through my own academic preparation. But, we used interpreters, which were very helpful, and we made efforts as Dr. Cornely has indicated to learn the language. I learned a lot of Spanish and I think certainly there is no reason why physicians cannot, if they are interested in their patients, learn to communicate with them.

Dr. CORNELY. As a matter of fact, one of the things I have suggested since I taught in the medical school here for 39 years, that in all medical education there should be a course in a second language, which would be conversational in nature, and that in all health care facilities there should be this kind of an approach so that individuals may have the opportunity to communicate with patients. And I think this would be a great thing to do.

Mr. EDWARDS. You suggest in your testimony that one form of discrimination is to isolate minority patients in inadequate rooms, over in the corner somewhere like that in hospitals or institutions that are allegedly, supposedly, integrated. And the GAO, when they testified, said that they did not find this type of action in the reviews of the institutions that they reviewed. Do you know of any specific instances where this is or has taken place?

Dr. KOPLIN. May I ask Mr. Merrill to respond to this, Congressman?

Mr. MERRILL. Yes. Last year, APHA was involved in a study in Mississippi where we had an opportunity to examine a lot of hospitals within the delta area. There were two things we found out through this study. One is, and maybe this is not what happened to the GAO people in their investigation, but it does happen, that, on a given day when the hospital is forewarned of a visit by some sort of enforcement agency, beds are shifted and it is very simple to shift a bed on wheels. And so coincidentally on that, and maybe for a couple of days, the hospital appears totally integrated. I am not saying that this happens at all hospitals, but we found a great deal of evidence in this one community.

The second thing is, and I think we allude to this more specifically in the testimony, that given current reimbursement practices if the hospital is required under medicaid to provide semiprivate care for medicaid recipients, then all of those medicaid patients in the community who, coincidentally might be black, or might be of a minority group are put into semiprivate rooms, and all other patients in that hospital who might be nonminority are put into private rooms and charged at rates similar or whatever. But, they claim that because of the structure of medicaid they can do this. Our claim is that, possibly, this is a very conscious way of discriminating or segregating beds within an institution. We saw this happen in a hospital in the area investigated last year.

Mr. EDWARDS. Mr. Waldie?

Mr. WALDIE. No questions, Mr. Chairman.

Mr. EDWARDS. Do you ever get complaints yourself in your organization from patients who feel they have been discriminated against?

Dr. KOPLIN. No.

Mr. MERRILL. Yes. And we send them to Marilyn.

Dr. KOPLIN. It is not a prominent feature of our work for the past few years.

Mr. EDWARDS. You do not have your own agency within your organization that accepts complaints?

Dr. KOPLIN. Well, no. We work in a more of an educative fashion with our membership, with our newspaper, with our journal, with our affiliated organizations to keep this idea alive. In fact, we spent a good deal of time encouraging public health agencies to look to their own employment roles and so on in that connection. Our interest is not limited only to personal health service. It has to do with admissions to health professional institutions, it has to do with employment, it has to do with the matter of environment, which we would like to talk about someday although it is not on the agenda for today, and so on. But we do not have a specific complaint mechanism. We get them, I think, almost by virtue of default somewhere else. I suppose we could operate that kind of activity, although I hesitate to commit the APHA to it on my own authority. But, if there was some national movement or national changes as Mr. Drinan has suggested, I think APHA would certainly give serious consideration to cooperation if it is going to provide an opportunity for increasing access or for solving this problem.

Mr. EDWARDS. We have already heard from some witnesses and I am sure we will hear from witnesses in the future as to why minority patients are clustered in Government-owned institutions. Is this necessarily going to happen, minority patients, for the reasons given, choice, convenience, the doctor-patient relationship, are we going to have this sort of de facto segregation in Government-owned institutions of minority patients?

Dr. KOPLIN. I think the way the health care payment financing mechanisms are developing should eliminated this. I think more and more people should be eligible for choices through medicare, which is supposedly a choice mechanism under which you can choose your own, as we have been saying here this morning, your own physician or hospital. This should obviate this problem.

I think the reason for the clustering is that this is a publicly financed service and there is not any other way the patient can get any care. I mean I do not know that people choose these institutions.

Mr. WALDIE. May I interrupt at that point, Mr. Chairman?

Dr. KOPLIN. Yes.

Mr. WALDIE. At the Martin Luther King Hospital in Los Angeles, it is almost, I do not know what, 90 percent black? It is true that it is, that it services essentially a 90-percent black area, segregated by housing. If the patients though in that hospital that are public-financed patients, are medicaid patients rather than medicare, it would seem to me that that might reflect this ability of the physicians to discriminate. The medicaid doctor can only sign up if he agrees not to discriminate. It would be instructive to learn how many white physicians in the periphery of the Martin Luther King Hospital, in fact, have medicaid patients. I suspect none.

I suspect most of the medicaid patients go to black physicians in that area who have hospital privileges at Martin Luther King and not elsewhere. Medicare patients, I would be interested in knowing, in the population of the Martin Luther King Hospital, how many are medicare, how many were black, and how many were referred from black physicians? My guess is the population at Martin Luther King is totally a function of the referral of physicians. Is there any other way they get there? Nobody walks off the street except on emergency and goes to the hospital and says I am about to have a baby, would you take care of me.

Dr. KOPLIN. This is one of the reasons I think—

Mr. WALDIE. So, if the referral forces the physicians for the vast majority of people in hospitals, the racial composition of that hospital has been established by the physicians that referred them, has it not?

Mr. MERRILL. Mr. Waldie, one thing, specifically about that hospital and the basic referral source is probably, as an example, the Watts Multi-Purpose Health Center, I would imagine.

But in responding to that, as well as in responding to your question before about the Japanese nursing home, I think, unfortunately, too often in enforcement we almost consider that things started today. This was point zero. I mean, the reason for what happened in Watts has very much to do with the fact that for 50 years before that the only place people could go in Watts, was to the county or some other municipal hospital and many of them never even saw doctors other than within that setting for they had no private physicians. And so if you were OCR and you asked me what should I do in terms of that Japanese nursing home, instead of looking at nursing home E I would look at nursing homes B, C, and D and find out whether over the last 10 years the hospital or nursing home ever hired any Japanese staff or refused admission to Japanese patients in that home. Possibly the reason is that there has been no place for extended care services to this population over the course of years and if that is the case then the discrimination might not have existed in E but it certainly might have existed in B, C, and D. I think it is not so much what is happening now, but what has happened over the last few years and the changes have to be made in those institutions as well as in the institutions where the problem exists.

Mr. WALDIE. Well, I would guess in Martin Luther King, even if there were no discrimination in terms of the doctors referred, I really want to check that out pretty closely, but it would still be primarily black simply because of the location of the hospital and the residential patterns for miles around it. But, it would be instructive to know if doctors are referring white patients to one hospital and black patients to Martin Luther King.

Dr. KOPLIN. This is something the Office for Civil Rights should certainly do.

Mr. WALDIE. Well, do they have the ability to do that? Can you go to a doctor in the Office for Civil Rights under any existing act and say, "Doctor, I want to see where your patients go, and what is the pattern of how you refer patients? You have privileges at hospital A and hospital B. I would like to see how many you refer to A and how many to B and why?" Can you ask that?

Dr. KOPLIN. This was done I think in the early days of the Office of Equal Health Opportunity in Alabama, I think, I believe. Is that not right?

Mr. MERRILL. You would not have to go to the doctor necessarily. You could just go to the medicaid office in the State and look at the referral pattern.

Mr. WALDIE. If they are under medicaid, yes, I guess that is true. Are there studies that have been made of this nature?

Dr. CORNELY. Not to my knowledge.

Dr. KOPLIN. There is one case in Mobile. I cannot put my finger on the exact dates of it.

Mr. EDWARDS. We will certainly find out.

Mr. WALDIE. Please. Yes. I would be less interested in Mobile, Ala., than I would be in Los Angeles, Calif.

Dr. KOPLIN. I am reminded by what Jeff has just said, when I started working for the mineworkers in Birmingham, Ala., in the 1940's, all hospitals were segregated. The communities decided to build a better hospital for blacks and build a denominational black institution which was also segregated. Now, when I got into the picture coming from New England, I was upset by this so I discussed this with our black coal miners, and they said, Dr. Koplin, let us get in the door with this mineworkers welfare card of ours and get some treatment before you start that battle, because they have not even been able to get in the door of any of these other places at all and they were relegated to the Hillman Hospital and other sorts of hospitals of the kind of District of Columbia General and I do not mean to imply the District of Columbia General is not a good hospital.

But, there was another example of the municipal clustering problem. As the years have gone by and the laws changed, a lot of things have happened. And if you use the analogy of education, what would you do there? I mean just think about the effort being made in education to ensure that segregation is broken up. It sort of creates almost shocking kinds of thoughts in our minds about what lengths we go to under law and I guess it is the same law that requires no discrimination in health. Apply that to the Martin Luther King Hospital.

Dr. CORNELY. Well, I would like to make this last comment. We are now beginning to talk about the whole structure of our society which certainly has a great deal of racism in it as has been indicated by the President's commission study. A variety of patterns have developed. The question then is, how are we going to attack it. Are we going to develop or change all people overnight to a feeling of brotherly love. This of course cannot be done.

Mr. WALDIE. No, we are not going to do that.

Dr. CORNELY. But when you look at health care we have also got to put it in the context of the community, its racial attitudes and so forth.

Mr. WALDIE. I think I agree with that, and my questions are really directed at that, where do we put the legal pressure, the governmental pressure to end discrimination? We are not going to change the hearts and souls of people that want to discriminate, but we can change the consequences of the discrimination by passing laws, particularly where dollars are connected. It is amazing how the luxury of discrimination

is forgone when it costs the discriminator money. Any therefore, I am really looking, exploring in the medical field whether we are not putting emphasis in the wrong area of institutions rather than the doctors. I really think the entire medical delivery system in all of its pattern is controlled by the doctors and, therefore, whatever defects exist in it, to the extent they are to be remedied, will be remedied by the decisions of the doctors, and those decisions, if not voluntary, ought to be compelled.

Dr. KOPLIN. Well, they should not have that decision, right, and in many States that is being changed.

Mr. WALDIE. Maybe not, but they do. In other words, I go to an institution not because I think this is a prettier hospital, I will get better care there. I do not even know that. I go there because my doctor tells me to go there. I do not do anything medically that my doctor does not decide for me. So if there is anything wrong medically it would seem to me that the best place to cure it is to look at that doctor. Now, that may be an oversimplification of a layman.

Dr. KOPLIN. Well, it depends on what sort of a professional context he is living and working in. He can be influenced by you as a consumer in terms of his livelihood if you happen to be on the board of directors of the hospital, or the board of directors of the neighborhood health center or the board of directors of the HMO or anything else of which he is a member and so when he functions in relation to patients he will have your particular patients' broader interests at heart. This is the sort of thing we talked about when we encourage consumer involvement. This is the way to change the doctors. You do not allow the prerogative of decision to be totally the doctors. You share them with us, with others and the people. I want to emphasize a point we made in our original statement that somewhere in the comprehensive health planning program there ought to be a way that that idea gets injected so that you do not have a permanent fixation of segregated hospitals, or nursing homes or things of that nature, so that there is a regionalization concept of where all of the doctors and all of the hospitals are and are going to be. Mr. Merrill said we have got to go back and look at what has brought us to this point. Through comprehensive health planning we have got to go forward and look at where we are going to be 20 years from now. I think that it is extremely important, and that is the reason we suggested that this be brought to the attention of comprehensive health planning agencies.

Mr. EDWARDS. Ms. Chavez.

Ms. CHAVEZ. In part of your testimony this morning, you focused on the admitting practices of some physicians and the roles which their practices can play in maintaining a dual health care system. When the General Accounting Office visited Los Angeles, it found that some hospitals restricted the granting of staff privileges based on three criteria. They restricted the granting of privileges to doctors whose medical specialty was in a short supply, whose medical capabilities were outstanding, or who were in practice with physicians who already had staff privileges. Some of these same hospitals have had complaints brought against them by minority physicians. HEW, however, has concluded that such a policy, although it places minority group physicians at a disadvantage, does not discriminate, and I am wondering if any of you would care to comment on this?

Dr. KOPLIN. Well, if I understand you correctly, no new physician independently in practice in the community, unless he has some sort of specialty or super special qualifications would have an opportunity. Does this mean that if he is a primary care physician he would have no opportunity, if he is in independent practice?

Ms. CHAVEZ. According to the General Accounting Office, this was the practice in some hospitals.

Dr. KOPLIN. This obviously means that if you add to the number of physicians, if you add a whole new medical complex for primary medical care, these people would have no opportunity to enter the hospital.

Ms. CHAVEZ. Do you feel this plays some sort of role in keeping black or Spanish speaking or other members of minority groups who are physicians out of certain hospitals and, therefore, denies access?

Dr. KOPLIN. And out of those communities too.

Dr. CORNELY. Well, surely. This has been happening all over the place, so that minority physicians are kept out and they do not have very many staff privileges at all. And I think that when HEW accepts this they are doing a disservice to the whole situation, because I think that hospitals should open up for various types of physicians. This of course goes back to what Mr. Waldie mentioned a few minutes ago, that the patterns that have been established for many, many years have continued and it is about time that we broke through them.

Dr. KOPLIN. That sounds like a medically determined policy and as I was saying to Mr. Waldie I do not know why a community hospital cannot be viewed by the Office for Civil Rights in terms of how it makes its policies. They should not be medically determined, they should be determined for the benefit of the community if the hospital is owned by the community. Now, that is what we have not said exactly in here but it seems to me that if you are evaluating a hospital, that is one of the things that you ought to look at, who makes policies about physicians' privileges anyway.

Ms. CHAVEZ. I would assume that the hospitals in question were private hospitals and not community controlled.

Dr. KOPLIN. Well, if they have Federal dollars coming in maybe there is a way to get a handle on that. Would they take all medicaid patients?

Ms. CHAVEZ. These are all hospitals participating in either medicare or medicaid.

Mr. EDWARDS. Mr. Blommer?

Mr. BLOMMER. Doctor, I notice that you said that you taught for many years at the Howard Medical School. The GAO found that there were very few black physicians, especially in the cities in the South, but very few black physicians. Would you care to make any comment about the medical schools in the United States?

Dr. CORNELY. I am glad you asked me that question. Yes; I think that this is one of the really interesting problems in our society—that at the present time in this country we have just about 6,000 black physicians. On the other hand, we have about 7,000 Filipino physicians in this country and it has always appeared to me peculiar, that this kind of situation should exist in our land.

Now, for many years, the black physicians in this country were being trained by just Howard and Meharry and then all of a sudden

legislation was passed and money was made available and medical schools, that is the other 100 or so other schools, began to open their doors and admit black students. And it was hoped that by 1975 about 12 percent of medical students in this country would be black. But, this is not happening. At the present time just about 5 percent of the students in our medical schools are black. And it is believed that we are not going to reach the level indicated.

One of the things that we must do is to open up our doors in all of the medical schools, not only for the admission of blacks, but also programs must be instituted that will retain and graduate blacks. Now, quite often these things have not been done and therefore, the black student has sort of floundered in the medical school because of not enough tutorial help, not enough financial help, not enough contact with black faculty members so they could act as a buffer for some of the racist situations that they have encountered in medical schools. So, it is just a tragedy that here in this country we have not been able to increase the number of black physicians to any respectable level for providing services for the country as a whole.

There is a second point that must be made also and that is that black students, good black students, do not have the financial capacity to go to medical schools. The tuition fee at most of the white schools now is about $3,500 for out of State and about $2,500 or $3,000 for in-State. And the students that are going to medical schools, the black students, are generally from the middle class and professional groups and therefore there needs to be help, financial and other kinds of help for poor black students who are qualified. We take more white students at Howard Medical School than seven or eight medical schools, so-called white schools. As a matter of fact, Dr. Cheeks, the president, has said that proportionately in the whole university of Howard, we take many more white students than universities take black students.

Mr. BLOMMER. Thank you.

Mr. EDWARDS. Are there any further questions?

Gentlemen, we thank you very much for appearing before us today with this very valuable testimony.

We stand adjourned until this coming Monday when the Office for Civil Rights will be here.

Dr. KOPLIN. Thank you very much.

Dr. CORNELY. Thank you very much, gentlemen.

[Whereupon, at 12 noon, the hearing was recessed to reconvene on Monday, October 1, 1973, at 10 a.m.]

27-401—74——9

TITLE VI ENFORCEMENT IN MEDICARE AND MEDICAID PROGRAMS

MONDAY, OCTOBER 1, 1973

HOUSE OF REPRESENTATIVES,
CIVIL RIGHTS AND CONSTITUTIONAL RIGHTS SUBCOMMITTEE
OF THE COMMITTEE ON THE JUDCIARY,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:05 a.m., in room 2226, Rayburn House Office Building, Hon. Don Edwards [chairman of the subcommittee] presiding.

Present: Representatives Edwards, Drinan, Wiggins, and McClory.

Also present: Alan A. Parker, counsel; Michael W. Blommer, associate counsel; and Linda Chavez, staff analyst.

Mr. EDWARDS. The subcommittee will come to order.

The Civil Rights and Constitutional Rights Subcommittee of the House Committee on the Judiciary meets this morning to hear testimony on the enforcement of title VI in facilities receiving Federal funds under the medicare and medicaid programs.

We have as our witnesses today, Mr. Peter E. Holmes, Director of the Office for Civil Rights at HEW. The Office for Civil Rights was organized in 1967 at the direction of the House Appropriations Committee as the title VI enforcement mechanism for all programs receiving HEW funds.

In addition to monitoring title VI enforcement in health and other programs, OCR monitors title VII and title VIII of the Public Health Service Act, prohibiting discrimination on the grounds of sex in health-related training programs; title IX of the education amendments, prohibiting sex discrimination in education programs receiving Federal funds; and the compliance status of school districts applying for and receiving funds under the Emergency School Aid Act of 1972.

The health and social services branch of OCR is directly responsible for title VI enforcement in health programs. The Office of Equal Health Opportunity in the Public Health Service preceded the health and social services branch of OCR in title VI enforcement at HEW. There are currently 89 persons assigned to the health and social services branch in the Washington and regional offices.

Mr. Holmes became the director of the Office for Civil Rights on April 12, 1973. Prior to his appointment as director, Mr. Holmes served as special assistant for policy coordination and director of public affairs in the Office for Civil Rights since May 1969.

Accompanying Mr. Holmes are Martin Gerry, assistant director of policy planning of OCR; Louis Rives, director, health and social

services division; Theodore Miles, assistant general counsel for OCR; William Van den Toorn, executive assistant to the director of OCR; and Lucille Reifman, associate commissioner for program planning of the Medical Services Administration.

We welcome you all here this morning, and, Mr. Holmes, first, let me interrupt and see if Mr. Drinan has an opening statement.

Mr. DRINAN. I welcome them here, and I look forward to their presentation. I have read their paper, and Mr. Holmes does not have to go through it for my purposes anyway, and I look forward to discussion.

Mr. EDWARDS. Very good.

I think that the committee would prefer your going through the statement and reading the statement, Mr. Holmes, and you may proceed.

TESTIMONY OF PETER E. HOLMES, DIRECTOR, OFFICE FOR CIVIL RIGHTS, HEW; ACCOMPANIED BY MARTIN GERRY, ASSISTANT DIRECTOR, POLICY PLANNING, OCR; LOUIS RIVES, DIRECTOR, HEALTH AND SOCIAL SERVICES DIVISION, HEW; THEODORE MILES, ASSISTANT GENERAL COUNSEL FOR CIVIL RIGHTS, HEW; WILLIAM VAN DEN TOORN, EXECUTIVE ASSISTANT TO THE DIRECTOR, OCR; AND LUCILLE REIFMAN, ASSOCIATE COMMISSIONER FOR PROGRAM PLANNING, MEDICAL SERVICES ADMINISTRATOR, SOCIAL AND REHABILITATION SERVICE, HEW

Mr. HOLMES. Fine. Thank you, Mr. Chairman and Congressman Drinan.

I appreciate the opportunity to comment on various aspects of a report issued by the General Accounting Office on July 13, 1972.

This report was based on a review of hospitals and other health care facilities in four metropolitan areas, to determine their compliance with the nondiscrimination provisions of Title VI of the Civil Rights Act of 1964. On September 12, the GAO updated its findings in testimony before this subcommittee.

In order to provide the subcommittee with an understanding of our perspective of the GAO report and its conclusions, I propose to first outline the approach the Office for Civil Rights has taken during the past several years in conducting compliance activity in the health and social services area.

Since 1968, OCR has concentrated its limited staff resources on the review of State health and welfare agencies. During such compliance reviews, visits are made to selected local areas within each State to determine the extent to which State agencies and local counterparts are carrying out their obligation to assure title VI compliance at the local level. Hospitals, nursing homes, vendors and other facilities are visited during a State agency review. Since March of 1968, onsite visits have been made to approximately 7,500 local agencies and facilities, including 3,300 hospitals and nursing homes.

After analyzing information gathered during a State agency review, OCR's procedure is to submit a report outlining title VI problem areas and request the State agency to take corrective action. Follow-

ing negotiations, the State agency makes a written response to OCR, in the form of commitments to remedy deficiencies. In regard to most State agencies, followup reviews have been conducted to reevaluate problem areas and ascertain whether commitments are being carried out. A major aspect of the State agency review process has been the provision of training to State agency staff who are responsible for assuring compliance in facilities from which the agency purchases services in behalf of its beneficiaries. In this regard, OCR regional staff have attempted to help State agency personnel develop competence in undertaking title VI onsite reviews. Since July of 1970, training programs involving approximately 1,000 members of State staffs have been conducted in 29 States.

In addition to the State agency reviews, OCR reviews the title VI compliance status of hospitals and extended care facilities applying for participation in medicare or when such facilities undergo a change in ownership. Finally, the regional offices investigate individual complaints of discrimination and carry out routine compliance reviews as resources permit.

In brief, this is the basic framework in which OCR has worked to enforce compliance with title VI. It has been a realistic policy, based in part on the large universe subject to our jurisdiction. Title VI applies to approximately 250 State agencies and their thousands of local counterparts, facilities and vendors administering the Department's grant-in-aid programs. OCR has compliance responsibility over rehabilitation centers, physicians, workshops for the handicapped, child caring institutions and approximately 7,000 hospitals, 5,000 extended care facilities, and 2,200 home health agencies participating in the medicare program.

It should be obvious that there are constraints to the extent of compliance activity which the office can efficiently undertake in this field. And, compared to earlier efforts designed to eliminate overt racial segregation, present-day investigations into referral patterns and the delivery of social services place a greater demand on staff time. As a result, priorities must be established, based on our assessment of variable such as the capability of particular State agencies to perform various fundamental compliance tasks, the nature and pattern of complaints, and the suspect compliance status of some programs in some geographic areas relative to other programs in other areas.

Now, let me turn to the GAO's principal conclusions.

In its report and in testimony presented to this subcommittee, the GAO claims that OCR has significantly reduced compliance reviews of medicaid and medicare facilities since the programs were enacted.

At the inception of the medicare program, the Department made extensive efforts to secure satisfactory assurances of compliance with title VI from participating facilities and to correct discriminatory practices that would have precluded participation of the facilities. Needless to say, without such efforts, it would have been difficult if not impossible to get the medicare program off the ground.

To suggest that this initial, broad-based compliance effort should have continued with full force into the future is to misunderstand its transitory purpose and to argue, by inference, that reviews, including onsite visits, of individual hospitals and nursing home facilities must

constitute a first and consuming program priority for OCR. I should stress that the 1965–66 compliance effort was essentially a clearance function to get the medicare program underway. Second, we would take exception to any recommendation which, at this stage, would commit all or nearly all of OCR's staff resources to the review of individual health facilities. It is not a question of whether such facilities warrant attention. Rather, it is a question of considering all possible alternatives and committing limited staff to a compliance program that promises to have the most consequential impact on the universe of minority clients and beneficiaries protected by title VI.

Recognizing that OCR could not alone assure the continued compliance of the thousands of facilities subject to title VI at any one point in time, we have attempted to enlist the resources of the State agencies. Each State agency must abide by methods of administration which generally require the conduct of title VI reviews, the dissemination of information about nondiscrimination standards to agency personnel and beneficiaries, and a mechanism to consider and resolve complaints. As indicated, the OCR State agency reviews have in part concentrated on the extent to which the State agencies were carrying out these obligations. It was precisely because of our limited manpower, and the fact that our area of title VI jurisdiction extends beyond the compliance of hospitals and skilled nursing homes, that OCR decided to review State agencies and focus on their ability to help carry out compliance activity.

At the same time, OCR has not forfeited and will not forfeit its compliance responsibility under title VI to the State agency. Between March 1970 and December 1972 approximately 1,600 hospitals were reviewed during the State agency review process.

As indicated earlier, OCR will continue to review facilities applying for medicare as well as complaints involving medicare facilities. Thus, in fiscal year 1973, the Atlanta regional Office for Civil Rights initiated routine reviews of 118 medicare hospitals and nursing homes; 57 complaints were received during this period, involving hospitals, nursing homes, State agency programs and other medicaid vendors, and of that number, investigations were completed in 22 cases. Clearance processing was completed with respect to 92 medicare applications and it is estimated that in 80 percent of these cases, it was necessary for OCR to schedule onsite visits, request additional documentation, and/or negotiate for compliance.

For instance, in the case of the Americus Sumter Hospital, Americus, Ga., which had applied for medicare participation information gained during onsite visits indicated a pattern of racial room assignments. Corrective action was required by OCR and subsequently taken by the facility. At Richland Memorial Hospital in Columbia, S.C., action was taken to correct identified problems in room assignments, the use of courtesy titles, and the assignment of nursing staff on a racial basis.

In regard to Bryan Whitfield Hospital in Demopolis, Ala., mentioned in earlier testimony, OCR initiated a compliance review in 1972 which finally resulted in clearing the facility's Hill-Burton grant application in March 1973.

This is a 67-bed, city-owned hospital located in a rural section of the State. The minority population of the service area is 50 percent, and

the review revealed that a minority utilization of the facility was proportionate. The major problem uncovered during the review was unequal treatment and the question of room assignments. It was determined that minorities were: (1) assigned to cheaper, multibed, less desirable accommodations, which resulted in racial clustering; (2) regardless of financial resources, minorities were never assigned to private rooms; (3) there was no biracial occupancy; (4) unlimited numbers of room transfers took place to avoid the possibilities of biracial occupancy; and (5) children and adults were assigned to share rooms in order to avoid biracial occupancy.

Apparently as a result of the investigation, a new hospital administrator was appointed, and a new room assignment clerk was also appointed. The hosiptal developed an acceptable room assignment procedure which was implemented. With the change in hospital personnel and the development and implementation of a new room assignment procedure, minorities are being assigned to all areas of the hospital and biracial occupancy has occurred in proportion to minority utilization of the hospital. We are now in the process of updating information regarding this facility, in order to identify any possible evidence of discrimination surfacing again.

On the basis of studies made of minority utilization of skilled nursing facilities under medicare in Richmond, Va., and in San Antonio, Tex., OCR intends to closely examine referral patterns in a number of locales to determine the extent to which racially discriminatory procedures are part of the referral process. We regret that, due to other commitments, this evaluation could not proceed earlier.

As the GAO testified, OCR assisted the Medical Services Administration in preparing a title VI monitoring form applicable to skilled nursing homes and participated in conducting many of the MSA reviews of skilled nursing homes under medicaid. With respect to three of the four States where reviews were conducted, State agency officials have submitted assurances satisfactory to MSA that the title VI problems identified during the reviews would be corrected. In regard to the fourth State—California—the regional office of HEW at San Francisco is negotiating with the California Department of Health on procedures for conducting annual reviews of medicaid nursing facilities.

In its report, GAO presented no findings of title VI noncompliance with respect to the hospitals and nursing homes surveyed in Atlanta, Ga.; Birmingham, Ala.; Wayne County, Mich.; and Los Angeles County, Calif. While not ruling out the possibility of subtle forms of discrimination, GAO did not find or document cases in which staff privileges were overtly denied the doctors on a racial basis or in which admissions or services were denied to minority group patients.

However, the GAO study indicates that many of the facilities were treating persons of predominently one race.

Many of the factors which evidently lie at the root of this pattern, such as the personal preference of physicians and patients, the accessibility of facilities, and the existence of outpatient clinics, do not appear to be attributable to racial discrimination in the context of title VI.

On the basis of OCR reviews conducted in San Antonio, Tex., and in Richmond, Va., it appears that patients at the lowest income levels,

which would include a strong ratio of minorities, are finding it more difficult to get admitted to skilled nursing homes under medicare than under medicaid. The reason for this may be that skilled nursing homes apparently prefer to admit patients under medicaid because they are more certain of payment. If a doctor refers a patient to a nursing home facility under medicaid, the facility is sure of payment. However, approval of medicare expenditures may not come for several weeks after admission and there is always a possibility that payment will not be certified. I mention this situation as an example of a low-visibility problem that works to the disadvantage of minorities with low income but which may not be directly traceable to deliberate acts of discrimination.

Compared to the situation that prevailed less than 10 years ago, progress has been made. This progress stems from the Government's initial effort to strip away overt racial barriers, the issuance of revised title VI guidelines applicable to hospitals and nursing homes in 1969, and the continuing OCR program of compliance reviews.

Nevertheless, the findings of the GAO report are irrefutable. As former Secretary Elliot L. Richardson pointed out to the chairman of this subcommittee last year, we continue to be greatly concerned about the problem of minority underutilization and the problem of racial clustering in certain facilities. In addition to review activities, whch will include evaluation of the referral process affecting nursing homes, OCR will conduct a survey of health care facilities during this fiscal year and the results will help to identify patterns warranting further inquiry.

In discussing the racial identifiability of certain facilities, the GAO commented on the reach of title VI, referring to unnamed HEW officials and representatives of civil rights organizations who suggested that the statute may not be adequate to deal with "more complex forms of discrimination—such as the general attitudes of whites toward nonwhites or the lack of understanding by white hospital staff of the cultural or economic backgrounds of minority group patients."

In later testimony, GAO goes on to assert that according to HEW officials, it may be necessary "to modify the law so that instances of gross underrepresentation of minority group patients in a hospital compared with community population" are sufficient to impose an affirmative legal obligation.

To begin with, let me say that title VI prohibits not just officially inspired or sanctioned racial segregation but so-called subtle forms of racial discrimination as well when perpetrated by recipients of Federal funds.

As with all title VI cases, there is the elementary question of establishing legally sufficient evidence to support a formal conclusion by the Department that a violation—discrimination—has occurred. And, as the more overt forms of discrimination, such as State-imposed illegal segregation, have largely been eliminated, both in the elementary and secondary education area as well as in the health facilities area, the task of clearly identifying the existence of discriminatory practices in violation of title VI has become more difficult.

However, title VI and the implementing regulation provide sufficient basis for correcting more subtle discriminatory practices, despite the increased time and greater investigative and analytical skills re-

quired to identify such discriminatory practices. The title VI regulation prohibits recipients of Federal funds from providing services which are different with respect to race, color, or national origin; it prohibits treating an individual differently from others on the basis of race or national origin in determining whether he satisfies any admission requirement or condition necessary to receive benefits provided under the program.

The regulation further states that a recipient of Federal financial assistance "in determining * * * the class of individual to be afforded an opportunity to participate in any * * * program, may not * * * utilize criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program as respect to individuals of a particular race, color, or national origin." (45 CFR section 80.3(b)(2).)

In its testimony the GAO mentions the lack of sensitivity or cultural awareness of hospital staff as an obstacle to access to hospitals on the part of minority-group patients. In reviewing the provision of social services by State and local welfare offices, OCR has found that in a number of cases the lack of cultural awareness and fluency in Spanish on the part of local welfare workers may have the effect of denying Spanish-speaking persons an equal opportunity to benefit from available services and programs in violation of title VI. The point is not that title VI fails to reach "subtle" problems such as the discriminatory effect of cultural and linguistic barriers. Rather, such issues are more complex to address in an investigative and remedial sense than blatant and officially sanctioned racial segregation in federally assisted facilities.

In regard to the question of minority use of hospitals as a index of possible noncompliance or as evidence of noncompliance, witnesses before the subcommittee have suggested or implied that on the basis of survey data alone, indicating disproportionate use of facilities in a particular community, title VI mandates some kind of corrective action, supposedly in the absence of a finding of discrimination.

We must emphasize that our authority to require corrective action in this area stems from title VI. Section 601 of the statute bars recipients of Federal assistance from discriminating on grounds of race, color, or national origin in federally supported programs or activities. But the term "discrimination" has been applied by the courts to mean an act or omission which is the responsibility of the person or institution being examined. It does not follow that a legal sanction, such as imposed affirmative action, may be required merely as a result of statistics showing a racially disproportionate utilization of facilities.

For example, the United States Supreme Court, in *Jefferson* v. *Hackney*, 406 U.S. 535, 32 L. Ed. 2d 285 (1973), recently refused to prevent the State of Texas from lowering AFDC benefits proportionately more than other categorical welfare programs even though it was shown that the result was a disproportionate burden on blacks and Mexican-Americans. The Court distinguished the decision from *Griggs* v. *Duke Power Co.*, 401 U.S. 424 (1971), precisely because in *Griggs* the racial disproportions evincing discrimination were proven

to be the result of an unjustifiable procedure (the imposition of employment tests found not job-related).

Where discrimination has been established, however, we can and do require affirmative action to assure that minorities are aware that federally supported facilities are open to receive them. The distinction between affirmative action which may be required by a Federal agency in the presence of past discrimination and affirmative action which is merely permissible is set out in the recent amendments to the Presidentially approved title VI regulation, a copy of which I have with me and would like to submit for the record at the conclusion of my statement, Mr. Chairman.

Mr. EDWARDS. It will be received without objection.

[The document referred to follows:]

[From the Federal Register, July 5, 1973]

NONDISCRIMINATION IN FEDERALLY ASSISTED PROGRAMS

Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d to d–4, prohibits discrimination on the ground of race, color or national origin in programs and activities receiving Federal financial assistance. At present, 21 Federal agencies have regulations implementing Title VI.[1]

Each of these agencies has adopted amendments to its Title VI regulation.[2] In addition, four agencies, the Civil Service Commission, Environmental Protection Agency, Federal Home Loan Bank Board, and National Foundation on the Arts and the Humanities, have adopted initial Title VI regulations. The regulation amendments of the 21 agencies and the four initial regulations have been approved by the President (FR Doc. 73–13407)[2a], in accord with section 602 of Title VI, 42 U.S.C. 2000d–1.

The background of the amendments and the new regulations is as follows: On December 9, 1971, uniform amendments to the Title VI regulations of 20 agencies and the initial regulation of the National Foundation on the Arts and the Humanities were published in the Federal Register as proposed rule making. See 36 FR 23447. Comments on the proposals were submitted to the Department of Justice which has responsibility, under Executive Order 11247, for coordinating implementation of Title VI by Federal agencies. On the basis of the comments, the Department of Justice recommended that agencies with major Title VI responsibilities adopt certain additional amendments.

As a result of the above steps, the original uniform amendments are, with limited exceptions, included in each set of amendments to existing regulations and in each of the four initial regulations.[3] The most important of these provisions involve: prohibiting discrimination in the selection of sites for facilities of Federally assisted programs, requiring affirmative action to overcome the effects of past discrimination, and providing that discriminatory employment practices are prohibited by Title VI to the extent that such practices tend to cause discrimination in the services provided to beneficiaries.

In addition, the amendments of 13 agencies with major Title VI responsibilities include provisions which the Department of Justice had recommended on the basis of public comments. These additional provisions relate to: prohibiting discrimination in the selection of members of planning and advisory bodies, referring to the obligation of recipients of Federal funds to maintain racial and ethnic data with regard to program beneficiaries, and extending (from 90) to 180 days the time for filing complaints.

The regulation amendments and the four initial regulations will take effect on July 5, 1973.

---

[1] Title VI regulations are presently in effect for the Departments of Agriculture, Commerce, Defense, HEW, HUD, Interior, Labor, Justice, State and Transportation and the following agencies: AID, AEC, CAB, GSA, NASA, NSF, OEO, OEP, SBA, TVA and VA.

[2] The amendments of four agencies, Commerce, HUD, OEO and OEP, are in the form of complete reissuance of their respective regulations.

[2a] Filed with the Office of the Federal Register.

[3] Subsequent to December 9, 1971, the regulations of the Civil Service Commission, Environmental Protection Agency and Federal Home Loan Bank Board and amendments to the Department of Transportation regulation were published in the Federal Register as proposed rule making.

TITLE 45—PUBLIC WELFARE

SUBTITLE A—DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, GENERAL ADMINISTRATION

PART 80—NONDISCRIMINATION UNDER PROGRAMS RECEIVING FEDERAL ASSISTANCE THROUGH THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE EFFECTUATION OF TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

Miscellaneous Amendments

Amendments to 45 CFR Part 80 are adopted for the purposes indicated below. Revisions similar to those described below (except for revisions described in items numbered 12–14) are uniform changes being adopted by other agencies which provide Federal financial assistance, pursuant to Title VI of the Civil Rights Act of 1964. The revisions described under items 12–14 below are not uniform; they are procedural in nature and designed for the regulation of this agency only. In addition, citations to statutory authority are added immediately after each section of 45 CFR Part 80.

1. A new subparagraph (1) (vii) is added to § 80.3(b) to prohibit discrimination in the selection of persons to planning or advisory bodies.

2. The present subparagraphs (3) and (4) of § 80.3(b) are renumbered (4) and (5), respectively, and a new subparagraph (3) is added to clarify nondiscrimination requirements with respect to the selection of sites and locations for facilities which affect the provision of federally-assisted benefits.

3. A new § 80.3(b)(6) is added as (i) to require recipients to take affirmative action to overcome the effects of prior discrimination, where the recipient has previously discriminated and as (ii) to indicate recipients are not prohibited from taking affirmative action to overcome the effects of conditions which resulted in limited program participation by persons of a particular race, color, or national origin.

4. A subparagraph is added to § 80.3(c) to state the rule concerning discriminatory employment practices which result in excluding individuals from participation in, denying them the benefits of, or subjecting them to discrimination under any program or activity to which this regulation applies.

5. Subparagraph (b) under § 80.3(c) relating to community work and training assisted under Title IV of the Social Security Act, 42 U.S.C. 609, is deleted.

6. Subparagraph (d) (formerly (e)) of § 80.3(c) is changed to read "rehabilitation facilities" instead of "sheltered workshops."

7. Section 80.4(a)(2) is revised to delete the requirement that surplus property transfers contain a reverter for breach of the nondiscrimination provisions and instead to authorize a reverter discretionary with the responsible department official in the case of any real property transfer. As revised, a covenant running with the land, to assure nondiscriminatory use, will be included when any Federal financial assistance is extended in the form of a transfer of real property by the Federal Government. In other cases where property is acquired or improved with Federal financial assistance, the amendment requires that the recipient agree to include such a covenant in any subsequent transfer.

8. Language of § 80.4(b) which provided that noncomplying features of existing continuing State programs could be corrected in the future has been deleted.

9. In § 80.6(b) a new sentence is added after the first sentence to require recipients to keep racial and ethnic data in relation to federally-assisted programs.

10. In § 80.6(c) new language is added after the last sentence to make clear that asserted considerations of privacy or confidentiality may not operate to bar the Department from requiring recipients to keep such data.

11. In § 80.7(b) the period for filing complaints is extended from 90 to 180 days in conformity with other Civil Rights regulations.

12. Section 80.9(a) provided that in the case of a waiver of a right to a hearing the decision may be made on the basis of "such information as is available." This is amended to provide that the decision in such a case may be made on the basis of "such information as may be filed as the record."

13. Under § 80.10, prior to the present amendment, a party to a proceedings could request the Secretary to review a hearing examiner's decision even though there was no request for the intervening review of the Reviewing Authority, which is a matter of right. The amendment to § 80.10(c) authorizes a request

for review by the Secretary only if the matter has first been considered by the Reviewing Authority.

14. Subparagraph (4) of § 80.10(g) duplicates the provision of the last sentence of subparagraph (3) of such section. Subparagraph (4) is deleted to eliminate that inadvertent duplication.

15. A sentence is added to § 80.12(c) specifying that actions taken by an official of another Department or Agency under an assignment of responsibility shall have the same effect as though taken by the responsible official of this Department.

16. In some provisions the word "program" has been used to refer to the arrangement under which Federal financial assistance is made available; in other places it was used to mean the operation or activity of the applicant or recipient. Technical revisions are made in the designation of Part 80 and throughout the regulation to eliminate the use of "program" to refer to the arrangement under which Federal financial assistance is made available.

17. Clause 3 is added to § 80.12(a) to make clear that these regulations and amendments will not affect the requirements for Emergency School Assistance as published in 35 FR 13442 and codified as 45 CFR Part 181.

18. The listing of Appendix A is revised to eliminate the use "program" to refer to the arrangement under which Federal financial assistance is made available and to bring the listings in the Appendix up to date.

1. The designation of Part 80 is amended to read as set forth in the heading above.

2. Section 80.2 is amended to read:

§ 80.2 Application of this regulation.

This regulation applies to any program for which Federal financial assistance is authorized to be extended to a recipient under a law administered by the Department, including the Federal assisted programs and activities listed in Appendix A of this regulation. It applies to money paid, property transferred, or other Federal financial assistance extended after the effective date of the regulation pursuant to an application approved prior to such effective date. This regulation does not apply to (a) any Federal financial assistance by way of insurance or guaranty contracts, (b) money paid, property transferred, or other assistance extended before the effective date of this regulation, (c) the use of any assistance by any individual who is the ultimate beneficiary under any such program, or (d) any employment practice, under any such program, or any employer, employment agency, or labor organization, except to the extent described in § 80.3. The fact that a type of Federal assistance is not listed in Appendix A shall not mean, if Title VI of the Act is otherwise applicable, that a program is not covered. Federal financial assistance under statutes now in force or hereinafter enacted may be added to this list by notice published in the Federal Register.

"(Secs. 602, 604, Civil Rights Act of 1964; 78 Stat. 252, 253; 42 U.S.C. 2000d–1, 2000d–3)"

3. Section 80.3 is amended by adding a new paragraph (b)(1)(vii) as set forth below. Paragraph (b) is amended by renumbering the present subparagraphs (3) and (4) as subparagraphs (4) and (5), respectively, and adding new subparagraphs (3) and (6). As so changed, subparagraphs (3), (4), (5) and (6) read as set forth below. Paragraphs (c) and (d) are amended to read as set forth below.

§ 80.3 Discrimination prohibited.

* * * * * * *

(b) Specific discriminatory actions prohibited. (1) * * *

(vii) Deny a person the opportunity to participate as a member of a planning or advisory body which is an integral part of the program.

* * * * * * *

(3) In determining the site or location of facilities an applicant or recipient may not make selections with the effect of excluding individuals from, denying them the benefits of, or subjecting them to discrimination under any programs to which this regulation applies, on the ground of race, color, or national origin; or with the purpose or effect of defeating or substantially impairing the accomplishment of the objectives of the Act or this regulation.

(4) As used in this section, the services, financial aid, or other benefits provided under a program receiving Federal financial assistance shall be deemed to include any service, financial aid, or other benefits provided in or through a facility provided with the aid of Federal financial assistance.

(5) The enumeration of specific forms of prohibited discrimination in this paragraph and paragraph (c) of this section does not limit the generality of the prohibition in paragraph (a) of this section.

(6) (i) In administering a program regarding which the recipient has previously discriminated against persons on the grounds of race, color, or national origin, the recipient must take affirmative action to overcome the effects of prior discrimination.

(ii) Even in the absence of such prior discrimination, a recipient in administering a program may take affirmative action to overcome the effects of conditions which resulted in limiting participation by persons of a particular race, color, or national origin.

(c) *Employment practices.* (1) Where a primary objective of the Federal financial assistance to a program to which this regulation applies is to provide employment, a recipient may not (directly or through contractual or other arrangements) subject an individual to discrimination on the grounds of race, color, or national origin in its employment practices under such program (including recruitment or recruitment advertising, employment, layoff or termination, upgrading, demotion, or transfer, rates of pay or other forms of compensation, and use of facilities), including programs where a primary objective of the Federal financial assistance is (i) to reduce the employment of such individuals or to help them through employment to meet subsistence needs, (ii) to assist such individuals through employment to meet expenses incident to the commencement or continuation of their education or training, (iii) to provide work experience which contributes to the education or training of such individuals, or (iv) to provide remunerative activity to such individuals who because of handicaps cannot be readily absorbed in the competitive labor market. The following, under existing laws, have one of the above objectives as a primary objective:

(*a*) Projects under the Public Works Acceleration Act, Public Law 87-658, 42 U.S.C. 2641-2643.

(*b*) Work-study under the Vocational Education Act of 1963, as amended, 20 U.S.C. 1371-1374.

(*c*) Programs assisted under laws listed in Appendix A as respects employment opportunities provided thereunder, or in facilities provided thereunder, which are limited, or for which preference is given, to students, fellows, or other persons in training for the same or related employments.

(*d*) Assistance to rehabilitation facilities under the Vocational Rehabilitation Act, 29 U.S.C. 32-34, 41a and 41b.

(2) The requirements applicable to construction employment under any such program shall be those specified in or pursuant to Part III of Executive Order 11246 or any Executive order which supersedes it.

(3) Where a primary objective of the Federal financial assistance is not to provide employment, but discrimination on the ground of race, color, or national origin in the employment practices of the recipient or other persons subject to the regulation tends, on the ground of race, color, or national origin, to exclude individuals from participation in, to deny them the benefits of, or to subject them to discrimination under any program to which this regulation applies, the foregoing provisions of this paragraph (c) shall apply to the employment practices of the recipient or other persons subject to the regulation, to the extent necessary to assure equality of opportunity to, and nondiscriminatory treatment of, beneficiaries.

(d) *Indian Health and Cuban Refugee Services.* An individual shall not be deemed subjected to discrimination by reason of his exclusion from the benefits of a program limited by Federal law to individuals of a particular race, color, or national origin different from his.

* * * * * * *

4. Section § 80.4(a)(2), (b), and (d) is amended to read as follows:

§ 80.4 Assurances required.

(a) *General.* (1) * * *

(2) Where Federal financial assistance is provided in the form of a transfer of real property or interest therein from the Federal Government the instrument

effecting or recording the transfer shall contain a covenant running with the land to assure nondiscrimination for the period during which the real property is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. Where no transfer of property is involved but property is improved with Federal financial assistance, the recipient shall agree to include such a covenant to any subsequent transfer of the property. Where the property is obtained from the Federal Government, such covenant may also include a condition coupled with a right to be reserved by the Department to revert title to the property in the event of a breach of the covenant where, in the discretion of the responsible Department official, such a condition and right of reverter is appropriate to the statute under which the real property is obtained and to the nature of the grant and the grantee. In the event a transferee of real property proposes to mortgage or otherwise encumber the real property as security for financing construction of new, or improvement of existing, facilities on such property for the purposes for which the property was transferred, the responsible Department official may agree, upon request of the transferee and if necessary to accomplish such financing, and upon such conditions as he deems appropriate, to forbear the exercise of such right to revert title for so long as the lien of such mortgage or other encumbrance remains effective.

(b) *Continuing State programs.* Every application by a State or a State agency to carry out a program involving continuing Federal financial assistance to which this regulation applies (including the Federal financial assistance listed in Part 2 of Appendix A) shall as a condition to its approval and the extension of any Federal financial assistance pursuant to the application (1) contain or be accompanied by a statement that the program is (or, in the case of a new program, will be) conducted in compliance with all requirements imposed by or pursuant to this regulation, and (2) provide or be accompanied by provision for such methods of administration for the program as are found by the responsible Department official to give reasonable assurance that the applicant and all recipients of Federal financial assistance under such program will comply with all requirements imposed by or pursuant to this regulation.

* * * * * * *

(d) *Assurance from institutions.* (1) In the case of any application for Federal financial assistance to an institution of higher education (including assistance for construction, for research, for special training project, for student loans or for any other purpose), the assurance required by this section shall extend to admission practices and to all other practices relating to the treatment of students.

* * * * * * *

5. The introductory statement of § 80.5 and paragraphs (a), (b), (e) and (h) are amended to read as set forth below; and new paragraphs (i) and (j) are added as illustrative examples of new § 80.3(b)(6).

§ *80.5 Illustrative application.*

The following examples will illustrate the programs aided by Federal financial assistance of the Department. (In all cases the discrimination prohibited is discrimination on the grounds of race, color, or national original prohibited by Title VI of the Act and this regulation, as a condition of the receipt of Federal financial assistance).

(a) In Federally assisted programs for the provision of health or welfare services, discrimination in the selection or eligibility of individuals to receive the services, and segregation or other discriminatory practices in the manner of providing them, are prohibited. This prohibition extends to all facilities and services provided by the grantee under the program or, if the grantee is a State, by a political subdivision of the State. It extends also to services purchased or otherwise obtained by the grantee (or political subdivision) from hospitals, nursing homes, schools, and similar institutions for beneficiaries of the program, and to the facilities in which such services are provided, subject, however, to the provisions of § 80.3(e).

(b) In federally-affected area assistance (P.L. 815 and P.L. 874) for construction aid and for general support of the operation of elementary or secondary schools, or in more limited support to such schools such as for the acquisition of equipment, the provision of vocational education, or the provision of guidance

and counseling services, discrimination by the recipient school district in any of its elementary or secondary schools in the admission of students, or in the treatment of its students in any aspect of the educational process, is prohibited. In this and the following illustrations the prohibition of discrimination in the treatment of students or other trainees includes the prohibition of discrimination among the students or trainees in the availability or use of any academic, dormitory, eating, recreational, or other facilities of the grantee or other recipient.

* * * * * * *

(e) In grants to assist in the construction of facilities for the provision of health, educational or welfare services, assurances will be required that services will be provided without discrimination, to the same extent that discrimination would be prohibited as a condition of Federal operating grants for the support of such services. Thus, as a condition of grants for the construction of academic, research, or other facilities at institutions of higher education, assurances will be required that there will be no discrimination in the admission or treatment of students. In case of hospital construction grants the assurance will apply to patients, to interns, residents, student nurses, and other trainees, and to the privilege of physicians, dentists, and other professionally qualified persons to practice in the hospital, and will apply to the entire facility for which, or for a part of which, the grant is made, and to facilities operated in connection therewith. In other construction grants the assurances required will similarly be adapted to the nature of the activities to be conducted in the facilities for construction of which the grants have been authorized by Congress.

* * * * * * *

(h) A recipient may not take action that is calculated to bring about indirectly what this regulation forbids it to accomplish directly. Thus, a State, in selecting or approving projects or sites for the construction of public libraries which will receive Federal financial assistance, may not base its selections or approvals on criteria which have the effect of defeating or of substantially impairing accomplishments of the objectives of the Federal assistance as respects individuals of a particular race, color or national origin.

(i) In some situations, even though past discriminatory practices attributable to a recipient or applicant have been abandoned, the consequences of such practices continue to impede the full availability of a benefit. If the efforts required of the applicant or recipient under § 80.6(d), to provide information as to the availability of the program or activity and the rights of beneficiaries under this regulation, have failed to overcome these consequences, it will become necessary under the requirement stated in (i) of § 80.3(b)(6) for such applicant or recipient to take additional steps to make the benefits fully available to racial and nationality groups previously subject to discrimination. This action might take the form, for example, of special arrangements for obtaining referrals or making selections which will insure that groups previously subjected to discrimination are adequately served.

(j) Even though an applicant or recipient has never used discriminatory policies, the services and benefits of the program or activity it administers may not in fact be equally available to some racial or nationality groups. In such circumstances, an applicant or recipient may properly give special consideration to race, color, or national origin to make the benefits of its program more widely available to such groups, not then being adequately served. For example, where a university is not adequately serving members of a particular racial or nationality group it may establish special recruitment policies to make its program better known and more readily available to such group, and take other steps to provide that group with more adequate service.

6. Paragraphs (b), (c), (d) of § 80.6 are amended to read:

§ 80.6 Compliance information.

* * * * * * *

(b) *Compliance reports.* Each recipient shall keep such records and submit to the responsible Department official or his designee timely, complete and accurate compliance reports at such times, and in such form and containing such information, as the responsible Department official or his designee may determine to be necessary to enable him to ascertain whether the recipient has complied or is complying with this part. For example, recipients should have available for the Department racial and ethnic data showing the extent to which members of

minority groups are beneficiaries of and participants in federally-assisted programs. In the case of any program under which a primary recipient extends Federal financial assistance to any other recipient, such other recipient shall also submit such compliance reports to the primary recipient as may be necessary to enable the primary recipient to carry out its obligations under this part.

(c) *Access to sources of information.* Each recipient shall permit access by the responsible Department official or his designee during normal business hours to such of its books, records, accounts, and other sources of information, and its facilities as may be pertinent to ascertain compliance with this part. Where any information required of a recipient is in the exclusive possession of any other agency, institution or person and this agency, institution or person shall fail or refuse to furnish this information the recipient shall so certify in its report and shall set forth what efforts it has made to obtain the information. Asserted considerations of privacy or confidentiality may not operate to bar the Department from evaluating or seeking to enforce compliance with this Part. Information of a confidential nature obtained in connection with compliance evaluation or enforcement shall not be disclosed except where necessary in formal enforcement proceedings or where otherwise required by law.

(d) *Information to beneficiaries and participants.* Each recipient shall make available to participants, beneficiaries, and other interested persons such information regarding the provisions of this regulation and its applicability to the program for which the recipient receives Federal financial assistance, and make such information available to them in such manner, as the responsible Department officials finds necessary to apprise such persons of the protections against discrimination assured them by the Act and this regulation.

§ 80.7 [Amended]

7. Paragraph (b) of § 80.7 is amended by deleting the phrase "90 days" and substituting "180 days".

8. Paragraph (a) of § 80.9 is amended to read:

§ 80.9 Hearings

(a) *Opportunity for hearing.* Whenever an opportunity for a hearing is required by § 80.8(c), reasonable notice shall be given by registered or certified mail, return receipt requested, to the affected applicant or recipient. This notice shall advise the applicant or recipient of the action proposed to be taken, the specific provision under which the proposed action against it is to be taken, and the matters of fact or law asserted as the basis for this action, and either (1) fix a date not less than 20 days after the date of such notice within which the applicant or recipient may request of the responsible Department official that the matter be scheduled for hearing or (2) advise the applicant or recipient that the matter in question has been set down for hearing at a stated place and time. The time and place so fixed shall be reasonable and shall be subject to change for cause. The complainant, if any, shall be advised of the time and place of the hearing. An applicant or recipient may waive a hearing and submit written information and argument for the record. The failure of an applicant or recipient to request a hearing for which a date has been set shall be deemed to be a waiver of the right to a hearing under section 602 of the Act and § 80.8(c) of this regulation and consent to the making of a decision on the basis of such information as may be filed as the record.

* * * * * * *

9. Paragraphs (e) and (f) of § 80.10 are amended to read as set forth below, and paragraph (g) (4) is deleted.

§ 80.10 Decisions and notices.

* * * * * * *

(e) *Review in certain cases by the Secretary.* If the Secretary has not personally made the final decision referred to in paragraphs (a), (b), or (c) of this section, a recipient or applicant or the counsel for the Department may request the Secretary to review a decision of the Reviewing Authority in accordance with rules of procedure issued by the responsible Department official. Such review is not a matter of right and shall be granted only where the Secretary determines there are special and important reasons therefor. The Secretary may grant or deny such request, in whole or in part. He may also review such a decision upon his own motion in accordance with rules of procedure issued by the responsible

Department official. In the absence of a review under this paragraph, a final decision referred to in paragraphs (a), (b), (c) of this section shall become the final decision of the Department when the Secretary transmits it as such to Congressional committees with the report required under section 602 of the Act. Failure of an applicant or recipient to file an exception with the Reviewing Authority or to request review under this paragraph shall not be deemed a failure to exhaust administrative remedies for the purpose of obtaining judicial review.

(f) *Content of orders.* The final decision may provide for suspension or termination of, or refusal to grant or continue Federal financial assistance, in whole or in part, to which this regulation applies, and may contain such terms, conditions, and other provisions as are consistent with and will effectuate the purposes of the Act and this regulation, including provisions designed to assure that no Federal financial assistance to which this regulation applies will thereafter be extended under such law or laws to the applicant or recipient determined by such decision to be in default in its performance of an assurance given by it pursuant to this regulation, or to have otherwise failed to comply with this regulation unless and until it corrects its noncompliance and satisfies the responsible Department official that it will fully comply with this regulation.

* * * * * * *

10. Paragraph (a) of § 80.12 is amended, and a new concluding sentence is added to paragraph (c), so that the amended paragraph reads as set forth below.

§ 80.12 Effect on other regulations, forms and instructions.

(a) *Effect on other regulations.* All regulations, orders, or like directions heretofore issued by any officer of the Department which impose requirements designed to prohibit any discrimination against individuals on the ground of race, color, or national origin under any program to which this regulation applies, and which authorize the suspension or termination of or refusal to grant or to continue Federal financial assistance to any applicant for or recipient of assistance for failure to comply with such requirements, are hereby superseded to the extent that such discrimination is prohibited by this regulation, except that nothing in this regulation shall be deemed to relieve any person of any obligation assumed or imposed under any such superseded regulation, order, instruction, or like direction prior to the effective date of this regulation. Nothing in this regulation, however, shall be deemed to supersede any of the following (including future amendments thereof): (1) The "Standards for a Merit System of Personnel Administration," issued jointly by the Secretaries of Defense, of Health, Education and Welfare, and of Labor, 45 CFR Part 70; (2) Executive Order 11063 and regulations issued thereunder, or any other regulations or instructions, insofar as such Order, regulations, or instructions prohibit discrimination on the ground of race, color, or national origin in any program or situation to which this regulation is inapplicable, or prohibit discrimination on any other ground; or (3) requirements for Emergency School Assistance as published in 35 FR 13442 and codified as 45 CFR Part 181.

* * * * * * *

(c) *Supervision and coordination.* The responsible Department official may from time to time assign to officials of the Department, or to officials of other departments or agencies of the Government with the consent of such departments or agencies, responsibilities in connection with the effectuation of the purposes of Title VI of the Act and this regulation (other than responsibility for review as provided in § 80.10(e)), including the achievements of effective coordination and maximum uniformity within the Department and within the Executive Branch of the Government in the application of Title VI and this regulation to similar programs and in similar situations. Any action taken, determination made, or requirement imposed by an official of another Department or Agency acting pursuant to an assignment of responsibility under this subsection shall have the same effect as though such action had been taken by the responsible official of this Department.

11. The following citations are added immediately after each of the listed sections of 45 CFR Part 80 as indicated below:

"§ 80.1: (Sec. 601, Civil Rights Act of 1964; 78 Stat. 252; 41 U.S.C. 2000d).
"§ 80.2: (Sec. 602, 604, Civil Rights Act of 1964; 78 Stat. 252, 253; 42 U.S.C. 2000d-1, 2000d-3).

27-401—74——10

"§ 80.3: Sec. 601, 602, 604, Civil Rights Act of 1964; 78 Stat. 252, 253, 42 U.S.C. 2000d, 2000d-1, 2000d-3).
"§ 80.4: (Sec. 601, 602, Civil Rights Act of 1964; 78 Stat. 252; 42 U.S.C. 2000d, 2000d-1, Sec. 182; 80 Stat. 1209; 42 U.S.C. 2000d-5).
"§ 80.5: (Sec. 601, 602, Civil Rights Act of 1964; 78 Stat. 252; 42 U.S.C. 2000d, 2000d-1).
"§ 80.6: (Sec. 601, 602, Civil Rights Act of 1964; 78 Stat. 252; 42 U.S.C. 2000d, 2000d-1).
"§ 80.7: (Sec. 601, 602, Civil Rights Act of 1964; 78 Stat. 252; 42 U.S.C. 2000d, 2000d-1).
"§ 80.8: (Sec. 601, 602, Civil Rights Act of 1964; 78 Stat. 252; 42 U.S.C. 2000d, 2000d-1. Sec. 182, 80 Stat. 1209; 42 U.S.C. 2000d-5).
"§ 80.9: (Sec. 602, Civil Rights Act of 1964; 78 Stat. 252; 42 U.S.C. 2000d-1).
"§ 80.10: (Sec. 602, Civil Rights Act of 1964; 78 Stat. 252, 42 U.S.C. 2000d-1).
"§ 80.11: (Sec. 603, Civil Rights Act of 1964; 78 Stat. 253; 42 U.S.C. 2000d-2).
"§ 80.12: (Sec. 602, Civil Rights Act of 1964; 78 Stat. 252; 42 U.S.C. 2000d-1).
"§ 80.13: (Sec. 602, Civil Rights Act of 1964; 78 Stat. 252; 42 U.S.C. 2000d-1)."

Effective date. This amendment shall become effective August 6, 1973.
Dated: August 8, 1972.

[SEAL]

ELLIOT L. RICHARDSON,
Secretary of Health, Education, and Welfare.

"APPENDIX A

"FEDERAL FINANCIAL ASSISTANCE TO WHICH THESE REGULATIONS APPLY

"*Part 1. Assistance other than for State-Administered Continuing Programs*

"1. Loans for acquisition of equipment for academic subjects, and for minor remodeling (20 U.S.C. 445).
"2. Construction of facilities for institutions of higher education (20 U.S.C. 701-758).
"3. School Construction in federally-affected and in major disaster areas (20 U.S.C. 631-647).
"4. Construction of educational broadcast facilities (47 U.S.C. 390-399).
"5. Loan service of captioned films and educational media; research on, and production and distribution of, educational media for the handicapped, and training of persons in the use of such media for the handicapped (20 U.S.C. 1452).
"6. Demonstration residential vocational education schools (20 U.S.C. 1321).
"7. Research and related activities in education of handicapped children (20 U.S.C. 1441).
"8. Educational research, dissemination and demonstration projects; research training; and construction under the Cooperation Research Act (20 U.S.C. 331-332(b)).
"9. Research in teaching modern foreign languages (20 U.S.C. 512).
"10. Training projects for manpower development and training (42 U.S.C. 2601, 2602, 2610a-2601c).
"11. Research and training projects in Vocational Education (20 U.S.C. 1281 (a), 1282-1284).
"12. Allowances to institutions training NDEA graduate fellows (20 U.S.C. 461-465).
"13. Grants for training in librarianship (20 U.S.C. 1031-1033).
"14. Grants for training personnel for the education of handicapped children (20 U.S.C. 1431).
"15. Allowances for institutions training teachers and related educational personnel in elementary and secondary education, or post-secondary vocational education (20 U.S.C. 1111-1118).
"16. Recruitment, enrollment, training and assignment of Teacher Corps personnel (20 U.S.C. 1101-1107a).
"17. Operation and maintenance of schools in Federally-affected and in major disaster areas (20 U.S.C. 236-241; 241-1; 242-244).
"18. Grants or contracts for the operation of training institutes for elementary or secondary school personnel to deal with special educational problems occasioned by desegregation (42 U.S.C. 2000c-3).

"19. Grants for in-service training of teachers and other schools personnel and employment of specialists in desegregation problems (42 U.S.C. 2000c–4).

"20. Higher education students loan program (Title II, National Defense Education Act, 20 U.S.C. 421–429).

"21. Educational Opportunity grants and assistance for State and private programs of low-interest insured loans and State loans to students in institutions of higher education (Title IV, Higher Education Act of 1965, 20 U.S.C. 1061–1087).

"22. Grants and contracts for the conduct of Talent Search, Upward Bound, and Special Services Programs (20 U.S.C. 1068).

"23. Land-grant college aid (7 U.S.C. 301–308; 321–326; 328–331).

"24. Language and area centers (Title VI, National Defense Education Act, 20 U.S.C. 511).

"25. American Printing House for the Blind (20 U.S.C. 101–105).

"26. Future Farmers of America (36 U.S.C. 271–391) and similar programs.

"27. Science clubs (P.L. 85–875, 20 U.S.C. 2, note).

"28. Howard University (20 U.S.C. 121–129).

"29. Gallaudet College (31 D.C. Code, Ch. 10).

"30. Establishment and operation of a model secondary school for the deaf by Gallaudet College (31 D.C. Code 1051–1053; 80 Stat. 1027–1028).

"31. Faculty development programs, workshops and institutes (20 U.S.C. 1131–1132).

"32. National Technical Institute for the Deaf (20 U.S.C. 681–685).

"33. Institutes and other programs for training educational personnel (Parts D, E & F, Title V, Higher Education Act of 1965) (20 U.S.C. 1119–1119c–4).

"34. Grants and contracts for research and demonstration projects in librarianship (20 U.S.C. 1034).

"35. Acquisition of college library resources (20 U.S.C. 1021–1028).

"36. Grants for strengthening developing institutions of higher education (20 U.S.C. 1051–1054); National Fellowships for teaching at developing institutions (20 U.S.C. 1055), and grants to retired professors to teach at developing institutions (20 U.S.C. 1056).

"37. College Work-Study Program (42 U.S.C. 2751–2757).

"38. Financial assistance for acquisition of higher education equipment, and minor remodeling (20 U.S.C. 1121–1129).

"39. Grants for special experimental demonstration projects and teacher training in adult education (20 U.S.C. 1208).

"40. Grant programs for advanced and undergraduate international studies (20 U.S.C. 1171–1176; 22 U.S.C. 2452(b)).

"41. Experimental projects for developing State leadership or establishment of special services (20 U.S.C. 865).

"42. Grants to and arrangements with State educational and other agencies to meet special educational needs of migratory children of migratory agricultural workers (20 U.S.C. 241e(c)).

"43. Grants by the Commissioner of Education to local educational agencies for supplementary educational centers and services; guidance, counseling, and testing (20 U.S.C. 841–844; 844b).

"44. Resource centers for improvement of education of handicapped children (20 U.S.C. 1421) and centers and services for deaf-blind children (20 U.S.C. 1422).

"45. Recruitment of personnel and dissemination of information on education of handicapped (20 U.S.C. 1433).

"46. Grants for research and demonstrations relating to physical education or recreation for handicapped children (20 U.S.C. 1442) and training of physical educators and recreation personnel (20 U.S.C. 1434).

"47. Dropout prevention projects (20 U.S.C. 887).

"48. Billingual education programs (20 U.S.C. 880b–880b–6).

"49. Grants to agencies and organizations for Cuban refugees (22 U.S.C. 2601 (b)(4)).

"50. Grants and contracts for special programs for children with specific learning disabilities including research and related activities, training and operating model centers (20 U.S.C. 1461).

"51. Curriculum development in vocational and technical education (20 U.S.C. 1391).

"52. Establishment, including construction, and operation of a National Center on Educational Media and Materials for the Handicapped (20 U.S.C. 1453).

"53. Grants and contracts for the development and operation of experimental preschool and early education programs for handicapped (20 U.S.C. 1423).

"54. Grants to public or private non-profit agencies to carry on the Follow Through Program in kindergarten and elementary schools (42 U.S.C. 2809 (a)(2)).

"55. Grants for programs of cooperative education and grants and contracts for training and research in cooperative education (20 U.S.C. 1087a–1087c).

"56. Grants and contracts to encourage the sharing of college facilities and resources (network for knowledge) (20 U.S.C. 1133–1133b).

"57. Grants, contracts, and fellowships to improve programs preparing persons for public service and to attract students to public service (20 U.S.C. 1134–1134b).

"58. Grants for the improvement of graduate programs (20 U.S.C. 1135–1135c).

"59. Contracts for expanding and improving law school clinical experience programs (20 U.S.C. 1136–1136b).

"60. Exemplary programs and projects in vocational education (20 U.S.C. 1301–1305).

"61. Grants to reduce borrowing cost for construction of residential schools and dormitories (20 U.S.C. 1323).

"62. Project grants and contracts for research and demonstration relating to new or improved health facilities and services (sec. 304, PHS Act, 42 U.S.C. 242b).

"63. Grants for construction or modernization of emergency rooms of general hospitals (Title VI, Part C, PHS Act, 42 U.S.C. 291j).

"64. Institutional and special projects grants to schools of nursing (sections 805–808, PHS Act, 42 U.S.C. 296d–296g).

"65. Grants for construction and initial staffing of facilities for prevention and treatment of alcoholism (sec. 241–2, Community Mental Health Centers Act, 42 U.S.C 2688 f and g).

"66. Grants for construction and initial staffing of specialized facilities for the treatment of alcoholics requiring care in such facilities (sec. 243, Community Mental Health Centers Act, 42 U.S.C. (2688h).

"67. Special project grants for training programs, evaluation of existing treatment programs, and conduct of significant programs relating to treatment of alcoholics (sec. 246, Community Mental Health Centers Act. 42 U.S.C. 2688j–1.)

"68. Grants for construction and initial staff of treatment facilities for narcotic addicts (sec. 251, Community Mental Health Centers Act, 42 U.S.C. 2688m).

"69. Special project grants for training programs, evaluation of existing treatment programs, and conduct of significant programs relating to treatment of narcotics addicts (sec. 252, Community Mental Health Centers Act, 42 U.S.C. 2688n–1).

"70. Grants for consultation services for Community Mental Health Centers, alcoholism prevention and treatment facilities for narcotic addicts, and facilities for mental health of children (sec. 264, Community Mental Health Centers Act, 42 U.S.C. 2688r).

"71. Grants for construction and initial staff of facilities for mental health of children (sec. 271, Community Mental Health Centers Act, 42 U.S.C. 2688u).

"72. Special project grants for training programs and evaluation of existing treatment program relating to mental health of children (sec. 272, Community Mental Health Centers Act, 42 U.S.C. 2688x).

"73. Grants and loans for construction and modernization of medical facilities in the District of Columbia (P.L. 90–457; 82 Stat. 631–3).

"74. Teaching facilities for nurse training (secs. 801–804, Public Health Service Act, 42 U.S.C. 296–296c).

"75. Teaching facilities for allied health professions personnel (sec. 791, Public Health Service Act, 42 U.S.C. 295h).

"76. Mental retardation research facilities (Title VI, Part D, Public Health Service Act, 42 U.S.C. 295–395e).

"77. George Washington University Hospital construction (76 Stat. 83, P.L. 87–460, May 31, 1962).

"78. Research projects, including conferences, communication activities and primate or other center grants (secs. 301, 303, 304, and 308, Public Health Service Act, 42 U.S.C. 241, 242a, 242b, and 242f).

"79. General research support (sec. 301(d), Public Health Service Act, 42 U.S.C. 241).

"80. Mental health demonstrations and administrative studies (sec. 303(a)(2), Public Health Service Act, 42 U.S.C. 242a).

"81. Migratory workers health services (sec. 310, Public Health Service Act, 42 U.S.C. 242h).

"82. Immunization programs (sec. 317, Public Health Service Act, 42. U.S.C. 247b).

"83. Health research training projects and fellowship grants (secs. 301, 433, Public Health Service Act, 42 U.S.C. 289c).

"84. Categorical (heart, cancer, etc.) grants for training, traineeships or fellowships (secs. 303, 433, etc., Public Health Service Act, 42 U.S.C. 242a, 289c, etc.).

"85. Advanced professional nurse traineeships (sec. 821, Public Health Service Act, 42 U.S.C. 297).

"86. Department projects under Appalachian Regional Development Act (40 U.S.C. App. A).

"87. Grants to institutions for traineeships for professional public health personnel (sec. 306, Public Health Service Act, 42 U.S.C. 242d).

"88. Grants for graduate or specialized training in public health (sec. 309, Public Health Service Act, 42 U.S.C. 242g).

"89. Health professions school student loan program (Title VII, Part C, Public Health Service Act, 52 U.S.C. 294–294(k)).

"90. Grants for provision in schools of public health of training, consultation and technical assistance in the field of public health and in the administration of state or local public health programs (sec. 309(c)), Public Health Service Act, 42 U.S.C. 242(g)(c)).

"91. Project grants for training, studies, or demonstrations looking metropolitan area, or other local area plans for health services (sec. 314(c), Public Service Act, 42 U.S.C. 246(c)).

"92. Project grants for training, studies, or demonstrations looking toward the development of improved comprehensive health planning (sec 314(c), Public Health Service Act, 42 U.S.C. 246(c)).

"93. Project grants for health services development (sec. 314(e), Public Health Service Act, 42 U.S.C. 246(e)).

"94. Institutional and special grants to health professions schools (Title VII, Part E, Public Health Service Act, 42 U.S.C. 295f–295f–4).

"95. Improvement grants to centers for allied health professions (sec. 792, Public Health Service Act, 42 U.S.C. 295h–1).

"96. Scholarship grants to health professions schools (Title VII, Part F, Public Health Service Act, 42 U.S.C. 295h–1).

"97. Scholarship grants to schools of nursing (Title VIII, Part D, Public Health Service Act, 42 U.S.C. 298c–298c–6).

"98. Traineeships for advanced training of allied health professions personnel (sec. 793, Public Health Service Act, 42 U.S.C. 295h–2).

"99. Contracts to encourage full utilization of nursing educational talent (sec. 868, Public Health Service Act, 42 U.S.C. 298c–7).

"100. Grants to community mental health centers for the compensation of professional and technical personnel for the initial operation of new centers or of new services in centers (Community Mental Health Centers Act, Part B, 42 U.S.C. 2688–2688d).

"101. Grants for the planning, construction, equipment and operation of multicounty demonstration health projects in the Appalachian region (sec. 202 of Appalachian Regional Development Act, P.L. 89–4, as amended, P.L. 90–103 40 U.S.C. App. 202).

"102. Education, research, training, and demonstrations in the fields of heart disease, cancer, stroke and related diseases (secs. 900–110, Public Health Service Act, 42 U.S.C. 299a–j).

"103. Assistance to medical libraries (secs. 390–399, Public Health Service Act, 42 U.S.C. 280b–280b–9).

"104. Nursing student loans (secs. 822–828, Public Health Service Act, 42 U.S.C. 297a–g).

"105. Hawaii leprosy payments (sec. 331, Public Health Service Act, 42 U.S.C. 255).

"106. Heart disease laboratories and related facilities for patient care (sec. 412(d), Public Health Service Act, 42 U.S.C. 287a(d)).

"107. Grants for construction of hospitals serving Indians (P.L. 85–151, 42 U.S.C. 2005).

"108. Indian Sanitation Facilities (P.L. 86–121, 42 U.S.C. 2004a).

"109. Research projects relating to maternal and child health services and crippled children's services (42 U.S.C. 712).

"110. Maternal and child health special project grants to State agencies and institutions of higher learning (42 U.S.C. 703(2)).

"111. Maternity and infant care and family planning services; special project grants to local health agencies and other organizations (42 U.S.C. 708).

"112. Special project grants to State agencies and institutions of higher learning for crippled children's services (42 U.S.C. 704(2)).

"113. Special project grants for health of school and preschool children (42 U.S.C. 709) and for dental health of children (42 U.S.C. 710).

"114. Grants to institutions of higher learning for training personnel for health care and related services for mothers and children (42 U.S.C. 711).

"115. Grants and contracts for the conduct of research, experiments, or demonstrations relating to the development, utilization, quality, organization, and financing of services, facilities, and resources of hospitals, long-term care facilities, or other medical facilities (sec. 304, Public Health Service Act, as amended by P.L. 90–174, 42 U.S.C. 242b).

"116. Health research facilities (Title VII, Part A, Public Health Service Act, 42 U.S.C. 292–292j).

"117. Teaching facilities for health professions personnel (Title VII, Part B, Public Health Service Act, 42 U.S.C. 293–293h).

"118. Project grants and contracts for research, development, training, and studies in the field of electronic product radiation (sec. 356, Public Health Service Act, 42 U.S.C. 263d).

"119. Project grants and contracts for research, studies, demonstrations, training, and education relating to coal mine health (sec. 501, Federal Coal Mine Health and Safety Act of 1969, Public Law 91–173).

"120. Surplus real and related personal property disposal (40 U.S.C. 484(k)).

"121. Supplementary medical insurance benefits for the aged (Title XXIII, Part B, Social Security Act, 42 U.S.C. 1395j–1395w).

"122. Issuance of rent-free permits for vending stands, credit unions employee associations, etc. (20 U.S.C. 107–107f; 45 C.F.R. Part 20; sec. 25, 12 U.S.C. 1770).

"123. Grants for special vocational rehabilitation projects (29 U.S.C. 34(a)(1)).

"124. Experimental, pilot or demonstration projects to promote the objectives of Title I, X, XIV, XVI, or XIX or Part A of Title IV of the Social Security Act (42 U.S.C. 1315).

"125. Social Security and welfare cooperative research or demonstration projects (42 U.S.C. 1310).

"126. Child welfare research, training, or demonstration projects (42 U.S.C. 626).

"127. Training projects (Title VI, Older Americans Act, 42 U.S.C. 3041–3042).

"128. Grants for expansion of vocational rehabilitation services (29 U.S.C. 34(a)(2)(A)).

"129. Grants for construction of rehabilitation facilities (29 U.S.C. 41a(a)–(e)) and for initial staffing of rehabilitation facilities (29 U.S.C. 41a(f)).

"130. Project development grants for rehabilitation facilities (29 U.S.C. 41a(g)(2)).

"131. Rehabilitation Facility improvement grants (29 U.S.C. 41b(b)).

"132. Agreement for the establishment and operation of a national center for deaf-blind youths and adults (29 U.S.C. 42a).

"133. Project grants for services for migratory agriculture workers (29 U.S.C. 42b).

"134. Grants for initial staffing of community mental retardation facilities (42 U.S.C. 2678–2678d).

"135. Grants for training welfare personnel and for expansion and development of undergraduate and graduate social work programs (42 U.S.C. 906, 908).

"136. Research and development projects concerning older Americans (42 U.S.C. 3031–3032).

"137. Grants to States for training of nursing home administrators (42 U.S.C. 1396g(e)).

"138. Contracts or jointly financed cooperative arrangements with industry (29 U.S.C. 34(a)(2)(B)).

"139. Project grants for new careers in rehabilitation (29 U.S.C. 34(a)(2)(C)).

"140. Children of low-income families (20 U.S.C. 241a–241m).

"141. Grants for training (29 U.S.C. 37(a)(2)).

"142. Grants for projects for training services (29 U.S.C. 41b(a)).

"143. Grants for comprehensive juvenile delinquency planning (42 U.S.C. 3811).

"144. Grants for project planning in juvenile delinquency (42 U.S.C. 3812).

"145. Grants for juvenile delinquency rehabilitative services projects (42 U.S.C. 3822, 3842).

"146. Grants for juvenile delinquency preventive service projects (42 U.S.C. 3861).

"147. Grants for training projects in juvenile delinquency fields (42 U.S.C. 3861).

"148. Grants for development of improved techniques and practices in juvenile delinquency services (42 U.S.C. 3871).

"149. Grants for technical assistance in juvenile delinquency services (42 U.S.C. 3872).

"150. Grants for State technical assistance to local units in juvenile delinquency services (42 U.S.C. 3873).

"151. Grants for public service centers projects (42 U.S.C. 2744).

"152. Grants to public or private non-profit agencies to carry on the Project Headstart Program (42 U.S.C. 2809(a)(1)).

"153. Project grants for new careers for the handicapped (29 U.S.C. 34(a)(2)(D)).

"154. Construction, demonstration, and training grants for university-affiliated facilities for persons with developmental disabilities (42 U.S.C. 2661–2666).

"Part 2. Continuing Assistance to State Administered Programs

"1. Grants to States for public library services and construction, interlibrary cooperation and specialized State library services for certain State institutions and the physically handicapped (20 U.S.C. 351–355),

"2. Grants to States for strengthening instruction in academic subjects (20 U.S.C. 441–444).

"3. Grants to States for vocational education (20 U.S.C. 1241–1264).

"4. Arrangements with State education agencies for training under the Manpower Development and Training Act (42 U.S.C. 2601–2602, 2610a).

"5. Grants to States to assist in the elementary and secondary education of children of low-income families (20 U.S.C. 241a–241m).

"6. Grants to States to provide for school library resources, textbooks and other instructional materials for pupils and teachers in elementary and secondary schools (20 U.S.C. 821–827).

"7. Grants to States to strengthen State departments of education (20 U.S.C. 861–870).

"8. Grants to States for community service programs (20 U.S.C. 1001–1011).

"9. Grants to States for adult basic education and related research, teacher training and special projects (20 U.S.C. 1201–1211).

"10. Grants to State educational agencies for supplementary educational centers and services, and guidance, counseling and testing (20 U.S.C. 841–847).

"11. Grants to States for research and training in vocational education (20 U.S.C. 1281(b)).

"12. Grants to States for exemplary programs and projects in vocational education (20 U.S.C. 1301–1305).

"13. Grants to States for residential vocational education schools (20 U.S.C. 1321).

"14. Grants to States for consumer and homemaking education (20 U.S.C. 1341).

"15. Grants to States for cooperative vocational education program (20 U.S.C. 1351–1355).

"16. Grants to States for vocational work-study programs (20 U.S.C. 1371–1374).

"17. Grants to States to attract and qualify teachers to meet critical teaching shortages (20 U.S.C. 1108–1110c).

"18. Grants to States for education of handicapped children (20 U.S.C. 1411–1414).

"19. Grants for administration of State plans and for comprehensive planning to determine construction needs of institutions of higher education (20 U.S.C. 715(b)).

"20. Grants to States for comprehensive health planning (sec. 314(a), Public Health Service Act, 42 U.S.C. 246(a)).

"21. Grants to States for establishing and maintaining adequate public health services (sec. 314(d), Public Health Service Act, 42 U.S.S. 246(d)).

"22. Grants, loans, and loan guarantees with interest subsidies for hospital and medical facilities (Title VI, Public Health Service Act, 42 U.S.C. 291 et seq.).

"23. Grants to States for community mental health centers construction (Community Mental Health Centers Act, Part A, 42 U.S.C. 2681–2687).

"24. Cost of rehabilitation services (Title II, Social Security Act sec. 222(d); 42 U.S.C. 422(d)).

"25. Surplus personal property disposal donations for health and educational purposes through State agencies (40 U.S.C. 484(j)).

"26. Grants for State and community programs on aging (Title III, Older Americans Act, 42 U.S.C. 3021–3025).

"27. Grants to States for planning, provision of services, and construction and operation of facilities for persons with developmental disabilities (42 U.S.C. 2670–2677c).

"28. Grants to States for vocational rehabilitation services (29 U.S.C. 32); for innovation of vocational rehabilitation services (29 U.S.C. 33); and for rehabilitation facilities planning (29 U.S.C. 41a(g)(1)).

"29. Designation of State licensing agency for blind operators of vending stands (20 U.S.C. 107–107f).

"30. Grants to States for old-age assistance (42 U.S.C. 301 et seq.); aid to families with dependent children (42 U.S.C. 601 et seq.); child-welfare services (42 U.S.C. 620 et seq.); aid to the blind (42 U.S.C. 1201 et seq.); aid to the permanently and totally disabled (42 U.S.C. 1351 et seq.); aid to the aged, blind, or disabled (42 U.S.C. 1381 et seq.); medical assistance (42 U.S.C. 1396 et seq.).

"31. Grants to States for maternal and child health and crippled children's services (42 U.S.C. 701–707); for special projects for maternal and infant care (42 U.S.C. 708).

"32. Grants to States for juvenile delinquency preventive and rehabilitative services (42 U.S.C. 3841).

"[FR Doc. 73–13285 Filed 3–7–73:8:45 am]"

Mr. HOLMES. Nevertheless, where facilities have racially disproportionate utilization certain presumptions may arise justifying closer examination as to whether the cause is within the control of the recipient or is due to the attitudes or preferences of the beneficiaries. Such an investigation might include an onsite visit to the facility and to other facilities in the area, discussions with staff and patients, and visits to persons in the minority community.

Finally, Mr. Chairman, I would like to comment briefly on the objectives we have charted for the Health and Social Services Division in OCR.

Previous testimony has raised questions as to our commitment to enforce title VI and the policies established to implement that commitment.

In the first place, let me assure the subcommittee that this office is dedicated to enforce the law firmly and with every available resource.

Admittedly, the record is not perfect. We have no doubt made our share of mistakes—and we certainly don't profess to have all the answers.

During the course of the hearings, a number of suggestions have been made to improve the title VI compliance program, and we will study them carefully.

In this connection, I might mention, Mr. Chairman, we have recently established a Health and Social Services Task Force and that task force will be working on revision of title VI guidelines in that program area.

By the same token, I believe that our present course is basically sound. While some persons may disagree with the emphasis placed upon the State agency reviews during the past several years this approach was essential to make State agencies aware of their title VI responsibilities and capable of undertaking a reliable and realistic compliance role to supplement OCR's efforts. Such a role will, in turn, make possible more extensive and fruitful field investigations of our own in the immediate future. Moreover, the reviews have helped to set the stage for a new phase of compliance activity by alerting OCR to the kinds of civil rights-related problems that prevail on a national scale.

By the end of the calendar year the State agency review process will draw to a close, except for a reporting and monitoring function that each OCR regional office will administer. During this transition phase, OCR will continue to shift the focus of attention to the conduct of indepth field investigations.

The program areas targeted for review in the coming months were considered on the basis of general criteria such as the potential impact of each proposed investigative project on beneficiaries or clients; the extent to which the reviews are likely to lead to the development of new or refined strategies and compliance standards applicable nationwide to similar federally assisted programs; and OCR's assessment of where major title VI problems are likely to exist, based on our experience to date in reviewing individual facilities and State agency operations. As indicated earlier, the referral practices affecting nursing homes will be examined in a number of locations. In addition, OCR intends to apply to new locations the investigative techniques already developed to identify discrimination against national origin group clients in the delivery of social services.

We also believe that as a matter of priority, indepth field reviews should be undertaken to investigate the existence of discrimination in such areas as vocational rehabilitation, mental health programs, the delivery of health services to American Indians, and comprehensive health planning. A proposed children's services review will analyze the delivery of a cross-section of services available in local communities in five program areas, including welfare social services, mental health, mental retardation, juvenile delinquency, and maternal and child health programs. The review will determine whether the services currently available in local communities are being utilized by minority children at the same rate as nonminority children, and whether the services which are provided meet the needs of minority children as well as nonminority children, including those whose primary language is one other than English. The review will aso determine whether the interrelationship of all of the programs available in a local community provides a service network which meets the needs

of children, regardless of age, handicap, and cultural and linguistic background.

Some of the special investigative activity undertaken recently and during the past 2 years is of particular interest because it has brought to the fore a number of serious problem areas that merit further inquiry and policy clarification.

Recently the Office for Civil Rights submitted to the Connecticut Department of Welfare findings indicating that local welfare offices, due to various practices, were not administering welfare benefits and social services in such a manner as to assure equal opportunity to Spanish-speaking clients or potential clients.

Briefly, the letter of findings pointed out that:

(1) Spanish-surnamed persons are being discriminated against in the delivery of public assistance benefits and social services because of their national origin. Because of the language and culture of most of these persons, their limited knowledge of the English language, and the failure of the State welfare department to adequately take account of these characteristics, such persons frequently receive inferior treatment and services. The failure of the department to employ sufficient bilingual staff to ensure equal treatment of current Spanish-speaking clients is compounded by the consistent failure of the district offices to make maximum use of current bilingual staff in order to reduce the number of unserved Spanish-speaking clients.

(2) The current practice by district offices of providing an equal amount of professional social service staff time per case in all district offices regardless of the number of persons per case and the number of service needs per person, results in a substantial reduction in the average time spent per client problem for minority as compared to non-minority social service clients.

The investigation of this case, undertaken to refine and update evidence gathered with respect to previous findings of a similar nature, closely paralleled an earlier case involving the Sonoma, Calif., County Department of Social Services. With your permission, Mr. Chairman, I would like to include in the hearing record copies of both reports at the conclusion of my remarks.

Mr. EDWARDS. They will be received without objection.

[The reports referred to follow:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE FOR CIVIL RIGHTS,
San Francisco, Calif., June 16, 1972.

Mr. PAUL M. ALLEN,
Director, Sonoma County Department of Social Service,
Santa Rosa, Calif.

DEAR MR. ALLEN: Let me express my appreciation for the courtesy and cooperation extended by the Department's personnel during our on-site review of the Department's operation and during subsequent discussions relating to the release of computer stored data.

As you are aware, the purpose of our reviews was to assess the current compliance of the Sonoma County Department of Social Service with Title VI of the Civil Rights Act of 1964. This letter sets forth a summary of our findings and conclusions.

Title VI and the departmental Regulation, 45 CFR Part 80 (a copy of which has been provided to you), prohibits discrimination on the grounds of race, color or national origin by recipients of federal financial assistance.

The Regulation provides that no person shall, on account of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to the provision of services in a discriminatory manner in the operation of any federally-assisted program. More specifically, the Regulation prohibits the operation of any such program in a manner which has "the effect of subjecting individuals to discrimination because of their race, color or national origin or [has] the effect of defeating or substantially impairing accomplishment of the objectives of the program as respect[s] individuals of a particular race, color or national origin."

This Office has reviewed a substantial amount of data related to the current operations of your Department. During our on-site visits to the county during August and September, 1971, members of the review team interviewed several members of the Department's staff as well as clients of the Department and other interested members of the community.

In addition, the Office has reviewed data files of the Department stored with Alpha Beta Associates, questionnaires completed by nearly all of the Department's current staff, and preliminary Fourth Count Census Data relating to the language characteristics of the Spanish-surnamed population of the county and the racial and ethnic characteristics of the poverty population of the county on a countywide basis (rather than by census tract).

On the basis of this information, we have concluded that the Sonoma County Social Services Department is in probable noncompliance with Title VI of the Civil Rights Act in that Spanish-surnamed potential and enrolled clients are frequently excluded from receiving public assistance benefits or receive inferior treatment and services not because of a lack of eligibility or legal entitlement to benefits, but solely because of their Spanish language and culture, their limited knowledge of the English language, and the County Department's failure to take account of these characteristics.

With regard to the exclusion of Spanish-surnamed potential clients from receiving public assistance benefits, preliminary Fourth Count Census data reveals that based on the efficiency of the Department in enrolling non-Spanish surnamed potential clients, at least 800–950 Spanish-surnamed clients have been excluded. While Spanish-surnamed persons and families constitute 11% of the county's population below "75% Poverty Level",[1] 11–12% of the county's population below "Poverty Level," and 12–13% of the county's population below "125% Poverty Level," Spanish-surnamed cases constituted only 5% (an estimated 608) of the public assistance caseload (12,342) and 6% (129) of the Social Service caseload (2024) as of January 31, 1972.

Using the efficiency of the Department in enrolling non-Spanish surnamed public assistance clients below "Poverty Level" as a base, approximately 41% of the Spanish-surnamed public assistance clients which this efficiency level would indicate should be enrolled are, in fact, enrolled. With regard to the population below "125% of Poverty Level," this percentage drops to approximately 39%. From our analysis of the data collected, we have concluded that the present operation of the Department has the effect of substantially impairing the accomplishment of the objectives of the program with respect to Spanish-surnamed individuals.

The barriers presented to Spanish-speaking applicants for welfare benefits are highlighted by the poor utilization of Spanish-speaking employees. During an on-site visit to the Department, a total of 7 employees were identified as Spanish-speaking. Of the 7 employees so identified, 3 were assigned in some capacity to the eligibility caseload, and 4 were assigned to the social service caseload. Of the 3 persons assigned to the eligibility caseload, one served as an eligibility supervisor, one as an intake worker, and one as a case aide. Of the 4 persons assigned to the social service caseload, one served as a social service supervisor, one as a social service caseworker, one as a foster home licensing worker, and one as a case aide. Questionnaires were completed by each of these persons and the data was incorporated in the estimate of current client service capability.

We have been informally notified that 4 more Spanish-speaking persons have been employed, that one of those previously identified—a social service case

---

[1] Items in quotations are classifications used in preliminary 1970 Fourth Count Census data tables.

aide—has left the Department, and that one—an eligibility supervisor—appears to have been assigned to other duties. Of the 4 newly hired Spanish-speaking employees, only 3 are professionals and only one has been assigned to the eligibility caseload. Thus, a total of 3 Spanish-speaking employees (two professionals and one aide) are currently assigned to the eligibility caseload. According to data supplied to us on January 31, 1972, the Spanish-speaking public assistance caseload was distributed among a total of 87 eligibility workers. Data revealed that the highest caseload of any worker in terms of the number of Spanish-speaking cases was 13 (5% of the total caseload for that worker) and that in only one instance did a Spanish-speaking caseload for any worker exceed 20% of the caseload—the exception being 35.7% (or 10 cases) of a total caseload of 28. It appears, therefore, that little effort has been made to allocate currently available Spanish-speaking staff so as to reduce as much as possible the number of Spanish-speaking public assistance cases unserved by bilingual staff. To the extent that Spanish-speaking personnel are not assigned to each identifiable unit within the Department, i.e., telephone, reception, eligibility intake, ongoing eligibility, and each of the categorical Social Service units, there is a denial of services to Spanish-speaking persons.

Our review also indicates that the current underenrollment of Spanish-surnamed clients is directly attributable to the failure of the County Department to utilize culturally and linguistically competent client contact staff to serve potential Spanish-speaking clients. Caseload data supplied by the Department indicate that as of January 31, 1972, approximately 75% of all Spanish-surnamed eligibility cases (and approximately 70% of currently served persons) are Spanish-speaking and approximately 65% of all Spanish-surnamed social service cases (approximately 67% of all currently served persons) were Spanish-speaking. Similarly, preliminary Fourth Count Census Data for the county shows that approximately 64% of all Spanish-surnamed persons in the county speak Spanish, not English, as the language of regular communication. The close correlation between census figures and the figures derived from computer printout data and questionnaires as to your eligibility caseload, cited above, leads to the conclusion that the term "Spanish-speaking" as used in this letter to refer actual or potential welfare clients means that such individuals use Spanish as their primary language of communication.

Computer printouts from Alpha Beta Associates and questionnaires from case workers reveal that of the 311 Spanish-speaking eligibility cases recorded as of January 31, 1972:

(*a*) approximately 292 or 93% of Spanish-speaking public assistance cases were not served by a bilingual eligibility worker;

(*b*) approximately 239 or 76% were not served by a bilingual eligibility worker or Department-provided translator; and

(*c*) approximately 216 or 69% were completely unserved either by a bilingual eligibility worker, agency-provided translator, or bilingual friend or acquaintance. Based on the estimated caseload of 608, the number of Spanish-surnamed eligibility cases would be approximately 438. The percentages in paragraphs *a*, *b* and *c* above, accordingly, would thereby increase to approximately 96%, 83%, and 78% respectively.

The failure to provide linguistically competent staff appears to be complete with regard to initial client contact. According to records of the Department supplied to our Office and questionnaries completed by Department staff, as of January 1, 1972, the Department employed no Spanish-speaking telephone operators or receptionists. Interviews with clients and caseworkers indicate that the absence of bilingual telephone operators has resulted in significantly greater burdens on Spanish-speaking potential clients as compared to other potential clients in terms of greater time delays, more required visits to the Department's office and, as a result, the additional burdens of child care, transportation time and expenses, and the like. Moreover, this breakdown of communication regarding general eligibility for benefits and enrollment procedures has led to a failure by Spanish-speaking clients to enroll for benefits to which they are entitled by law.

From interviews with caseworkers and clients, our Office has also determined that the non-existence of bilingual reception services results in Spanish-speaking potential clients receiving markedly different treatment than other potential clients. For instance, Spanish-speaking clients are often told to come back at another time, which imposes additional burdens of child care, transportation,

and the like. Spanish-speaking clients are also told to come back with a child or neighbor who can translate, thereby deterring them from returning because of an understandable reluctance or refusal to have to disclose to children, neighbors and acquaintances private information which the Welfare Department, by its own criteria, rightfully regards as highly personal and confidential. Spanish-speaking clients are also asked to wait long periods of time in order for a translator to be located, thereby deterring enrollment or causing hardships not suffered by non-minority clients.

The lack of bilingual eligibility workers has also led to a breakdown of necessary communication with Spanish-speaking potential clients.

Interviews with caseworkers reveal that the lack of staff capability to communicate in Spanish often results in a failure to enroll Spanish-speaking clients. Data gathered during the review indicates that non-bilingual workers frequently require potential clients to use translators from the non-professional staff of the agency who do not understand the basic eligibility requirements and, therefore, cannot adequately explain them, or children, neighbors, or bilingual persons who happen to be in the waiting room, and who neither understand the basic eligibility requirements nor, in any event, are appropriate persons to discuss or have knowledge of confidential information about potential clients.

Another area of concern which has arisen as a result of our review is the apparent unequal delivery of services to Spanish-speaking clients who have been enrolled despite whatever obstacles may have existed at the initial eligibility stage. For example, the inability of the Department to assist Spanish-speaking clients in communicating changing circumstances has apparently led to a failure by eligibility workers to make available upward adjustments or emergency financial allocations to such clients. From interviews with clients and caseworkers, the Office has also determined that unwarranted reductions of benefits and terminations of assistance have resulted from the inability of eligibility workers to communicate directly with the clients.

These interviews also indicate that the inability of eligibility workers to communicate with Spanish-speaking clients has resulted in the inability of Spanish-speaking clients, who are in need of social services, effectively to communicate their need. Computer printouts from Alpha Beta Associates and questionnaires from caseworkers reveal that of the 129 estimated Spanish-surnamed social service cases as of January 31, 1972, approximately 81 or 63% of such cases are primarily Spanish-speaking. With regard to these cases:

(a) approximately 42 or 52% are not served by a bilingual social service worker;

(b) approximately 39 or 48% are not served by either a bilingual social service worker or Department provided translator; and

(c) approximately 36 or 44% of such cases are completely unserved by a bilingual social service worker, agency-provided translator, or bilingual relative, friend, or acquaintance.

Testimony of Spanish-speaking clients also indicates that important welfare-related problems of many Spanish-speaking clients are never understood by non-Spanish speaking social service workers responsible for evaluating clients' needs. We have concluded that the failure of the Department to employ more than four Spanish-speaking social service workers, one of whom incidentally, is a supervisor not in direct contact with clients, results in the discriminatory treatment of Spanish-speaking clients. Again, the use by non-Spanish speaking social service workers of children or neighbors as translators creates a barrier to communication with the Spanish-speaking client who, like the English-speaking client, seeks and is entitled to privacy. Thus, the use of translators may also have the effect of defeating or substantially impairing the objectives of the program with respect to many Spanish-surnamed clients.

From information gathered during the review, we have also concluded that the absence of any form of agency-provided cultural awareness training to client contact and supervisory personnel has resulted in a significantly lower level of understanding by the staff of the unique characteristics of Spanish-speaking clients—such as religious beliefs, family life, self-concept, and similar areas—than the level of staff understanding of such matters with regard to non-Spanish speaking clients. As we know you will recognize, an understanding of client behavior has an important and legitimate bearing on whether and how welfare benefits should be delivered. The lack of such understanding on the part of your staff has, in our opinion, been a material factor in the current lack of delivery or differential delivery of benefits to the Spanish-speaking community.

In accordance with the findings set forth in this letter, we are requesting that you inform us within 30 days of what specific actions will be taken by the Sonoma County Department of Social Services to correct the deficiencies identified. Since we recognize that you may not have given adequate thought or planning to correct these deficiencies, we are also ready to be of immediate assistance with regard to further discussions on the problems set forth, and the preparation and design of appropriate remedies. In this connection, as you may know, our office is also currently conducting similar reviews of other county welfare departments, and is working with the California Department of Social Welfare both to provide appropriate remedies in county welfare departments, and to identify appropriate steps to be taken at the State level. We are providing the State Department with a copy of this letter, and except that the design and implementation of appropriate remedies in your county system will be consistent with those that may be identified in conjunction with our State agency review.

We would also like to inform you that, in the absence of clear and convincing rebuttal to any points we have raised, or adequate and prompt remedies for those deficiencies which we have identified, and may identify further in the course of our discussions, formal enforcement steps under Title VI of the Civil Rights Act of 1964 will be taken.

We look forward to hearing from you to begin discussions with your staff as promptly as possible. Please feel free to call me at area (415) 556-8586, or write to me as Regional Director, Office for Civil Rights, 760 Market Street, Room 700, San Francisco, California, 94102.

Sincerely,

(S) ROBERT L. BROWN,
for FLOYD L. PIERCE,
Regional Civil Rights Director.

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF THE SECRETARY,
Washington, D.C., June 22, 1972.

HEW's Office for Civil Rights Director J. Stanley Pottinger has informed the Sonoma County, California, Social Services Department that it is in probable noncompliance with Title VI of the Civil Rights Act of 1964.

Title VI prohibits the use of Federal funds for programs that discriminate as to race, color, or national origin.

In a letter to Paul M. Allen, Director of the Sonoma County agency, mailed June 16, 1972, Pottinger said:

> Spanish surnamed potential clients are frequently excluded from receiving public assistance benefits or receive inferior treatment and services, not because of a lack of eligibility or legal entitlement to benefits, but solely because of their Spanish language and culture, their limited knowledge of the English language, and the County Department's failure to take account of these characteristics.

Pottinger said a compliance review indicates, for example, that 800 to 950 Spanish-surnamed clients are excluded from receiving public assistance benefits as a direct result of the County Department's failure to communicate with them in a language they understand.

OCR's study further indicates, he said, that 93 percent of the Spanish-speaking clients currently receiving public assistance are not served by a bilingual eligibility case worker. Seventy-five percent were not served by a bilingual eligibility worker or Department-provided translator, and 69 percent were unserved by a bilingual worker, agency provided translator, or Spanish-speaking friend or acquaintance.

The County Department employs no Spanish-speaking telephone operators or receptionists, which means that initial contact by Spanish-speaking persons is a serious initial barrier. Spanish-speaking persons may be turned away by the language barrier without a chance to explain their needs. The alternatives which frequently face the Spanish-speaking applicant include:

> Instructions to come back later, imposing additional burdens in arranging for child care, and additional transportation expense.
>
> Instructions to return later with a child or neighbor who can translate, which presents a discouraging obstacle to citizens who do not wish to discuss their private lives with children and neighbors.
>
> Instructions to wait for long periods of time until a translator can be located by the County.

"The crux of the problem is the failure of the Sonoma County Social Services Department to deal effectively with the language and cultural barriers of those who are unable to communicate except in Spanish," Pottinger said.

The Office for Civil Rights asked the Sonoma County Department of Social Services to inform it within 30 days of what specific steps it will take to correct the violations of the Civil Rights Act of 1964.

"The action we have taken deals only with the situation in Sonoma County. We have informed the California Department of Social Welfare of the request made upon the Sonoma County Department of Social Services and will keep the State agency informed of developments," Pottinger said.

The Office for Civil Rights is currently working with the California Department of Social Welfare to determine where other similar deficiencies may exist in the State and how they can best be remedied.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE.
OFFICE FOR CIVIL RIGHTS,
Boston, Mass., August 31, 1973.

Mr. NICHOLAS NORTON,
Commissioner, State Welfare Department,
Hartford, Conn.

DEAR MR. NORTON: Let me express my appreciation for the courtesy extended by Ms. Caroline Packard and other members of your staff during our meeting with representatives of the Department in Hartford on June 18, 1973 and in subsequent contacts. Let me also express my appreciation for the courtesy and cooperation extended by the Department's personnel in each of the district offices during our review of the overall state system. Your assistance in facilitating our collection of centrally located (i.e. Fair Hearing, Quality Control and Recipient Fraud) and computer stored data is much appreciated.

As you are aware, complaints were submitted to the Administrator, Social and Rehabilitation Service (SRS) in April, 1972 alleging that the State Welfare Department of Connecticut and its constituent district offices are failing on the basis of national origin to provide equal services to Spanish-speaking clients and potential clients. In a letter dated November 9, 1972 from Mr. Joseph P. Mirabella, Acting Regional Commissioner, SRS, to Mr. Henry C. White, the results of a joint complaint investigation conducted by the Regional SRS and Office for Civil Rights (OCR) offices in Boston were made available to the State Welfare Department.

In the letter, Mr. Mirabella reported that OCR had expressed serious concern that the facts revealed by the investigation were indicative of a state of affairs inconsistent with the requirements of Title VI of the Civil Rights Act of 1964. The letter goes on to cite specific examples of the failure to provide services or the provision of inferior services to Spanish-speaking clients which in turn resulted from a failure of client contact staff to communicate effectively with these clients. The letter also raised questions regarding the failure of the Department to make available Spanish-speaking Fair Hearing officers and word-for-word (as compared with summary) translation of statements made by recipients. Further, the letter notes that most of the forms used by the Department are not available in Spanish, a situation which we understand has been recently addressed by your office.

On May 2, 1973 members of our staff met with your staff to initiate an active Title VI compliance review of the Department's operations. Subsequent meetings were held on June 18, June 22 and July 20, 1973. We have now completed our review pursuant to Title VI of the Civil Rights Act of 1964 of the issues raised by the complainants. This letter sets forth a summary of our findings and conclusions relating to such issues.

Title VI and the Departmental Regulation, 45 CFR Part 80 (a copy of which has been provided to you), prohibit discrimination on the grounds of race, color, or national origin by recipients of Federal financial assistance. The Regulation provides that no person shall, on account of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to the provision of services in a discriminatory manner in the operation of any federally-assisted program. More specifically, the Regulation prohibits the operation of any such program in a manner which has "the effect of subjecting individuals to discrimination because of their race, color, or national origin or [has] the

effect of defeating or substantially impairing accomplishment of the objectives of the program as respect[s] individuals of a particular race, color, or national origin." 45 CFR 80.3(b)(2).

On-site reviews were conducted by members of our Regional and Washington Office staffs at the central office of the Department, each of the seven district offices, and at the State Personnel Department in Hartford. During these reviews, a large number of interviews with state employees, clients, and other interested community members and organizations were conducted. In addition, we have reviewed numerous files and reports maintained by the State Welfare Department including, but not limited to, the Payments Listings of Cases by District; Child Welfare Case Load and Child Welfare Protective Services Case Load Listings (for all districts); Fair Hearing case files and summary sheets for all cases during the period July–December, 1972; Quality Control Schedules and Worksheets for the period January–June 1972; Monthly Report (May, 1973) of Families and Children Served, Report of Applications and Report of Active Cases for each of the district offices; List of Spanish-speaking Employees prepared by the State Welfare Department (April 27, 1973); and various reports submitted by the Department to SRS during 1972 and 1973. Unless otherwise noted, all of the data forming the basis for the conclusions set forth in this letter were collected from sources within your Department.

On the basis of this information we have concluded that the State Welfare Department of Connecticut is in noncompliance with Title VI of the Civil Rights Act of 1964, for the following reasons:

Analysis of data obtained during the review revealed that in district offices a substantial number of Spanish-speaking eligibility and social services cases are not serviced by a bilingual worker or agency-provided translator. In District Office I (Hartford) a total of 3,352 Spanish-surnamed public assistance cases are currently enrolled on the assistance payments caseload. The Department's April 27, 1973 list of Spanish-speaking employees indicates that: 9 Spanish-speaking employees are assigned to the Main Street Office (which serves virtually all of the Spanish-speaking public assistance clients in the district); 2 Spanish-speaking employees are assigned to the Manchester Office; 5 Spanish-speaking employees are assigned to the Asylum Avenue Office (food stamps, eligibility, interim activity, resources, telephone and payment review units); and 2 Spanish-speaking protective service workers are assigned to the Barbour Street Office (protective services only). Of the 9 persons assigned to the Main Street Office, the list reports that they include 2 professionals (1 caseworker II and 1 eligibility technician II), 2 homemakers, 3 interpreters, 1 clerk (receptionist) and 1 welfare aide.

On-site interviews conducted in Spanish reveal that the 2 homemakers are both fluent in Spanish but are regularly assigned out of the Office. Neither of the two professionals assigned to the Main Street office appears to possess sufficient oral fluency in Spanish to carry on a simple conversation with a Spanish-speaking client. The receptionist is able to communicate only simple directions. Only 4 non-professional staff (3 interpreters and 1 welfare aide) are, in fact, available to serve any Spanish-speaking client or potential client. While these persons are making a diligent effort to serve as translators for as many clients as possible, none of the 3,000+ Spanish-speaking public assistance clients currently enrolled receives services from a bilingual professional and the vast majority of these clients cannot even be provided with services by a translator or interpreter.

While one of the two "Spanish-speaking" professionals assigned to the Manchester Office is fluent in Spanish, employees at the Office reported very few Spanish-surnamed cases. At the Asylum Avenue Office, of the two "Spanish-speaking" professionals, one is fluent in Spanish but serves in the Income Maintenance Review (Interim Activity) as opposed to Intake Eligibility unit. Both of the "Spanish-speaking" professionals assigned to the Barbour Street Office are fluent in Spanish, and State employees at that office indicated that an additional 4 or 5 Spanish-speaking professional staff is needed to adequately serve current Spanish-speaking clients.

A similar in-depth review of client service capability was conducted in each of the other 6 district offices. In Districts II (New Haven); III (Bridgeport); VI (Waterbury); and VII (Middletown) where in each from 500 to 2,218 Spanish-surnamed public assistance clients are currently enrolled, the same pattern of totally inadequate client service capability exists. In District VI, for example, only one Spanish-speaking interpreter is available to serve 523 Spanish-surnamed

assistance payments and 279 Spanish-surnamed social service cases. The lack of client service capability is particularly evident when compared with maximum caseload limits of 60 active cases for Preventive and Children's Services and 30 active cases for Protective Services. Our review indicated that as of June 1, 1973, 112 Spanish-surnamed Preventive Services cases, 48 Spanish-surnamed Children's Service cases and 116 Spanish-surnamed Protective Services cases were enrolled in District Office VI. None of the District Offices with an appreciable enrollment of Spanish-surnamed clients showed the capability, in terms of bilingual/bicultural client service staff, to adequately communicate with Spanish-speaking eligibility and social service clients currently on the caseload.

Although repeatedly requested by this office, data relating to the primary language skills and client service needs of Italian, French and Polish speaking clients and potential clients has not been gathered or reported by the State Welfare Department. A review of 1970 Fourth Count Census Data indicates that a significant number of persons with primary language skills in these languages should be represented on the current caseload.

An analysis of caseload data which your Department has provided shows a significant under-representation of Spanish-surnamed welfare clients receiving social services from the Department when compared with the current assistance payments caseload and relevant poverty population data. For example, in District Office III (Bridgeport) Spanish-surnamed families as of May 31, 1973 constituted approximately 23% of the AFDC assistance payments caseload and only 16% of the Preventive Services caseload; 10% of the Protective Services caseload and 12% of the Children's Services caseload. Similar disparities exist in the current service populations of the other district offices serving appreciable numbers of Spanish-surnamed clients. Interviews reveal that this disparity is attributable at least in part to the inability of social service, intake eligibility and interim activity staff to communicate in Spanish and the concomitant breakdown of communication. This breakdown of communication occurs at all levels of contact between the district offices and the potential Spanish-speaking social service clients.

The failure of the district offices to provide linguistically competent initial client contact staff, i.e., telephone operators, receptionists and walk-in unit staff, often results in Spanish-speaking potential clients receiving markedly different treatment than other potential clients. Spanish-speaking clients are often told to come back at another time, which imposes greater time delays, more required visits to the Department's offices and, as a result, the additional burdens of child care and transportation expenses. Spanish-speaking clients are also told to come back with a child or neighbor who can translate, thereby deterring them from returning because of an understandable reluctance or refusal to have to disclose to children, neighbors, and acquaintances private information which the Department by its own criteria, rightfully regards as highly personal and confidential. Spanish-speaking clients frequently wait long periods of time in order for a translator to be located, thereby deterring enrollment or causing hardships not suffered by non-minority clients. In the potential client's initial contact with the Department, the language barrier has caused a breakdown of communication regarding general eligibility for benefits and enrollment procedures which has led to a failure by Spanish-speaking clients to enroll for benefits to which they are entitled by law.

The inability of non-Spanish-speaking eligibility workers to communicate with Spanish-speaking clients has resulted in (1) the failure by intake eligibility workers to process applications in a timely fashion, explain available financial services, make appropriate determinations of eligibility status and calculate proper levels of assistance; (2) the failure by interim activity unit workers to make available necessary adjustments or allocations because of "catastrophic events" to such clients when their changing circumstances allowed or required such adjustments or allocations; (3) unwarranted denials, reductions of benefits and termination of assistance to Spanish-speaking clients and (4) the exclusion of many eligible Spanish-speaking clients from social services because of the intake or interim activity worker's inability to identify their social service needs.

Further, the failure of non-Spanish-speaking social service workers to understand the important welfare-related problems of many Spanish-speaking clients has resulted in the failure of such clients to receive needed social services. As in the case of the initial client contact staff, the use by non-Spanish-speaking eligibility and social service workers of children or neighbors of clients or potential

clients as translators has the effect of defeating or substantially impairing the objectives of the program with respect to many Spanish-speaking clients.

We have, therefore, concluded that the failure to provide adequate numbers of Spanish-speaking intake eligiblity workers, interim activity unit workers, and social service workers results in the discriminatory treatment of Spanish-speaking clients.

Our review of Quality Control schedules, worksheets, and Fair Hearing case files showed a consistently higher rate of benefit computation and eligibility determination errors in the case files of Spanish-surnamed as compared with Anglo clients. For example, with regard to the Adult programs, the Quality Control active sample showed a 67% higher error rate for Spanish-surnamed as compared to Anglo clients. As compared with Anglo clients, Spanish-surnamed clients had a substantially higher rate of underpayment and a significantly higher rate of overpayment. Of the 96 Spanish-surnamed Fair Hearing case files (for the period July–December, 1972) reviewed, 33 (34% of the total cases) clearly indicated that a communication breakdown problem (often not only related to the disputed Department action but also to the Fair Hearing process itself) was at the core of the Fair Hearing dispute. In an additional 48 cases (50% of the total cases) the case record strongly suggests that client communication problems contributed significantly to an improper computation of benefits or determination of eligibility. In one case file reviewed, the Fair Hearing official stated that "a great deal of the difficulty in this case appears to have arisen from the failure of appellant and her family to communicate adequately with the Department." She went on to place the burden of the communication breakdown on the client (rather than the Department) by stating "while it is granted that communication is a big obstacle for appellant herself, with her inadequate command of the English language, she has at least two children who can communicate in English who could have made sure that her needs and problems were made known."

Other case files document adverse actions taken by the Department as a result of communication breakdown. In several cases, totally disabled Spanish-speaking clients were denied benefits because non-bilingual medical review teams were unable to ascertain critical facts, particularly case histories. Many Spanish-speaking clients were denied benefits because, for example, intake eligibility workers were unable to obtain coherent information as to client needs. As a result of either oral or written communications, for instance, workers misunderstood the number of rooms in a client's apartment, the identity of the seller of furniture, the fact that a client was being evicted and had to move, etc.

Our review of the district offices also reveals that little effort has been made to allocate currently available Spanish-speaking staff so as to reduce as much as possible the number of Spanish-speaking public assistance cases unserved by bilingual staff. Interviews with most Spanish-speaking social service workers revealed that little or no effort is made to assign such workers to Spanish-speaking social service clients. Even utilizing a reduced caseload (75% of regular caseload because of the increased difficulty involved in dealing with only Spanish-speaking clients) our review indicates that significantly greater numbers of Spanish-speaking clients than are presently served could be served through a reallocation of current bilingual staff. Many of the persons listed by the State Welfare Department in the April 27, 1973 list indicated that their language skills are either rarely utilized or utilized only to the extent that Spanish-speaking clients are randomly assigned to their caseloads.

In district offices serving an appreciable number of Spanish-speaking clients, to the extent that Spanish-speaking personnel are not assigned or available to each identifiable client contact unit within such offices (i.e., telephone, reception, walk-in, intake eligibility, interim activity, food stamp, resource unit, and each of the categorical social service and WIN units), there is an unlawful denial of service to Spanish-speaking persons. Our concern over the current lack of bilingual client service is heightened by the rapid and continuing increase in the numbers of potential Spanish-speaking clients throughout the state.

From information gathered during the review, we have concluded that, in most of the district offices, the absence of any form of agency-provided cultural awareness training for client contact and supervisory personnel has resulted in a significantly lower level of understanding by the staff of the unique characteristics of Spanish-surnamed clients (such as religious beliefs, family life, self-concept, and similar areas) than the level of staff understanding of such

matters with regard to non-Spanish-surnamed clients. We know you will recognize that an understanding of client behavior has an important and legitimate bearing on whether and how welfare benefits should be delivered. The lack of such understanding on the part of some of the staff of district offices has, in our opinion, been a material factor in the current lack of delivery or differential delivery of benefits to the Spanish-surnamed clients. One particularly disturbing espisode revealing not only a lack of awareness and sensitivity but an open disregard for the needs of Spanish-speaking clients involved a Department official. During discussions with two members of our staff, the official in question openly derogated members of a minority group (in general) in a fashion which raises serious concern on our part as to his commitment to the goals of equal opportunity. In direct contrast, our discussions with other officials indicated a genuine concern for the clients and client service needs of the Department. Our concern is that the attitudes of even one official may undo the conscientious efforts of many others to ensure a service delivery environment free from racial and cultural bias.

With regard to the second finding set forth above, our review indicates that as a result of the use of the fixed caseload method (by which a specific number of cases is determined for every social service worker regardless of the number of persons per case and the number of service needs per person), a substantial reduction of the time spent per client and per client problem for minority as compared to non-minority clients has occurred. Based on the data collected during our review, including interviews with Department personnel, the communication breakdown detailed in our first finding appears to exacerbate the problem created by the current caseload assignment system, in that the use of translators reduces the actual amount of communication within a given period of time by at least 50%. Our review indicates that the average number of persons per minority case is significantly larger than the average number of persons per non-minority case, and that the number of client service problems per minority case for both the ongoing eligibility service and social services provided by the agency is significantly greater than the number of client service problems per non-minority case. Therefore, the utilization of a system in which the allocation of staff time is based on the number of cases as opposed to the number of client service problems has resulted in the provision of inferior services to minority clients in violation of Title VI of the Civil Rights Act of 1964.

As you will have noted already, our review has concentrated on the difficulties experienced by the Spanish-speaking client. The complaints filed with us required us to address the issue of services to Spanish-speaking clients. However, in the course of the review questions and findings regarding the current practices of the Department as they impact or may impact on other minorities were identified and are pointed out here so that you may have a fuller picture of our findings.

In this regard, we must renew our request that the Department collect and report to us data regarding the location and number by program category of clients whose primary language skills are in Italian, French, or Polish. Additionally, we requested and have not received a listing of agency personnel by district office and job category who possess oral fluency in these languages.

Because we know that you share our concern not only for the compliance of the State Welfare Department with the requirements of Title VI of the Civil Rights Act, but also with the basic issues related to the delivery of services to minorities raised in the findings set forth above, we anticipate your cooperation in the development of a statewide plan by which appropriate action will be taken by the State to correct the deficiencies identified. We must request that such a plan be prepared and submitted to us within 90 days. We are ready to be of immediate assistance with regard to further discussions on the problems set forth and the preparation and design of appropriate remedies. The plan, in order to meet the requirements of Title VI of the Civil Rights Act, must set forth the specific steps which will be taken to provide:

(1) Bilingual/bicultural services (including basic client contact) to Spanish-speaking assistance payments and social service clients, including programs to identify and provide public assistance and social services to eligible Spanish-surnamed clients who have not received such benefits and services.

(2) Staff allocation and caseloads based on client service needs rather than on the number of cases.

During the course of our review, we became aware of the significant efforts of many employees (in most cases on an individual basis) to correct many of the deficiencies identified in this letter. These efforts lead us to believe that through aggressive leadership at the State level a substantial improvement in the delivery of services to such clients can be achieved.

Sincerely yours,

JOHN G. BYNOE,
Regional Civil Rights Director.

Mr. HOLMES. Thank you.

Another recent case involved the Southern Nevada Comprehensive Mental Health Center headquartered in Las Vegas where a compliance review was initiated in 1972 to determine the extent to which the center and satellite clinics were providing equal services to the minority community. It is noteworthy that Federal policy guidelines under the program require that a community mental health center be accessible to all persons in the catchment area.

Although the information gathered during the review did not disclose any overt indices of an intent to discriminate against minorities, there were deficiencies that had the effect of impairing the delivery of care to minority persons. The limited outreach services were considered to have an unequal effect with respect to the ability of particularly Spanish surnamed and American Indian persons to avail themselves of the center's care. By virtue of the location of its major service facility, the inadequate number of outpost clinics, and the lack of nonblack minorities and bilingual persons on the staff, the program did not prove to be equally accessible to significant segments of the minority population. On the basis of findings of noncompliance with title VI, the southern Nevada center submitted an acceptable plan to overcome the problems. The findings, methodology, and remedial action developed in connection with this case will be used to investigate other mental health facilities and evaluate the need for clarifying pertinent sections of the title VI regulation in the form of a more specific title VI guideline applicable to this program area.

We are currently working with the Indian Health Service on an interagency agreement to provide that American Indians (both on reservations and in urban areas) must be informed of their entitlement to title XIX medicaid benefits and must be certified and given identification cards for medicaid. Such a policy would, in addition, provide that pursuant to title VI, no federally assisted hospital could continue the present-day practice of turning away Indian patients on the ground that, except in emergencies, such patients must receive care at IHS hospitals. The effect of the agreement would be to remove significant obstacles to the delivery of health care to Indians. Indians eligible for medicaid would receive medicaid benefits, while the Indian Health Service would continue to pay for the health care of Indian patients not eligible for medicaid.

In two Louisiana parishes, OCR recently completed an onsite field review of all federally supported services to mentally retarded children and adolescents. Analyses of the information gathered indicate that gaps and inadequacies in the services provided by various programs resulted in the exclusion of disproportionately large numbers of minority children from participation in the programs. For example, the education of many children is disrupted at ages 12–13, when those ado-

lescents are not eligible for the vocational rehabilitation program until age 16. As a result a large number of mentally retarded minority children between ages 14–16 were found in the juvenile courts. The approach to the review should provide a model for the conduct of other OCR delivery of health services reviews.

We have also become concerned about the tendency of innercity hospitals to relocate to suburban areas or shift resources to predominantly white residential communities. To the extent that such transfers are in part facilitated by Hill-Burton assistance and portend a diminution in the health services available to minority persons, the situation raises title VI questions and the Chicago Regional Office for Civil Rights has been involved in discussions with specific facilities as well as HEW officials concerning these questions. In one recent case, a list of assurances were incorporated in the loan application of a Gary, Ind. hospital, designed to provide mostly minority patients with continuing hospital care services.

Although the conduct of indepth field reviews of selected program areas is now the first program priority, OCR also plans to evaluate and update existing policy guidelines during this fiscal year to take account of our experience to date in reviewing State agencies, individual facilities, and the delivery of health care and social services. For instance, in some policy areas there is a strong need to define or clarify nondiscrimination standards, such as the extent to which title VI may apply to employment practices that are per se discriminatory or that have the effect of denying equal opportunity, notwithstanding section 604 of the statute. I should mention here that the consideration of new policy guidelines is particularly appropriate in light of the recently issued amendments to the title VI regulation. Revised guidelines will enumerate nondiscrimination requirements and reaffirm in a single forum the uniform title VI compliance tasks that State agencies must perform to give effect to their assurances of compliance.

Mr. Chairman, I have outlined certain program areas that OCR has been evaluating with the purpose of identifying and correcting practices that serve to deny to minorities an equal opportunity to health care and welfare benefits. The scope of the investigative activity undertaken in the recent past and projected for the future reflects our view that title VI is an effective instrument to cope with discriminatory practices in this area. We intend to field a vigorous compliance program in the months and years ahead.

Thank you very much.

Mr. EDWARDS. Thank you very much, Mr. Holmes, for a helpful statement.

One of the criticisms of your work made by previous witnesses was the lack of affirmative action programs to bring about a diminution of the alleged racial discrimination in hospital and nursing home care. Under the new guideline section 80.3, when the recipient has previously discriminated against persons on the grounds of race, color or national origin, the recipient must take affirmative action to overcome the effects of prior discrimination. That is correct?

Mr. HOLMES. That is correct.

Mr. EDWARDS. That is correct; right.

27–401 O–74——12

Now, Mr. Holmes, how many people do you have in your Office of Health and Social Services Branch within the Office for Civil Rights?

Mr. HOLMES. Yes, Mr. Chairman. There are currently 89 people in the Health and Social Services program. That is on an office-wide, national basis. In fiscal 1974, there will be, assuming that we receive the budgeted appropriation, an increase to 104, and we are projecting, although I cannot be specific about it now, a substantial increase in that staff for fiscal 1975.

Mr. Chairman, I might add that the figure of 89 people currently in Health and Social Services may be inconsistent with the figure you have here. This is the result of a recent reorganization in the office which added five additional staff to the Health and Social Services.

The CHAIRMAN. No, it is not inconsistent, Mr. Holmes. However, it does not indicate an increase in this particular responsibility anywhere near proportionate to the increase in your budget and the increase in permanent personnel assigned to the Office of Civil Rights. In fiscal year 1970 your budget, total budget for OCR was $5,894,000 with 401 permanent positions and 75 persons in Health and Social Services. And in fiscal 1974, the appropriation is nearly $18 million with 871 permanent positions, and only the 89 in the Office of Health and Social Services Branch.

Mr. HOLMES. No, it will go to 104 in fiscal 1974, 104 out of a total of 871 for fiscal 1974, once the Labor-HEW Appropriations bill is passed and approved.

Mr. Chairman, in fiscal 1974 the Health and Social Services Division on a nationwide basis represents about 12 percent of our total staff. By comparison, the elementary and secondary education division represents about 35 or 36 percent of our total staff. Thus, you can see in staff allocations over previous years where the focus, where the emphasis on a program-wide basis has been primarily placed.

Mr. EDWARDS. Thank you.

Now, in guideline 1, first promulgated in 1965, and I quote it:

> The hospital ensures that staff physicians do not consider race, color or national origin as a factor in selecting hospitals for their patients. Where there is a significant variation between the patient census and available population census data for the service area or potential service area, the hospital has a responsibility to determine the reason for such variation and to take whatever action may be necessary to correct any discrimination.

Now, in the new regulation for title VI enforcement that you mentioned in your testimony, section 80.3, subsection (b) (6), this does not require hospitals to take affirmative action to insure nondiscrimination unless the facility has formerly been found to discriminate. Now, is this not a step backward?

Mr. HOLMES. No, I think if you——

Mr. EDWARDS. Are you telling us that you have to find, there has to be an allegation of discrimination before an affirmative action program is initiated.

Mr. HOLMES. I might have Mr. Miles, the Assistant General Counsel, refer to this. But, I think you will find in guideline No. 1, which you read, that the hospital must take whatever steps are necessary to correct discrimination.

Mr. MILES. I think the critical words in guideline 1, as OCR has been carrying it out, are "to correct any discrimination." In other

words, the inquiry must be made when there is a disproportion, but if it is found that there are reasons other than discriminatory reasons for the disproportion, there is no obligation under guideline 1, or the new title VI regulations for affirmative action. What the new regulations do is to say that if a hospital or any other Federal recipient, decides to take action on its own, as might be analogous to an Executive order affirmative action, that that would not be considered in violation of title VI.

Mr. HOLMES. We do not view it as a step backward.

Mr. MILES. Yes. It is really consistent.

Mr. HOLMES. Yes, it is. If I may go on, it is consistent and applies broadly to our title VI program, that affirmative action concept.

Mr. EDWARDS. Well, you cite this *Jefferson* case in your testimony, to show that in the absence of past discrimination, affirmative action is not required by law; is that correct?

Mr. MILES. Yes.

Mr. EDWARDS. In other words, you have got to prove past discrimination before you think there should be any affirmative action?

Mr. MILES. This is a very difficult area to address categorically because statistics may be used as evidentiary matters to prove or to create an inference that there has been an institutional exclusion by race. What happened in Jefferson, was that the Supreme Court did not accept that inference in a situation where there was a very significant disproportion of impact. So, we are referring to the case simply to show that you cannot just assume that you have made a case because you do show a disproportion of impact.

Mr. GERRY. Maybe it would help clarify, if I could, Mr. Chairman.

Mr. EDWARDS. Yes.

Mr. GERRY. Affirmative action, as it is often used in the context of the Executive order issued by President Johnson, goes beyond the kinds of approaches used to enforce title VI and other civil rights statutes, in that it requires affirmative action in the absence of discrimination, just absolutely by its terms, as a result of an underutilization of persons in certain employment categories. In other words, the Executive order says that affirmative action is required based on statistics, and really only on statistics, whereas the civil rights statutes all talk about, as Mr. Holmes reported earlier, prohibiting discrimination and once having found discrimination, then the regulations talk about affirmative action, and title VI, since it is necessary to overcome the past effects of discrimination.

Mr. MILES. It might be better to say corrective action rather than affirmative action.

Mr. GERRY. It is really a more accurate use of the term, I think, in this area because affirmative action has come to mean something a little bit different.

Mr. WIGGINS. Would the chairman yield at this point?

Mr. EDWARDS. Mr. Wiggins?

Mr. WIGGINS. You are one of the Counsel at the Office for Civil Rights?

Mr. HOLMES. Mr. Gerry is the Assistant Director for Policy Planning in OCR.

Mr. WIGGINS. Well, I would like Counsel's input as well as Mr. Gerry's answer. I agree with you when you say that Executive orders

have gone beyond the limitations of the civil rights statute. What is your response to the question of the source of power for such Executive orders? Where does the President get off making them, is what I am saying?

Mr. MILES. I think the President's authority has been set out in the *Contractors Association* case in Philadelphia, upholding the Philadelphia plan, and it is to basically—it is part of the procurement power, or the power of the President, the responsibility to see that the procurement in the Government is carried out in the way that is consistent with national policy, and thus carries out Federal policy, too.

Mr. WIGGINS. Now, that is really no guidance at all, as to the President. Could you respond as to whether or not there is specific statutory authority for the President to make such an order?

Mr. MILES. Well, sir; that is why it is an Executive order.

Mr. WIGGINS. Because there is no specific statutory authority?

Mr. MILES. It comes from the President's constitutional powers.

Mr. WIGGINS. Well, now, I understand the President's constitutional powers to be, in general, with respect to domestic affairs, to execute the Office of the Presidency. It does not even say in the Constitution to execute fully and faithfully the laws of the United States. It is the Office of the Presidency which is to execute the laws of the Congress. Some parts of this Congress are very upset that he goes beyond what they think they have prescribed that he should execute. This is a rather important question, I think, and a rather important legal question, I think, because it is true that the President, for the best of motives, has been issuing Executive orders in this field which cannot be bottomed upon the 14th amendment, as that amendment has been explained by the courts, which might be bottomed upon the commerce clause or might be based upon the power of Congress in spending its money. But, Congress has not articulated that power and mandated that the President exercise it in a particular way, so far as I know.

Now, if you have received some intelligence there, I would be happy to hear that, too.

Mr. MILES. I am sorry, sir. Could you repeat the last part of your question?

Mr. WIGGINS. The question is, what is the source of power for the President to issue Executive orders stating what he thinks ought to be right in the field of civil rights?

Mr. MILES. Well, I think that question is explored very fully by the Third Circuit in the *Shultz* case and——

Mr. WIGGINS. That is the employment case?

Mr. MILES. That is right, which challenged the propriety of the order and there were a number of different grounds. They did refer, I believe, to the—I think it is in title V, the general procurement responsibility of the President. There are a number of areas in which the Executive has discretion, you know, to carry out a particular administrative function in a way that is most appropriate and is consistent with Federal policy.

Another example of that would be in the case, also in the Third Circuit, that Secretary Romney was the defendant. I do not remember the plaintiff's name, but it said, in effect, that because title VI and the Housing Discrimination Act of 1968 were both on the books, HUD

had a responsibility to take the racial impact of local urban renewal planning into effect, into account, in its urban renewal regulations, and in its manner of carrying out the urban renewal program.

Mr. WIGGINS. Well, I do not wish by these questions to imply necessary disagreement. I do object to the Congress conferring carte blanche authority to the Chief Executive to implement a national policy with which it, the Congress, has been unwilling to articulate itself. I doubt very much if this Congress or a predecessor would, if called upon to vote with respect to some of the affirmative action matters promulgated by the executive department, would have sustained those actions. I doubt it very much. In other words, the Chief Executive is making his own national policy and the Congress is either afraid to touch it, or, at least, is being excessively timid in this field.

Mr. GERRY. I think there is one point we can add, and which I think is one of the major points, which is emphasized by the Justice Department in a series of cases as background to the issuance of Executive Order 11246, by President Johnson: There was a history of officially sanctioned discrimination in the country.

Mr. WIGGINS. Agreed.

Mr. GERRY. The President certainly had notice of the discrimination, and it was appropriate to take into consideration in formulating what would be an effective administrative policy. In other words, what I am saying is that one could argue that because of the scope and the breadth of the kind of employment discrimination which historically had existed in many parts of the country, it was a reasonable step by the President at that point in time, to sort of make a general finding of past discrimination. Instead trying to track down in each individual case a history that might go back 15, 20, 25 years to some identifiable point, it was more practical or more reasonable simply to, in order to avoid past effects, impose this general affirmative action requirement. The theory was that there was such entwinement throughout the country in the past discriminatory practices that it would be for practical purposes merely just extending the legal time necessary in any particular corporation to trace the practices back to the State law or whatever.

Mr. WIGGINS. Well, I understand that argument or that rationalization, I should say, because there is no question but that the objective here is to change social practices, whether they are bottomed upon active discriminatory practices or not. We want change for the better, as we see it, and without reference to discrimination as that term is understood under the 14th amendment.

Now, we could rationalize a lot of things but that is not really what we are getting at. My series of questions only sought to elicit from you the power to do this sort of thing. And I think you have responded sufficiently.

Mr. Chairman, thank you very much.

Mr. EDWARDS. Mr. Drinan?

Mr. DRINAN. Yes; thank you very much, Mr. Holmes, and your associates. I have a series of questions that I would like to ask. In all candor, I do not think you have been able to, or have responded, to all of the contentions made by the American Public Health Associa-

tion, and by the leadership conference and the GAO, and I have a series of questions going back, first, to Mr. Edwards' question, where you state in here and you cite it here about three times that the number of personnel is limited. Why is it limited, and how many did you ask for and did the OMB say no?

Mr. HOLMES. I think we have—excuse me, just a moment. We have been successful in recent years at both OMB and at the congressional level.

Mr. DRINAN. Why is it still limited then? You still have stated that there is an inadequate number, and you are apologizing to us and you say you have not carried out these things because the staff is limited. It is not the Congress or the OMB that has put the limitation, it was you and your predecessor, Mr. Holmes.

Mr. HOLMES. I was not suggesting for a moment that it was Congress or OMB.

Mr. DRINAN. Who is it?

Mr. HOLMES. I think I had noted, Congressman, the facts and that this program has not received the same level of emphasis or attention by the Office for Civil Rights as has the elementary and secondary education program. That is an admission on the record by me of that fact. And we are trying to do something about it. As I indicated——

Mr. DRINAN. You are the new Director since April, and how many people have you asked for?

Mr. HOLMES. How many people?

Mr. DRINAN. New people?

Mr. HOLMES. I have asked for 32 additional people.

Mr. DRINAN. Is that sufficient? You will not say that it is limited, then, if you have 32 more?

Mr. HOLMES. I do not know. That depends where we are a year after we have the 32 people.

Mr. DRINAN. Well, that is your responsibility, and you are trying to say all of this has gone on and we still have a segregated pattern and a dual system of health care facilities——

Mr. HOLMES. I did not say we have a dual system.

Mr. DRINAN. Well, the GAO does and you, in effect, say that you have not done enough and so all I am asking is if you have asked for 32 more people, and if they were granted——

Mr. HOLMES. This would be for fiscal 1975, Congressman.

Mr. DRINAN. Have you asked for supplementary funds for fiscal 1974?

Mr. HOLMES. No.

Mr. DRINAN. So you going to continue with a limited staff, and you keep telling us three or four times it is limited staff resources, are you going to continue for the next year, yes or no?

Mr. HOLMES. I beg your pardon?

Mr. DRINAN. Yes or no?

Mr. HOLMES. I do not know whether I will be limited or not.

Mr. DRINAN. You are not making——

Mr. HOLMES. May I respond, please?

Mr. DRINAN. Yes.

Mr. HOLMES. We are requesting 15 additional positions in fiscal 1974. In fiscal 1975 we have requested more than double that. All

right? So, I guess your statement that 15 additional through fiscal 1974 could, on that basis alone, be regarded as continuing a limited or even an inadequate manpower program in that area. But, we have asked in our fiscal 1974 budget, Congressman, for a total of 165 additional positions for the Office of Civil Rights, and the 15 of that is very small. I concede that.

Mr. DRINAN. Well, why do you concede it? And I say, excuse me, if I have oversight functions, then I would recommend right now that you go and get additional members so that a year from now you will not come and say that during the past fiscal year we had a limited number of people, and ultimately, the civil rights people and public health people will blame this on the Congress and say, why doesn't Congress give more. Well, I am prepared to recommend more. Why don't you go and say this is my first recommendation for fiscal 1974, that you get the number of people that you need to carry out all of the mandates that you have? I mean, is there any answer why you cannot immediately apply to the OMB to get more help?

Mr. HOLMES. Yes; I think there is, Congressman.

Mr. DRINAN. What?

Mr. HOLMES. It is that we have right now. We have established an objective for ourselves during fiscal 1974 to complete our State agency reviews by the end of the calendar year. This was noted in my testimony, and then we intend to proceed to do some of the type of in-depth investigation that we think much of the testimony here was directed to and that we have felt for some time should be done in the office. I mentioned during the course of my testimony, that we have established a task force for Health and Social Services, and one of its duties will be to revise the guidelines. I am not going to suggest that the staff of 104 in Health and Social Services to going to be adequate. I have already indicated that I have asked for more people in fiscal 1975, which is the first time I have been able to impact on that request. But, I think that we have to proceed in some orderly fashion. We have to see if clarification of our guidelines and a reevaluation of our policies, conducting in-depth investigations, will result in a better program and a more effective program, and without substantial additional staff needs.

I might add that, as you know, we have many other program areas in the Office for Civil Rights that we have responsibility for. And, as I said, we are requesting a grand total in fiscal 1974 of 165 additional people.

Mr. DRINAN. Well, Mr. Holmes, on page 17 you say this office is dedicated to enforce the law firmly and with every available resource, and you conclude again with the promise that we intend to field a vigorous compliance program in the months and years ahead. Do you feel for the next fiscal year you have every available resource?

Mr. HOLMES. Congressman, I have to say again that I have to introduce two facts. We have requested additional people for fiscal 1975. Secondly, we are trying to focus internally in the office on new approaches, the development of sophisticated data collection and other analysis of techniques, new investigative approaches. And I just do not feel that I am in a position to say what the results of that evaluation will be.

Mr. DRINAN. Well, all right, Mr. Holmes, I do not want to pursue this any longer because you do not want to give a responsive answer.

Mr. HOLMES. I feel I was responsive, Congressman.

Mr. DRINAN. A year from now you are not going to be able to say you had limited resources.

Mr. HOLMES. I do not know whether I will be able to say that a year from now or not, Congressman. That is the point that I was trying to make.

Mr. DRINAN. You have made a commitment that you will carry out with every available resource and people would be presumably available, if you asked, and you are a new Director, and all I am saying is that a year from now you cannot use that. And the GAO, apparently, in the two studies seems to say that there are a number of people in HEW that feel that the existing law is not adequate to carry out the program required. And you, apparently, say that you feel that title VI and the guidelines, and the amended or updated guidelines, that you are going to work on are sufficient and there is, obviously, a clash of policy here. Would you elaborate on that, and how many people in HEW, and who are these unnamed people the GAO spoke to who feel that the OCR apparently is not getting at the root of the problem and that they feel that the law and the regulations should be strengthened?

Mr. HOLMES. Congressman, I do not know who the unnamed people are, and that is why I noted they were unnamed. Throughout the other testimony before the subcommittee, it is implied that title VI is adequate to reach only overt forms of discrimination. I think I addressed that in my testimony. That is not the case. It reaches any form of discrimination. It is an elementary question of establishing the specific evidence of that discrimination. I might mention the reviews we have been doing, for example, of the Connecticut State Welfare Department. I do not think that there is overt discrimination in employment practices by the Connecticut Welfare Department. But there are, as a result of a lack of sufficient numbers of employees with a bilingual capability, denials of services to the non-English-speaking minority client in Connecticut, and we found so. I guess that could be classified as a subtle as opposed to an overt form of discrimination. And we are negotiating there for a correction of that now.

Mr. EDWARDS. Mr. Holmes——

Mr. HOLMES. I feel that the law is adequate, as I testified, and it does not address just overt forms of discrimination.

Mr. EDWARDS. May I ask just one question there?

Mr. DRINAN. Surely.

Mr. EDWARDS. In the Connecticut case you mentioned, was it not the Puerto Rican Legal Defense Fund that filed an action here against the Connecticut Department of Welfare.

Mr. HOLMES. I have read Miss Rose's testimony on that and our investigation was not initiated by a complaint filed by the Puerto Rican Legal Defense Fund. The Puerto Rican Legal Defense Fund became involved in the case subsequent to a joint review of the Connecticut Welfare Department by OCR and the Boston SRS Regional Office.

Mr. EDWARDS. In other words, you were doing that anyway?

Mr. HOLMES. Right.

Mr. DRINAN. Mr. Holmes, I assume you have a list of all hospital facilities that have, in fact, discriminated in the past, and under the regulations promulgated in July of this year they must have an affirmative action program. How many people, or how do you carry out this review, that I assume that you do, going to each and every one of them and seeing what sort of affirmative action program they are carrying out, and do you propose a new model for affirmative action, and when do you think that this affirmative action program that they presumably have initiated, or reinitiated since July, when will that begin to show some visible effects?

Mr. HOLMES. I guess, Congressman, that you are referring to the title VI regulations that were issued. The question there becomes, as to the hospital that was discriminatory in 1968, has it overcome its past discrimination prior to issuance of the July title VI regulation, and whether there is an affirmative action requirement on the part of such a hospital that may have overcome the effects of its past discrimination from the 5-year period, 1968 to 1973. If the effects of past discrimination had previously been eliminated, I do not think there is an affirmative action obligation on the part of the hospital. If it is shown that there is discrimination that has resulted in an exclusion of minority patients, then affirmative action would be required, and this would be a matter of again advising the State agency in connection with our own review of facilities, the work of the State agencies and making investigations of these types of facilities. But, as I indicated, we are trying to draw to a close by the end of this calendar year the State agency review process. We will have a monitoring mechanism in place and a reporting mechanism in place with those agencies during the coming fiscal year, and we are going to try to concentrate our resources on more in-depth type of investigations which will include hospital referrals or nursing home referral systems.

Mr. DRINAN. Well, I would like an answer on the question, and the question put another way is this: What do you do when you find statistics that were brought to our attention by previous witness? In certain cities, such as New Orleans, there is obvious discrimination going on, there is a checkerboard pattern where hospitals that do, in fact, receive medicare have virtually no blacks, and yet they continue to receive funds. And, also, in further previous testimony, nothing has been done to date in Mobile and other cities with this pattern. Well, now, then, Mr. Holmes, this affirmative action, do you cut off funds, do you report them to Justice, do you recommend litigation? What do you do?

Mr. HOLMES. Well, we conduct a review, first, Congressman, to ascertain more facts than just simply the statistical information.

Mr. DRINAN. Having completed the review, what do you do?

Mr. HOLMES. The regional office will conduct an onsite review, and I might let Mr. Rives, the director of the Health and Social Services Division go through step-by-step what one of those reviews would consist of.

Mr. DRINAN. Well, sir, if I may say, that is not my question. I assume that you go and review. I am saying, what do you do then? How many cases do you refer to Justice; how many times do you actually get involved in litigation? It has been contended here that OCR does

not move, first, it waits for private organization and, but for them, they would not be involved on the side of the plaintiffs. All I am saying is, how affirmative, how many actions are you involved in? And what have you done with the Justice Department; what do you really do as an ultimate sanction?

Mr. HOLMES. Well, the ultimate sanction is either administrative enforcement proceedings, pursuant to title VI regulations, or referring the matter to the Department of Justice for court action.

Mr. DRINAN. How often do you do it, sir?

Mr. HOLMES. Before that—well, we have right now a nursing home, for example, in California, that is terminated, Federal financial assistance is terminated.

Mr. DRINAN. One. And how many have been terminated in the last 5 years or 3 years?

Mr. HOLMES. Approximately——

Mr. RIVES. There have been no terminations in the last 3 years.

Mr. DRINAN. Now, I would like the answer. No terminations?

Mr. HOLMES. Mr. Rives says that there have been no terminations other than the one that is currently terminated in the last 3 years. Prior to that, there were approximately 15 hospitals that were terminated.

Mr. RIVES. Thirteen; yes, sir.

Mr. HOLMES. Thirteen hospitals whose Federal financial assistance had been terminated. This was in 1967–68, and the hospitals subsequently revised their procedures and came into compliance. But, before we take that action, Congressman, if I may add, we will conduct a review. We do not respond just to complaints. In connection with a State agency review, we will go on site at facilities. As I noted, in the 3-year period from 1970–73 we conducted onsite reviews of some 3,300 hospitals, all told, and when we identify problems at those hospitals, we will so notify the hospital, and then negotiate for compliance. I mention in my testimony also that in 1973, the Atlanta regional office of the Office for Civil Rights had medicare clearance responsibility over 92 facilities where we estimated in 80 percent of those cases it was required that we go onsite and identify problem areas there, and so advise the institution. They then gave us the satisfactory assurances and commitments that established their compliance status, and thus they were cleared.

Mr. DRINAN. Well, what would you say if someone wrote to you, as we have had testimony, that the situation in Mobile today is the same as it was in the summer of 1967, when the case brought by HEW was dropped?

Mr. HOLMES. I would say that their facts may be somewhat wrong. I believe that we have been in Mobile in 1972. Was that when it was, Mr. Rives?

Mr. RIVES. Yes.

Mr. HOLMES. And had conducted an investigation of those hospitals in question at that time, and had found them to be in compliance. I might mention one of the hospitals. I think it was Doctors Hospital which had very low minority utilization. It had six black physicians with staff privileges at that hospital. But, we were in Mobile in 1972 and conducted an investigation at that time, and found the hospital to be in compliance.

Mr. DRINAN. Does compliance mean that 3 percent of the total patient load is black?

Mr. HOLMES. It may or may not.

Mr. DRINAN. Well, that is the key question, sir.

Mr. HOLMES. I believe it is the key question.

Mr. DRINAN. Well, what is your answer?

Mr. HOLMES. Let me, if I may, have Mr. Rives outline the procedures we go through in conducting onsite investigations.

Mr. DRINAN. Well, Mr. Holmes, that is not my question. I am very familiar with them. I have done this work for a number of years. I just want to say, or ask, what do you do when you find 3 percent of the patient load is black in 1967, and it is the same in 1972; what do you do?

Mr. HOLMES. That is what I would like to ask Mr. Rives to set forth, if I may.

Mr. RIVES. In conducting a review of the hospital, certainly a reason for conducting a review would be the 3 percent utilization. If you review the hospital and look, at first, whether or not it has established open admission policies, made those a matter of record, and made them public to physicians, to referral agencies, to community organizations in the area, that is one thing. Second, whether or not the staff of the hospital is open to any person who meets the staff eligibility requirements, regardless of race, color, or national origin. This would be another determination that we would make.

And then, of course, whether or not within the operation of the hospital, there is any evidence of discriminatory room assignment, or inequitable treatment in charges, or in the extension of credit, on any factor which would influence the admission of persons to that facility. And then, finally, whether or not in its referral process to nursing homes or other facilities, there is discrimination.

If we find in none of these situations, is there any action which indicates discrimination, then there well may be other factors that are involved, such as the economics of the situation, whether or not it is a private pay hospital, whether or not it takes charity cases, whether or not it has an outpatient clinic, which would be a source of referrals. Whether or not it accepts medicaid patients. All of these factors then would have to be looked at to determine whether or not, in its operation, it was treating minorities any differently than it was treating members of the majority. If we find, based on all of the facts that we can gather that even though the ratio of the utilization is extremely low, that there is no factor that can identify as a discriminatory factor, we would find the facility in compliance.

Mr. DRINAN. This brings us back to the key question that nothing is changing, that Mobile is not atypical, that you have other cities in the North and South that have this pattern of total underutilization by minority, black or Chicano, and you are telling me if there is no overt act, then there is nothing that HEW can do. Now, that is why I assume many in HEW, and many across the country say that something more is required to break down the segregated facilities that are federally subsidized.

Mr. HOLMES. Congressman, may I interrupt?

Mr. DRINAN. Yes; sure.

Mr. HOLMES. Could I have your advice on what you think should be done in a situation like that from a civil rights standpoint? Now, there have been some suggestions that have been made that institutions be required to participate in medicaid, for example. The medicaid relationship is one that is established between the State agency and the individual facility. Another suggestion is made that hospitals must be required to establish outpatient clinics when they have never had an outpatient clinic before. I do not know. These are suggestions that have been made by people that have testified here and I think careful consideration has to be given to them.

Mr. DRINAN. I can recommend a large number of things that HEW has not sufficiently done. There could be a preaudit test of a new hospital that is built by Hill-Burton funds. Many hospitals flee into the suburbs leaving the black or the poor without adequate facilities.

Mr. HOLMES. Congressman, I agree with you on that, and, as I testified, we are becoming very much involved in just that very issue.

Mr. WIGGINS. Would my colleague yield?

Mr. HOLMES. The Chicago region office, I might add, has initiated a very effective program on the clearance of Hill-Burton construction on the location of hospitals.

Mr. DRINAN. Mr. Wiggins?

Mr. WIGGINS. Thank you for yielding.

And I am grateful because I wanted to respond to the question you posed to Congressman Drinan. The problem is that many people are complaining that you are not enforcing a policy which Congress has failed to articulate. And if we object to that, then Congress ought to be more precise and enact a Civil Rights Act of 1973, in which it clearly and concisely mandates that your agency and all other governmental agencies go beyond discrimination in the historical sense, and seek to effect change without finding the background of discrimination, and take the ambiguity out of the law. Let the Congress address itself to that program and make a decision. Therefore, it is my answer to you that you should not undertake to do more than enforce the law, as it is written. And it is the function of Congress to change that law if it is inadequate to meet the problems of society.

Mr. HOLMES. Well, I appreciate that statement, Congressman. In any law, you know regulations are developed and policies are developed. As you know title VI, on paper, is very brief and the legislative history of that statute may not be at all that clarifying.

Mr. WIGGINS. Let me say that title VI is apparently too long, because, if I understand it, there is one section in there that you have overlooked and neglected and do not intend to enforce.

Mr. HOLMES. Which is that, sir?

Mr. WIGGINS. Section 604. You do not have it, but let me just throw out a hypothetical illustration, please.

Mr. HOLMES. We have not—I do not understand the basis for your concluding that we have overlooked it.

Mr. WIGGINS. I do not expect you to off the top of your head. Let me say, you find in the State of Connecticut, a situation where hospitals up there are failing to provide adequate services to certain minorities because they do not, themselves, hire sufficient bilingual

people. Now, have I stated the essence of the facts that have involved your agency in trying to change that pattern?

Mr. HOLMES. Yes. It is the county welfare offices, but, essentially, it is the same example; yes.

Mr. WIGGINS. You are really complaining about their employment practices?

Mr. HOLMES. The issue, Congressman, is a denial of services to the beneficiaries of Federal financial assistance.

Mr. WIGGINS. I understand that. But, the remedy is to change employment practices.

Mr. HOLMES. Mr. Gerry has led that investigation. He can address that.

Mr. WIGGINS. And address your answer to section 604, which I think maybe Congress ought to repeal.

Mr. GERRY. Yes. I think that section 604, as we have interpreted it consistently, prohibits us from essentially overlapping a jurisdiction with the Equal Employment Opportunity Commission under title VII of the Civil Rights Act in the sense of conducting investigations, the purpose of which is to identify the discriminatory practices in employment, per se. Now, really our involvement in this overlap, or how we have handled it, started back several years ago with regard to the teacher discrimination, teacher firing situation which occurred in many Southern States in which the question was, did section 604 prohibit the Office of Civil Rights from doing anything with respect to discrimination in teacher firing, and the position was, at that point, no, it did not when the teacher fired, had an impact on children; that is, the discriminatory employment practices had an impact on school children who were specific beneficiaries of title VI. And the courts have used a similar analysis and there was a development of policy for some time which is still extant in the office that discrimination in teacher employment practices teacher hiring or firing, teacher promotion, has enough of an impact on the children to be reachable under title VI.

Now, when you move to the welfare system, you have a much stronger involvement between the beneficiary and the staff. Here we are not talking about discriminatory practices of not hiring persons of one ethnic group or another. We are really talking about job skills; we are talking about one group of people who can walk into an office and face personnel who are technically capable to communicate and provide client services to the person and another group of people who walk into an office and do not need a person who can provide them services.

Mr. WIGGINS. I totally agree with you in that it ought to be law, that is law made by the Congress. You are really saying that Congress made a terrible mistake, and are going around trying to rationalize it. And I would think maybe section 604 ought to be deleted and this subcommittee might make that recommendation, because you have gotten yourself in conflict with the clear words of the statute.

Mr. GERRY. Well, I want to point out one thing on that specific point, without going off. Our position really is not that the State has to adopt any different employment practices. Our position is that people with certain skills have to serve clients. Now, there are several ways

that the State can provide people with those skills that are not directly related to any specific employment. Training might be one, for example, which would not involve hiring people of any particular—certainly not of any particular ethnic group or any particular language skills. What we are saying is that the duty is to provide the capability. Employment may be one way to get that capability, but training might be another. Reallocation, I think, as the statement points out, of existing staff could be a big way of handling it. I think the point we are trying to make, and I wonder if I could add this; that in some sort of an obscured way, I do not think the problem with title VI is that the statute is not broad enough or does not cover the issues and I do not think that our problem is so much with the wording of the statute. But, I think that what you have to do, and what we are trying to do, and what cases that we have been developing attempted to do, is to develop the tools, the practical real world tools to develop title VI cases, which are data collection techniques, and analysis techniques, ways of investigating, ways of getting information that is necessary to provide the evidentiary support, and in the last analysis the articulation of policies. Without those kinds of skills, which we are trying to develop, and rapidly trying to develop, we would not get to the point of really reaching the number of institutions with the effect that we want to have.

So, I would emphasize that our big task right now is the development and refinement of those skills. And it is something, in terms of the delivery of services, per se, that we have not spent very much time on in the past, that we now are attempting to spend a great deal of our time on. And I think it goes to the number of staff we need, for example, the fact that increasing staff without the skill, without the approaches, and without the ways of making cases, will not necessarily get us closer to better client service. So, I think as Mr. Holmes indicated, this is the year that we see to really try to intensively increase our capability to get, not only the evidence, but analyze it and then reach some firm conclusions. Once reaching the firm conclusion, I think our record has been historically one of taking an aggressive posture.

Mr. WIGGINS. Well, I thank the gentleman for yielding.

Mr. DRINAN. I thank you, Mr. Wiggins.

Mr. Holmes kindly asked me for suggestions. We have had a number of them and I hear no rebuttal or explanation. The American Public Health Association indicated that there are deposits required regularly of minority and poor people, and they indicated sometimes those deposits are very large. And I think we ought to have a survey or review of that.

Second, it has been stated that there is no full-time health expert on the staff of OCR.

Third, it has been stated that the OCR does not talk formally and regularly and consistently with designated members of minority groups.

Fourth, I think there is a misinterpretation of the U.S. Supreme Court decision in Mr. Holmes' paper. I do not think the *Jefferson* decision supports the contention he makes on page 15.

I could go on, in specifics, but however the assumption is, you, yourself, made the assumption that if you had sufficient personnel that then you could carry out the purposes of title VI. That is what I gathered, that all we need is more people and more court suits and that type of thing, and yet, I am not certain because as I read it, and see all of the evidence, the situation today is the same as it was, as outlined in that George Washington University Law Review article in 1968.

Mr. HOLMES. What situation today is the same as it was in 1968?

Mr. DRINAN. Three percent Negro utilization in Mobile.

Mr. HOLMES. Are you talking about Mobile, in particular, or are you talking about the Nation?

Mr. DRINAN. Nationwide.

Mr. HOLMES. The facts do not support that, Congressman.

Mr. DRINAN. All right.

Mr. HOLMES. I am sorry, but they do not support that on a nationwide basis. We are conducting, I might add, another survey this year, Congressman Drinan. We conducted one in 1968–69, and we are going to conduct another one this year. It is a hospital survey to check on current room occupancy and patient population for all hospitals. But implicit in your statement, Congressman, and I cannot let it go by, I am sorry, is that nothing has been done by us in the last 5 years to enforce this program. I have a staff of some 89 people who are strongly committed to enforcing this program, who have been working hard for the last 5 years to make the gains that have been made. We have been far from perfect. And I concede that in my testimony. But, to suggest that the situation today in health care for minorities is no different than it was 5 years ago is just not supported by the facts in the record.

Mr. DRINAN. I would assume that you feel that the GAO, in the survey that came out in July of 1972 did, in fact, have accurate statistics about the clustering of patients?

Mr. HOLMES. They had accurate statistics, I am sure, regarding the four areas that they worked on. And I think that their report indicated, Congressman, that there have been minority access to health care facilities which have increased in those areas. There is still the issue of the racially identifiable facilities, that is right, and that they noted in Los Angeles, Detroit, and other communities.

Mr. EDWARDS. May I interrupt there for a moment?

Mr. DRINAN. Yes.

Mr. EDWARDS. Mr. Holmes, why do you not ask or require of hospitals and nursing homes receiving Federal money that they publicize the fact that they are available for all patients?

Mr. HOLMES. Congressman, we do ask that they do that. They must publicize them. Mr. Rives would you like to outline that, please?

Mr. RIVES. Well, each time we do a review, and in connection with our compliance reports, we require that a facility make it clear to the public, as I mentioned above, to minority groups and to the referral sources, including physicians, that the facility has an open admission policy. That is a requirement, a routine requirement.

Mr. EDWARDS. Where is that published? Is that put in the newspaper or the post office? I think Mr. Drinan, in an earlier hearing on

this subject, pointed out that you cannot expect sick people on a stretcher to ascertain in advance whether or not they are going to be discriminated against in a particular facility. They are not in a position to know, so would you explain how this is made, this information is made generally available to the people and, especially, to the minority community?

Mr. RIVES. Well, the matter of posters, and as notices in the newspapers, in my estimation, is not an effective way of doing it. It is done in many facilities having posters and putting ads in the newspapers. The effective way is to let organizations, community organizations, minority organizations, the physicians, themselves, who are the primary source of referral, the welfare agencies, church groups maybe, whatever the best means of getting information disseminated to the people that are going to use the facility will be, and all of these are required to be used, particularly, where you find a low rate of utilization or a racially identifiable facility. In all of those we make sure in our reviews that all steps that we can reasonably think of, be taken to inform the minority community of the fact that this is a facility that has an open admissions policy, and that they would not be discriminated against if they go there.

Mr. HOLMES. Congressman, I think there is much more that can and should be done in this area, in the dissemination of information. I do not think there is any question about it. The GAO reports mentioned the Medical Services Administration program, and Mrs. Reifman may be able to address that, because I understand that some things are being developed there currently.

Mrs. REIFMAN. Well, I do believe that there is a public—I understand that there is. That the Medical Services Administration within SRS is in the process of preparaing a public information booklet, which would assist the people first of all, in understanding the opportunities which are available to them under medicaid, and the requirements of the procedures under the medicaid program.

Mr. EDWARDS. Well, the committee would be interested in your past efforts along these lines, and your future efforts so if you could submit it for the record, some correspondence or memorandum on this, it would be appreciated.

Mr. HOLMES. I think that there is much more that can be done, Congressman.

Mr. EDWARDS. I do not want us to leave here today without discussing this business of the staff physicians, their private practices and their referral practices and what, if anything, you can or cannot do about it. We were all disturbed, and I am sure you are just as disturbed as we were, with the charts submitted by the General Accounting Office showing that insofar as the segregation of minorities in hospitals, all white hospitals, or all black hospitals, or all brown and so forth, the results have not been remarkable. The charts look about the same now as they did a few years ago. And we understand how difficult it is, and that there is a problem of housing and convenience and everything else. But, the charts still are there for us to be looking at.

Now, what rational basis is there for allowing hospitals to limit their admission of patients to members of one race just because the

staff physicians happen to have private practices limited to members of one race, or the staff physicians determine patient referrals based on race? In order not to discriminate, do not hospitals have some sort of an affirmative obligation to overcome these practices?

Mr. HOLMES. Yes; there is no question about it. Congressman, let me be very straightforward about it. We have had a policy, and one that is somewhat troublesome to me, and that we must review, that says, in effect, that if a hospital has a sufficient number of physicians with biracial practices, and, as a result of those biracial practices, there is some proportionate or near proportionate use of the facility by minorities, we would not necessarily question the granting of staff privileges to a physician who had a uniracial practice. I do not know whether it would be a discriminatory practice but a uniracial practice.

Now, we have examples, and there is an example recently in 1973—it was the Kings Daughter Hospital in Yazoo City, Miss.—where we discovered that there was a substantial underutilization of the hospital by minorities, and we discovered that the physicians there with biracial practices were not referring their minority patients to the hospital, but were referring them largely to other hospitals that they were connected with. We asked the hospital to grant staff privileges to the one black physician in the county who did not previously have staff privileges at the hospital. Are those facts essentially correct?

Mr. RIVES. Yes, essentially.

Mr. HOLMES. Again, I say that we have largely looked at whether a sufficient number of physicians at the hospital have biracial practices and are they refering their patients to hospitals in a nondiscriminatory way. We have not gone much beyond that to, for instances, examine whether all doctors who have staff privileges should have biracial practices. And I think that is something that, in connection with our review of existing policies, we have to look at very closely.

Mr. EDWARDS. Now, if a doctor decides to place white patients in a particular institution, well, suppose he decides to treat only white patients, is that not racial discrimination, any way, whether or not it is in violation of the Federal law?

Mr. HOLMES. There is no question about it.

Mr. EDWARDS. And this doctor is entitled to the medicaid program, then could he be dealt with by title VI?

Mr. HOLMES. Certainly.

Mr. EDWARDS. But not with medicare?

Mr. HOLMES. Not medicare, medicaid, yes, but not medicare.

Mr. EDWARDS. Mr. McClory?

Mr. MCCLORY. Thank you, Mr. Chairman. I am interested in all of these civil rights issues in trying to determine not only the deficiencies which we are experiencing, but, also, the progress which we are making. It always seemed to me to be important in promoting civil rights to demonstrate examples of where the efficacy of nondiscrimination or integration had produced the kind of beneficial results that we all know can result. I believe I am in a very fortunate situation in my congressional district. I do not see that any bad examples have been cited regarding Waukegan, Ill., for instance. We have one Catholic hospital and one nondenominational hospital. I believe that the patients are treated equally and in a nondiscriminatory way in

27-401 O-74——13

each, and where we are experiencing some progress insofar as the staff is concerned.

However, I am rather discouraged, myself, at the relatively few blacks who appear to be entering the professions, I do not think it is entirely the result of the educational institutions. I think there is something else that is involved. Have you made any study or do you have any statistics which would indicate the extent of progress that we have made with regard to medical doctors or with regard to those that are serving in the health care field.

Mr. HOLMES. Congressman, I do not know how responsive I can be with regard to statistics. I do understand that recent publications indicate that there are presently approximately 338,000 physicians in the United States and of that number only 4,800 are black, a very low number of black physicians. I think that that figure is somewhat of an increase over previous years, but I am not certain because I have not seen previous surveys. However, our jurisdiction under title VI is broad and goes to admission practices, for example, of medical schools, of colleges, and universities. It is an area where we have been very active. We also are currently very active in regard to 10 Southern States where the issue of the dual system of higher education is before us. But, the issue there is a matter of accessibility to higher education opportunities by minorities and professional opportunities in the medical or health professions. We have had complaints of discrimination in this area, and we have pursued them.

Mr. MCCLORY. Do we have any special educational efforts or any advertising programs to encourage people in the black communities to become nurses, or practical nurses, or registered nurses, or anything of that nature? [See app. 3 at p. 286.]

Mr. HOLMES. Congressman, I cannot respond, offhand, but I would be glad to go to the Public Health Service and submit that for the record. I would imagine that there are such types of programs, and there may be even financial assistance programs. We would be glad to provide that as an insert for the record.

Mr. MCCLORY. That would not be involved in the HEW authority, is that it?

Mr. HOLMES. Well, under the Public Health Service there are various grantmaking programs, but not directly under us. Of course, we are very interested about the nondiscrimination policies of medical schools and undergraduate schools.

Mr. MCCLORY. I have the feeling that an individual who enters the hospital and is served, for instance, for the first time by a black nurse or an attendant of some kind has a change of attitude almost immediately. And I do not know how the public attitude gets changed except by experiencing the benefits of treating people equally, and just get rid of that prejudice which existed until you experienced the benefit of nonprejudice.

Mr. HOLMES. I think that is right.

Mr. MCCLORY. I feel that if we take these statistics of how many black doctors are serving in the hospitals as you indicate, 4,800 against 338,000 white doctors; why to provide any kind of balance in the hospitals across the country would be just virtually impossible because we do not have the qualified professionals to include in the hospitals.

Mr. HOLMES. The balancing of staff.

Mr. MCCLORY. Yes. My experience has been more in the educational field where I sensed a definite problem there of trying to get qualified black professors to balance the faculty and to try to respond to what the students, themselves, want, and which the administration is struggling with. In my own district I know I have that problem right now.

Well, I appreciate your testimony, and your efforts. And I have no further questions, Mr. Chairman.

Mr. EDWARDS. Thank you.

Mr. HOLMES. Thank you, Congressman.

Mr. EDWARDS. Mr. Holmes, how much notice do you give an institution, if any, when you are going to make an onsite inspection?

Mr. HOLMES. Mr. Rives?

Mr. RIVES. It will vary. If it is a routine review and there is no evidence that there is any attempt to avoid the responsibility, we would probably give them a week's notice. If, on the other hand, the record has indicated perhaps less than candor on the part of the facility, we would review them with no notice.

Mr. EDWARDS. That is a good idea. But, you do not have to get a complaint in order to make an onsite investigation?

Mr. RIVES. Absolutely not, no, sir.

Mr. EDWARDS. Well, on the average, how long would it take before an action would be brought against an institution, a final resolution? What is the time frame in finding a difficulty, in filing an action, if necessary, and the determination?

Mr. RIVES. The first step, of course, when we find something wrong is to try to negotiate correction of it to get voluntary compliance.

Mr. EDWARDS. Is that done promptly?

Mr. RIVES. Yes, sir; that is usually initiated at the time of the review and the reviewer notes that something is not proper. There may be the necessity for a report to the facility for some negotiation with them, and the nature of the problem sometimes will influence the length of time involved in the negotiating process. We feel that if through reasonable good-faith efforts, we cannot achieve voluntary compliance, then the regional office would refer the case to Mr. Holmes for enforcement and the Office of the General Counsel, in conjunction with our staff, would review the case, determine whether any additional information was necessary, and make another effort to get voluntary compliance. And if it failed, it would either be certified to Justice or the sanctions provided for through the administrative enforcement would be followed. And the time after the certification for administrative enforcement will vary with the requirements of the hearing, the notices that are required, the time factors after the hearing and the decision by the Secretary. That can take, as you know, as much as perhaps 10 months from the time of the initiation of the hearing. But, the resolution in most of our cases is accomplished by the fact that the hospital knows what the guidelines require and knows that through the demonstration of the fact that facilities will be terminated that they will comply and then they have to be monitored to make sure that the compliance is carried out. So, most of our cases are handled by negotiation and settlement, by the facility agreeing to take the corrective action we request, and that is why we do not have a great number of enforcement hearings.

Mr. EDWARDS. They might think that you are a paper tiger because you actually have not cut off funds for a long time, is that right?

Mr. RIVES. But, if they come into compliance then there is no point in cutting off the funds.

Mr. EDWARDS. Well, let me see now. What about Demopolis, Ala., which took 4 years of negotiations to get them into compliance? Why would that situation take 4 years?

Mr. RIVES. In that situation, we had the staff do the investigation that was required in Demopolis in the Atlanta region, and the action was taken pretty rapidly. I agree that the information that we had in 1968 probably should have indicated a more rapid followup on the case. But, we have had in the Atlanta region the problem of having to take those facilities which have the greatest impact and trying to work with those. And we have had a staff turnover in Atlanta prior to the last 2 years, and the program was not as effectively administered as it should have been.

Mr. HOLMES. I might say, Congressman, for the record, it is the Bryan-Whitfield Hospital, is it not, in Demopolis? Our last onsite review there was in March 1973, the last census was on August 23, 1973, showing a total patient census of 64, of which 30 approximately, just about 50 percent were black. I think the service area, that Ms. Rose made reference to in her testimony, is about 50 percent black.

Mr. EDWARDS. Mr. Drinan?

Mr. DRINAN. Well, I find myself, Mr. Chairman, and Mr. Holmes, and your associates, with a series of questions which are still unanswered. And I see really no pattern of any affirmative action program that will reach the clustering of people. It may be that we are destined to have two Americas, one white and one black. But, we keep talking about racially identifiable facilities, and we do not refer very often to a dual system, but that is what it has been, up until the recent past, at least. And in all candor, I do not see, Mr. Chairman, how the Office of Civil Rights expects to get rid of the traces or the vestiges of the dual system, and they say they are not certain of the scope of title VI and their regulations and all I said is that as a Member of Congress, I want to——

Mr. HOLMES. I do not think that we questioned the scope of title VI, Congressman.

Mr. DRINAN. I want to be able to break down the dual system and the racially identifiable facilities, and those are the ones that are 97 percent black or 97 percent white all over the country, North, and South.

Mr. HOLMES. If we can show evidence of discrimination having caused those facilities to be that way, yes. I might mention that I just referred to the Bryan-Whitfield Hospital where a substantial gain has been made. We have recognized that, and we have focused, Congressman, on the agency review. My testimony indicated that some people may question that focus of our program. We are nearing the end of that review activity which has been 5 years ongoing. My testimony mentioned the Richmond, Va., and the San Antonio reviews, where it was ostensibly a question of minority underutilization of skilled nursing homes. That review indicated that there was a disproportionate minority utilization of skilled nursing homes in those two communities. And our feeling is that a more indepth investigation of referral processes is called for and we want to move in that direction,

Congressman. But, at the same time, let me say that we have a very large program with many facilities. We have tried to enlist the State agencies and the substantial manpower that is available there. Mr. Rives estimated for me the other day that people in the State agencies devoted to title VI type of investigations and compliance activities, range about 10 to 1. I mean 10 State agency officials devoted to that type of work compared to one OCR or Federal official. And we have trained those State agencies and so we have tried to enlist their support and the manpower available through them.

But, the point I was making is that we have a broad range of facilities and programs to look at, of which a portion are hospitals and nursing homes.

Mr. DRINAN. All right.

Mr. Chairman, I would just like to for the record, state all of the questions to which I have not received answers and I hope that in the future this committee can have a regular flow of information from the Office of Civil Rights. I am not challenging anyone's good intention there. All I am saying is this subcommittee and this Congress and OCR and HEW, are trying to break down the two worlds that exist out there. These are the questions and if you would like, you could get them for the record and send us information. [See app. 3 at p. 285.]

Is the Chicago preaward procedure now being used nationwide and, if so, with what results? If not, why not?

Mr. HOLMES. May I respond to the questions, sir? You indicated these are questions that you have not gotten responses to?

Mr. DRINAN. No, I mean I want them in the future. I am not saying that you avoided them. All I am saying is that we need this.

Mr. HOLMES. I thought I heard you say that, Congressman, and I apologize. I will be glad to answer them now. I do not know what the subcommittee's time is.

Mr. DRINAN. I did try to pick them off because we are going into session.

Mr. HOLMES. We will be glad to supply answers then for the record. [See app. 3 at p. 286.]

Mr. DRINAN. And the second question is that in the 1969 survey, was there evidence there of a dual system among hospitals and nursing homes? I assume that there was and that, in the future, the new survey—I assume there has been no survey since 1969 done by OCR and in the new survey, will there be substantial progress noted, or what are we actually looking for in that survey?

On medicaid, it seems to me on the cutoff of medicaid patients, both by hospitals and doctors, we skirted around that. Why is that not a violation of title VI? Do you need a further regulation by the Congress to title VI?

Mr. HOLMES. Can I just ask for clarification on that question if we are going to respond for the record subsequently? What do you mean the cutoff? [See app. 3 at p. 286.]

Mr. DRINAN. Well, many private physicians say we simply are not going to take medicaid patients, as they did in California, for example. The GAO survey says in a group practice comprised of 28 physicians in 1970–71, they just said we do not want these medicaid people any more, and then there are hospitals.

Mr. HOLMES. Oh, they were serving medicaid and then they discontinued that service. All right.

Mr. DRINAN. And how many are there like that all over the country and how many hospitals similarly say, that we do not want these medicaid patients? I mean, these are all of the things that are in the law. And then another thing that we did not get into at all, what about the quality of care at a hospital that is 97-percent black? In Wayne County, the GAO has told us there are hospitals that regularly have 95- to 97-percent black occupancy and just on a similar basis of review by physicians or by qualified people, is the quality of care there less than the quality of care in all white hospitals? [See app. 3 at p. 286.]

Well, all of these questions surge up, Mr. Holmes, and all of you people want the law to be implemented and effectuated and so do we. But, we have insufficient evidence and on the basis of the evidence that I have anyway, I am not certain we could tighten the regulations even if that were required. So, I would hope that we can have regular sessions where we can learn more about the problems that we have heard about. This is now about the fourth or fifth session. And one last point that I have not received answers to all of the contentions made in the GAO report by the American Public Health Association and by the Leadership Conference, and if you are so inclined, I would like to have a memo from you or from your staff taking point-by-point on everything that has been told to this committee and explain it or accept it or say what you are doing about it.

Thank you very much.

Mr. HOLMES. Yes, Congressman.

I appreciate your statement that we are together trying to examine these problems and see how we can overcome them to assure adequate and quality care for minority citizens of this country. I appreciate that and we would be glad to be of full and complete assistance. I think I can speak in that regard for all agencies of the Government—the Medical Services Administration, the Hill-Burton people, what have you. I would just like the record to show that we would be glad to respond to the questions that you indicated were unanswered, and that because of time limitations, there was not an opportunity to do so this morning.

Mr. EDWARDS. Yes, Mr. Holmes.

And, in particular, we would like to get a response to the four questions raised on page 9 of the GAO testimony of September 12, 1973, where GAO mentioned four actions that HEW was taking or supposed to take in July of 1972, but GAO testified to us that action was taken or being taken in only one of the four.

Mr. HOLMES. Yes. [See app. 3 at p. 286.]

Mr. EDWARDS. We would appreciate that.

Are there further questions? Yes, Miss Chavez?

Miss CHAVEZ. Just a couple of questions to try and clarify some of these statements that you have made today. Is guideline 1, first promulgated in 1965, still in effect or do the new regulations take precedence over it?

Mr. HOLMES. No. It was issued in 1969, and it is still in effect. New regulations, title VI regulations, are consistent with guideline 1.

Miss CHAVEZ. You also mentioned that some of the regulations are now in the process of being reviewed. Do these regulations referred to, are these the July 5 regulations issued this year?

Mr. HOLMES. No. I mentioned the existence of the Health and Social Services Task Force and also, as a part of our planned objectives for the office during the fiscal year, a reevaluation of current health and social service program guidelines, with a view to updating those guidelines. My reference to that did not pertain specifically to the July 5 title VI regulation.

Miss CHAVEZ. Thank you.

Mr. EDWARDS. Mr. Parker?

Mr. PARKER. Thank you, Mr. Chairman.

Mr. Holmes, in your prepared statement you refer to conducting a survey of health care facilities during this fiscal year?

Mr. HOLMES. Yes.

Mr. PARKER. I take it you mean fiscal year 1974?

Mr. HOLMES. Right.

Mr. PARKER. Has that survey begun?

Mr. HOLMES. Yes.

Mr. RIVES. The contract has been let, it is being done on a contract basis. The questionnaire is currently scheduled to be mailed to hospitals and nursing homes participating in the medicare program on October 15.

Mr. PARKER. Is there a completion date scheduled for that survey?

Mr. HOLMES. How long did the last survey run?

Mr. RIVES. The last survey took too long, but the data will be in within 30 days, and the analysis of it and the review of the problems that are raised by it, are contemplated to be completed by the end of the fiscal year.

Mr. PARKER. Mr. Holmes, do you see any problem in sharing the results of that survey with the subcommittee?

Mr. HOLMES. No; none whatsoever and if you do not have the results of our 1969 survey, you should.

Mr. PARKER. We do not.

Mr. HOLMES. It is public information, I think. They were released at the time the survey was completed before, and we would be glad to get those to the subcommittee, and I regret that you have not had it before.

Mr. PARKER. One minor point: In at least two places, you refer to an evaluation of referral processes affecting nursing homes. Is that, therefore, a reason that rather than using the phrase "referral processes affecting health care facilities," are you limiting your survey just to nursing homes?

Mr. HOLMES. Our surveys in Richmond and San Antonio were limited just to nursing homes. The issue of minority utilization of nursing homes in those two communities. But, no, we are not limiting ourselves from the standpoint of examining the need for that type of referral analysis, or investigation. It goes beyond nursing homes, in other words.

Mr. PARKER. The GAO report refers to the fact that HEW officials told GAO that the referral practices in each State would be investigated beginning in July 1972. Is this the same survey that HEW officials were referring to that would begin in July 1972?

Mr. HOLMES. Survey?

Mr. PARKER. They just had a statement in their report that said, HEW officials told GAO that the referral practices in each State would be investigated beginning in July 1972. I take it that was not done, and that that survey we are referring to here is the same survey?

Mr. HOLMES. Well, let us separate it. We used survey in a different context before. The data collection survey, similar to the one we had conducted in 1969, that is a different issue. The survey of referral processes is the same survey related to the GAO reference to the July 1972 commitment.

Mr. PARKER. Thank you very much.

Mr. EDWARDS. Mr. Blommer?

Mr. BLOMMER. Thank you, Mr. Chairman.

Mr. Holmes, I have a long series of questions having to do with the power of the Secretary of HEW, pursuant to title VI, regarding discriminatory employment practices, a subject that was discussed with Mr. Wiggins. I will not ask those questions in the interest of time, but I wonder if you could provide or have your counsel provide for our record a legal memorandum addressed to the point of the relationship between the clear, broad, unequivocal language of section 604 and regulations which I think you put in the record; section 80.3(d)(3). It is my view that section (d)(3) is clearly beyond the power of the Secretary to enforce. It is not even speaking in an area where Congress is silent but is speaking in an area where Congress has specifically stated what the power shall be. Any legal memorandum supporting the legality of that would be very much appreciated by me.

Mr. HOLMES. I will be glad to have the Office of General Counsel supply you such information. [See app. 3 at p. 287.]

Mr. BLOMMER. Thank you very much.

Mr. MILES. If you have specific questions—you said you had a long series of questions—and if you could just send us a copy of those, it would be helpful so that we would be sure we were being responsive.

Mr. BLOMMER. Well, my questions have to do with the perimeters of that power, that you think have or that you state that you have here in section (3) and regard specific instances, specific fact situations. If you will provide me the legal basis of this section, I can apply that myself, and then, if I have questions, I will send you a whole list of fact situations and will go through them one by one as to exactly what the Secretary of HEW can do to nursing home A, to hospital A, and down the line. But, I think that it would be, from my point of view, much easier, and I think much clearer for our records.

Mr. MILES. Fine.

Mr. EDWARDS. If there are no further questions, we will adjourn. This concludes the first phase of this particular inquiry by the Civil Rights and Constitutional Rights Subcommittee, and subject to the decision of the members of the subcommittee, we will issue a report on our investigation to date. We are pleased to have had the opportunity to become acquainted with your office, Mr. Holmes. We are looking forward to close cooperation and a close association with you in the future. And we thank you for your testimony and we thank your colleagues for appearing with you today.

Mr. HOLMES. Thank you, Mr. Chairman.

[Whereupon, at 12:15 p.m., the hearing was concluded.]

APPENDIX 1

REPORT TO THE
COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

Compliance With Antidiscrimination Provision Of Civil Rights Act By Hospitals And Other Facilities Under Medicare And Medicaid B-164031(4)

Department of Health, Education, and Welfare

BY THE COMPTROLLER GENERAL
OF THE UNITED STATES

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

B-164031(4)

Dear Mr. Chairman:

In accordance with a request from your Subcommittee No. 4, dated June 3, 1971, we are submitting to you a report on our review of compliance with the antidiscrimination provisions (title VI) of the Civil Rights Act of 1964 by hospitals and other facilities under Medicare and Medicaid.

As authorized by the Subcommittee, we have obtained comments from the Department of Health, Education, and Welfare on a draft of this report. The Department's comments have been incorporated in the final report.

In accordance with your Subcommittee's request, we are also preparing another report, which will be sent to you separately, on our review of compliance with title VI of the Civil Rights Act of 1964 by facilities receiving assistance under the Hill-Burton Facilities Construction and Modernization Program.

We plan to make no further distribution of this report unless copies are specifically requested, and then copies will be distributed only after your approval has been obtained or public announcement has been made by you concerning the contents of this report.

Sincerely yours,

Elmer B. Staats

Comptroller General
of the United States

The Honorable Emanuel Celler
Chairman, Committee on the Judiciary
House of Representatives

Contents

ABBREVIATIONS

ECFs	Extended-care facilities
HEW	Department of Health, Education, and Welfare
OCR	Office for Civil Rights
OEHO	Office of Equal Health Opportunity

COMPTROLLER GENERAL'S REPORT TO THE COMMITTEE ON THE JUDICIARY HOUSE OF REPRESENTATIVES

COMPLIANCE WITH ANTIDISCRIMINATION PROVISION OF CIVIL RIGHTS ACT BY HOSPITALS AND OTHER FACILITIES UNDER MEDICARE AND MEDICAID
Department of Health, Education, and Welfare B-164031(4)

DIGEST

WHY THE REVIEW WAS MADE

At the request of the Chairman, House Committee on the Judiciary, the General Accounting Office (GAO) examined whether hospitals, extended-care facilities (ECFs), and nursing homes participating in Medicare or Medicaid were complying with title VI of the Civil Rights Act. Title VI provides that no person shall be subjected to discrimination on the basis of race, color, or national origin under any program receiving Federal financial assistance.

GAO evaluated the policies and procedures used by the Department of Health, Education, and Welfare (HEW), to ensure that medical institutions participating in these programs did not discriminate. GAO's review included visits to medical facilities in four metropolitan areas--Atlanta, Georgia; Birmingham, Alabama; Wayne County (including Detroit), Michigan; and Los Angeles County, California.

FINDINGS AND CONCLUSIONS

Shortly after Medicare and Medicaid were enacted, HEW made extensive efforts to enforce title VI compliance; since then it has significantly reduced its activities in this area.

HEW now makes relatively few onsite visits to hospitals, ECFs, or nursing homes. HEW officials advised GAO that during 1971 its Office for Civil Rights (OCR) made 950 reviews of hospitals and ECFs to determine their compliance status; slightly over 300 of these visits were onsite reviews.

Instead, HEW relies more on information reported by institutions participating in Medicare and Medicaid; on compliance reviews by State and local agencies; and on complaints by beneficiaries, physicians, and others to identify institutions which may require enforcement action. HEW officials advised GAO that in 1971 OCR made over 1,700 visits to State and local agencies to monitor their civil rights compliance activities, including these agencies' reviews of the compliance status of hospitals and nursing homes under the Medicaid program. (See pp. 14 to 27.)

HEW officials have told GAO that the type of discrimination existing today is substantially different from that existing when title VI was first enacted. The law was aimed at remedying overt discrimination which had existed in some States. Discrimination in health facilities today is not overt and is therefore difficult to detect or to prove. (See p. 12.)

In gaining access to the health system, discrimination against the poor is prevalent but cannot be dealt with by HEW under title VI. HEW officials believe that past racial discrimination in such areas as employment and housing have placed members of minority groups in an economically disadvantaged position and, as a consequence, in a poorer state of general health. (See p. 67.)

Disproportionate use of government-owned hospitals

Most hospitals, ECFs, and nursing homes under Medicare and Medicaid in the four metropolitan areas were integrated, and all were considered to be in compliance with title VI. This does not mean that discrimination was completely nonexistent but only that it did not exist in an overt form subject to objective analysis and detection.

However, a disproportionate share of minority-group patients received their health care from government-owned hospitals (State, county, or city). These hospitals attracted minority-group patients because they

--provided medical care at little or no cost to indigent patients,
--were easily accessible,
--had traditionally been used, and
--had made special efforts to accommodate minority groups.

At most private hospitals patients can be admitted only by a physician having admitting privileges. Because there are relatively few physicians in many areas where minority groups live, these people often must rely on outpatient clinics at government-owned hospitals for their general medical needs. When hospitalization is necessary, they are then admitted to these institutions. (See pp. 39, 43, and 61.)

In two of the four metropolitan areas visited by GAO, minority-group patients were unaware that their Medicare or Medicaid coverage entitled them to use private hospitals as alternatives to the traditionally used government-owned hospitals. Actions to increase such awareness might result in greater use of private hospitals. HEW officials advised GAO that one of its component organizations had developed a proposal to increase the awareness of Medicaid recipients of benefits and services available to them. (See pp. 10, 35, 43, 46, and 66 to 68.)

Other reasons for clustering of minority-group patients

Many hospitals, ECFs, and nursing homes were treating only patients of one race--or had few patients of other races--even though the facilities published open admission policies. Clustering of minority-group patients in certain

facilities is very likely not the result of current discriminatory policies or practices but is more likely the result of

--personal preferences by patients and their physicians,

--convenience of the institutions to the minority-group communities, and

--familiarity of the minority-group communities with the institutions from prior associations. (See pp. 32, 35, 46, 50, and 67.)

Most of these facilities were in areas heavily dominated by one racial group. Also some of these facilities were established to serve special religious or ethnic groups or had established policies which restricted admission to people with substantial financial resources. Although their policies did not preclude admission on the basis of race, color, or national origin, they did effectively limit the numbers of patients of races, colors, or national origins not common to the religious, ethnic, or economic character of these facilities. (See pp. 48, 59, and 60.)

Civil rights groups and HEW officials attributed patterns of predominantly black or white ECFs and nursing homes partially to the practices of State and local health and welfare departments in referring patients to these facilities. HEW officials told GAO that the referral practices in each State would be investigated beginning in July 1972. (See pp. 11, 15, 42, and 43.)

According to HEW statistics, nonwhite beneficiaries were not using extended-care facilities under the Medicare program to the same extent as white beneficiaries. On the other hand, nonwhites had substantially increased the lengths of their hospital stays after Medicare was enacted.

Some black physicians have told GAO that blacks--more frequently than others--care for ill members of their families at home and do not use ECFs or nursing homes for convalescent care after discharge from hospitals. These factors--increased hospital stays and home convalescent care--possibly may account for the disproportionate use of ECFs. (See pp. 15, 16, and 38.)

Comments of HEW officials and representatives of civil rights groups

HEW officials believe that title VI has helped to remedy overt discrimination in health care. However, these officials, as well as representatives of civil rights organizations, believe that title VI may not be adequate to deal with the more complex forms of discrimination--such as the general attitudes of whites toward nonwhites or the lack of understanding by white hospital staff of the cultural or economic backgrounds of minority-group patients. (See pp. 12 and 52.)

According to HEW officials, to deal with the subtle forms of discrimination existing today, it may be necessary to modify the law so that instances such as a disproportionate number of minority patients in a hospital compared

with the number in the community population are considered sufficient evidence for HEW to compel a facility to take action to increase the number of its minority patients or demonstrate why more minority patients are not served. (See p. 67.)

HEW has developed a form for regional office use to determine the extent to which States are enforcing compliance with title VI in skilled nursing homes participating in the Medicaid program. HEW is also promoting the establishment of ombudsman units in each State government to review and follow up complaints made by, or on behalf of, nursing-home patients. This should provide another source for the receipt of civil rights complaints. (See p. 13.)

CHAPTER 1

INTRODUCTION

At the request of the Chairman, Committee on the Judiciary, House of Representatives, we examined whether hospitals, extended-care facilities (ECFs), and nursing homes participating in the Medicare and Medicaid programs were complying with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d-2000d-6). Medicare and Medicaid are two of the major health programs which receive Federal financial assistance and which are subject to the provisions of title VI of the Civil Rights Act.

Title VI of the Civil Rights Act of 1964 provides that:

> "No person in the United States shall, on the ground of race, color, or national origin be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

The Department of Health, Education, and Welfare (HEW) regulations implementing title VI provide that all federally assisted activities provide assurance that their programs or institutions are operated without discrimination. Before being approved by HEW for Medicare or Medicaid, medical institutions are required to execute an "assurance of compliance" statement which certifies that they will comply immediately and fully with title VI and HEW regulations.

We evaluated the policies and procedures used by HEW in its attempts to obtain compliance with title VI by hospitals, ECFs, and nursing homes participating in the Medicare or Medicaid programs. We also analyzed data in four major metropolitan areas--Atlanta, Georgia; Birmingham, Alabama; Wayne County (including Detroit), Michigan; and Los Angeles County, California--to determine whether minority groups had been given an equal opportunity to obtain medical services.

27-401 O - 74 - 14

DESCRIPTION OF MEDICARE PROGRAM

The Medicare program, established by the Social Security Amendments of 1965 (42 U.S.C. 1395-1395 11), is administered by the Social Security Administration in HEW. Eligible persons aged 65 and over are provided with two basic forms of protection against most of the costs of health care.

One form, designated as Hospital Insurance Benefits for the Aged (part A), covers care provided (1) by hospitals during acute stages of illness and (2) by ECFs when skilled nursing care is required on a continuous basis for a condition previously treated more intensively in a hospital. Part A benefits are financed primarily by special social security taxes collected from employees, employers, and self-employed persons. Over 20 million persons have part A coverage.

The second form of protection is a voluntary program, designated as Supplementary Medical Insurance Benefits for the Aged (part B), and covers physicians services and a number of other medical and health benefits, including outpatient hospital services and certain home care. Part B is financed by premiums collected from each eligible beneficiary who has elected to be covered by the program and by matching amounts appropriated from the general revenues of the Federal Government. Over 19 million persons have part B coverage.

Although the Social Security Administration has primary responsibility for administering the Medicare program, HEW has contracted with (1) private organizations called fiscal intermediaries and carriers to assist in reviewing and paying benefit claims and (2) the States to determine the eligibility of facilities to participate in the program.

All hospitals and other facilities participating in the Medicare program are subject to the provisions of title VI of the Civil Rights Act of 1964. If a facility fails to comply with title VI, it becomes ineligible to receive Medicare payments except for hospital services provided in emergency situations.

HEW regulations state that services provided by physicians and other medical suppliers under part B of Medicare are not subject to the provisions of title VI because the Government's contractual agreement under part B is with the beneficiary not the supplier of medical services.

Medicare payments for care provided by hospitals under parts A and B and ECFs under part A amounted to $4.8 billion in fiscal year 1970.

DESCRIPTION OF MEDICAID PROGRAM

The Medicaid program, established by the Social Security Amendments of 1965 (42 U.S.C. 1396), is administered by the Social and Rehabilitation Service in HEW. Medicaid is a grant-in-aid program under which the Federal Government participates in costs incurred by the States in providing medical assistance to persons, regardless of age, who are unable to pay for such care.

State Medicaid programs are required by law to provide inpatient and outpatient hospital services, laboratory and X-ray services, skilled nursing-home services, physicians services, home health services, and early and periodic screening and treatment to eligible persons. Additional items, such as dental care and prescribed drugs, may be included if a State so chooses.

All persons and institutions providing services under the Medicaid programs are subject to the provisions of title VI of the Civil Rights Act of 1964.

The Federal Government pays for 50 to 83 percent (depending on the per capita income in the States) of the costs incurred by States in providing medical services under their Medicaid programs. For fiscal year 1970, these State programs reported expenditures for hospital and skilled nursing-home care of about $3.3 billion, of which about $1.7 billion represented the Federal share.

ADMINISTRATION OF TITLE VI

In December 1965 the Secretary, HEW, delegated to the Public Health Service the responsibility to see that all

hospitals and other medical facilities receiving Federal funds complied with title VI.

In February 1966 the Office of Equal Health Opportunity (OEHO) was established within the Public Health Service to administer title VI on medical facilities. In November 1967 the Secretary, HEW, transferred title VI enforcement responsibilities for hospitals and other medical facilities from OEHO to the Office for Civil Rights (OCR). The primary responsibility for securing title VI compliance rests with the regional civil rights director in each of HEW's 10 regional offices.

The Health and Social Services Division of OCR, with a staff of about 50 civil rights specialists, administers title VI policies with respect to all health and social service (welfare) programs. In the health-care area, OCR is responsible for (1) seeing that hospitals and other medical facilities are complying with title VI before they participate in Medicare or Medicaid, (2) ensuring that these institutions continue to comply with title VI, and (3) investigating complaints of title VI violations by these institutions.

In a public information booklet, OCR states that any person who believes that discrimination exists in <u>any</u> program aided by HEW should notify OCR. Internal procedures for handling complaints specify that OCR will (1) advise the person or facility against which a complaint is filed of the nature of the complaint and request a written reply, (2) interview the complainant, and (3) conduct an onsite investigation. Title VI requires that when a facility appears to be in noncompliance, the administering agency should attempt to secure voluntary compliance.

Before OCR certifies that a hospital or an ECF is complying with title VI--and is therefore eligible to participate in Medicare--each institution is required to complete (1) an assurance-of-compliance statement in which it agrees to comply with title VI and (2) a compliance report--a two-page questionnaire pertaining to the nondiscriminatory policies and practices of the institution.

OCR officials advised us that compliance reports must be submitted by all hospitals and ECFs applying to enter Medicare and by those institutions already under Medicare that have changed ownership. OCR officials said that the factors they considered in analyzing the reports included

--the reported ethnic composition of the population in the surrounding geographic area of the facilities compared with those of the patients served,

--the policies of the facilities in advising the communities that they did not discriminate,

--the composition of the hospitals' medical staffs, and

--the sources of patient referrals to ECFs and nursing homes.

States participate in many programs with the Federal Government and share the costs involved in providing services to recipients of those programs. With the enactment of title VI of the Civil Rights Act, it became the responsibility of State and Federal agencies to ensure that no beneficiary of a federally assisted program is subjected to discrimination because of race, color, or national origin. A 1966 HEW instruction specified that the States were to be responsible for ensuring that onsite compliance reviews of all nursing homes in the Medicaid program are made at least annually.

State reviews are a major portion of OCR's compliance program in health and social services. When hospitals and ECFs participate in State Medicaid or other grant-in-aid programs and these same facilities are under Medicare, a dual compliance responsibility exists. OCR, however, has final responsibility for ensuring compliance of facilities receiving Federal funds and monitors the State's reviews to ensure their validity.

CHAPTER 2

CONCLUSIONS ON REVIEW OF COMPLIANCE WITH TITLE VI BY HOSPITALS AND OTHER FACILITIES UNDER MEDICARE AND MEDICAID

We believe that most hospitals, ECFs, and nursing homes--under Medicare and Medicaid in the four major metropolitan areas where our review was made--were in compliance with title VI. This is not to say that discrimination in providing health services to minorities was totally absent. The types of discrimination that were reported to us, however, were indirect and subtle and did not involve overt denial by medical institutions of staff privileges to minority-group physicians or of admissions or services to minority-group patients.

DISPROPORTIONATE USE OF GOVERNMENT-OWNED HOSPITALS

Although most hospitals participating in Medicare and Medicaid in these four metropolitan areas were integrated, a disproportionately large share of minority patients received their health care at government-owned hospitals (State, county, or city). Minority-group patients were reported to be drawn to these hospitals because they (1) provided medical care at little or no cost to indigent patients, (2) were easily accessible to minority-group communities, (3) had traditionally been used by members of minority groups, and (4) had made special efforts to accommodate minority groups.

At most private hospitals patients can be admitted only by a physician having admitting privileges. Because physicians are in short supply in many areas where minority groups live, persons in such groups often must rely on outpatient clinics at government-owned hospitals for their general medical needs. When hospitalization is necessary, they are then admitted to these institutions as inpatients.

In two of the four metropolitan areas visited by us, minority-group patients were often unaware that their Medicare or Medicaid coverage entitled them to use private

hospitals as alternatives to the traditionally used government-owned hospitals. Measures to increase such awareness by minority-group patients might result in their greater use of private hospitals. HEW officials advised us that one of its components--the Medical Services Administration of the Social and Rehabilitation Service--had developed a proposal for consumer education to help ensure that each Medicaid recipient is informed of all Medicaid benefits and services available in his State.

OTHER REASONS FOR CLUSTERING
OF MINORITY-GROUP PATIENTS

Many hospitals, ECFs, and nursing homes were treating only patients of one race--or few patients of other races--even though the facilities published open admission policies. Physicians; patients; hospital and ECF officials; and representatives of civil rights organizations, medical societies, and welfare organizations have told us that minority-group patients' being clustered in certain facilities is very likely not the result of current discriminatory policies or practices but is more likely the result of (1) personal preferences by patients and their physicians, (2) convenience of the institutions to the minority-group communities, and (3) familiarity of the minority-group communities with the institutions from prior associations.

We found that most of these facilities were in areas heavily dominated by one racial group. Also some of these facilities were established to serve special religious or ethnic groups or had established policies which restricted admission to persons with substantial financial resources. Although their policies did not preclude admission on the basis of race, color, or national origin, they did effectively limit the numbers of patients of races not common to the religious, ethnic, or economic character of these facilities.

Civil rights groups and HEW officials have reported that patterns of predominantly black or white ECFs and nursing homes are partially caused by the practices of State and local health and welfare departments in referring patients to ECFs or nursing homes. HEW officials advised us that regional office personnel from OCR and the Medical Services

Administration would investigate the referral process and would perform a number of onsite visits to skilled nursing homes in each State beginning on July 1, 1972.

According to HEW statistics, nonwhite beneficiaries were not using their proportionate share of ECF days under Medicare compared with white beneficiaries. On the other hand, nonwhites had substantially increased the lengths of their hospital stays after the passage of Medicare. Some black physicians have told us that blacks--more frequently than others--care for ill members of their families at home and do not use ECFs or nursing homes for convalescent care after discharge from hospitals. It is possible that these factors--increased hospital stays and home convalescent care--may account for the disproportionately low use of ECFs by nonwhites.

COMPLIANCE ACTIVITIES OF HEW

Shortly after the Medicare and Medicaid programs were enacted, HEW made extensive efforts to enforce title VI compliance; since then it has significantly reduced its activities in this area. HEW now makes relatively few onsite visits to hospitals, ECFs, or nursing homes. Instead, HEW relies more on information reported by institutions participating in the Medicare and Medicaid programs; on compliance reviews by State and local agencies; and on complaints by beneficiaries, physicians, and others to highlight those institutions which may require enforcement action.

COMMENTS OF HEW OFFICIALS AND
REPRESENTATIVES OF CIVIL RIGHTS GROUPS

HEW officials have told us that the type of discrimination existing today is substantially different from that existing when title VI was first enacted. They said that the law was aimed at remedying forms of overt discrimination which had existed in some States; discrimination in health facilities today is not overt and is very hard to detect or prove.

HEW officials have advised us that, within the health system, discrimination against the poor is more prevalent than discrimination on the basis of race, color, or national origin.

It appears that, on the basis of discussions with HEW officials and representatives of organizations interested in civil rights matters and our reviews at hospitals, ECFs, and nursing homes, title VI has done much to remedy the forms of overt discrimination that existed in the past in the health-care area. However, these officials and representatives have told us that title VI may not be adequate to deal with today's more complex forms of discrimination--such as the general attitudes of whites toward nonwhites or the lack of understanding by white hospital staff of the cultural or economic backgrounds of minority-group patients. According to HEW officials, to deal with the subtle forms of discrimination existing today, it may be necessary to modify the law so that instances such as gross underrepresentation of minority-group patients in a hospital compared with community population are considered prima facie evidence sufficient for HEW to compel a facility to take affirmative action to increase the number of its minority patients or demonstrate why more minority patients are not served.

HEW officials advised us that its Medical Services Administration had developed a detailed reporting form for regional office use in cooperation with OCR regional offices to monitor compliance with title VI in skilled nursing homes under Medicaid. The form was designed to determine the extent to which States are enforcing compliance with title VI.

Under HEW's current efforts to enforce nursing-home standards, it is promoting the establishment of investigative ombudsman units in each State government to review and follow up complaints made by, or on behalf of, nursing-home patients. The ombudsman units should provide another avenue available to people in local communities for lodging civil rights complaints, according to HEW officials. The Health Services and Mental Health Administration is sponsoring demonstrations in five States to develop model ombudsman units.

- - - -

The results of our work (1) at OCR headquarters in Washington, D.C., (2) at OCR regional offices in Atlanta, Georgia; Chicago, Illinois; and San Francisco, California, and (3) in four metropolitan areas, which served as the basis for our overall conclusions, are discussed in the following chapters.

CHAPTER 3

ACTIVITIES OF HEW TO ENSURE COMPLIANCE WITH CIVIL RIGHTS LEGISLATION BY HEALTH-CARE FACILITIES

Access of members of minority groups to hospitals, ECFs, and nursing homes has increased significantly since enactment of title VI of the Civil Rights Act of 1964. In all parts of the country, but particularly in Southern and border States, many hospitals have admitted and treated black patients for the first time. Also, at many hospitals black physicians have been allowed to practice for the first time and to admit and care for their own patients instead of having to refer them to a white doctor who has staff privileges. We believe that these changes have occurred largely because of HEW's efforts to enforce compliance with title VI by hospitals, ECFs, and nursing homes participating in Medicare and Medicaid.

Most of the changes occurred during the early days of the programs (especially 1966 and 1967) when hospitals, ECFs, and nursing homes were being approved by HEW. Since then HEW has significantly reduced its title VI compliance staff to the point where the staff's principal duties are to prevent hospitals, ECFs, and nursing homes from reverting to previous overt discriminatory policies and practices. OCR efforts in this area consist mostly of reviewing States' activities; ensuring title VI compliance by health-care institutions participating in federally assisted programs; and investigating complaints by beneficiaries, physicians, and others to highlight institutions which may require enforcement action.

In recent years OCR has not made annual onsite reviews to all facilities under Medicare and Medicaid programs to ensure that they comply with title VI. Rather, it has relied more on information reported by the facilities, complaints from the public, and State agency reviews to alert it to violations.

HEW STUDIES ON USE OF
THESE FACILITIES BY MINORITY GROUPS

In 1969 all hospitals and ECFs participating in Medicare or receiving other types of Federal financial assistance were requested to send compliance reports to OCR. Compliance reports had previously been obtained from most hospitals and ECFs during 1966 and 1967, shortly after they were initially certified to participate in Medicare. The 1969 reports were requested so that OCR could (1) assess the compliance of each hospital and ECF to identify any facility needing further investigation, onsite review, or consultation to bring them into compliance with title VI and (2) compare the 1969 reports with those reports submitted in 1966 and 1967 to measure the changes which had taken place in minority groups' access to hospitals and ECFs. Comparative statistics generally showed improvements in minority groups' access to hospitals and ECFs.

From 1966 to 1969, the number of hospitals serving minority-group patients increased 24 percent and the number of minority patients in hospitals increased 30 percent. Also the number of hospitals having minority-group physicians and dentists on their staffs increased 61 percent. Because of these increases, OCR concluded that access to hospitals by minority patients was no longer a major or a widespread problem.

The utilization of ECFs by members of minority groups, however, gave OCR concern. The number of ECFs serving minority-group patients increased by 82 percent from 1967, and the number of minority-group patients in ECFs increased 75 percent. However, the 1969 compliance reports showed that members of minority groups still represented only a small percentage (5.2 percent) of all patients in ECFs and OCR's analysis of the reports showed that many ECFs in racially mixed areas were treating only patients of one race even though the facilities published open admission policies.

In a May 1970 memorandum to OCR regional offices, a headquarters official pointed out that the racial imbalance of ECFs and nursing homes has been a major problem. Of

33 States in which OCR has completed reviews, he said, all but two had patterns of all-white and all-black ECFs and nursing homes. This OCR official believed that the patterns were caused partially by the referral practices of State and local health and welfare departments. The OCR official directed that each State agency that refers persons to nursing homes under federally assisted programs ensure not only that the homes do not practice discrimination but also that persons are not referred to these homes on a discriminatory basis.

A research study performed for the Social Security Administration showed that the number of days of hospital care per year for each 100 black persons over age 65 increased from 237 days in 1965 (prior to Medicare) to 351 days in 1967 (after Medicare). For each 100 white persons of the same age group, the number of days of hospital care per year increased from 320 in 1965 to 396 in 1967. Thus, the difference in 1965 of 83 days of hospital care per year between white and black persons (320 minus 237) had been reduced to 45 days in 1967 (396 minus 351). The increase in days of hospital care for black persons has been due to longer lengths of stay per admission. Between 1965 and 1967 the number of admissions per 100 black persons actually decreased. The increase in days of hospital care for white persons was due primarily to an increase in the number of admissions for each 100 white persons.

The research study also produced evidence that the Medicare program had "enhanced the dignity" of the Nation's elderly, particularly the black elderly, by providing payments for much of their care. Hospital days per 100 blacks aged 65 and over for which charges were imposed rose from 96 per year in 1965 to 234 per year in 1967.

Other data compiled by the Social Security Administration showed that on July 1, 1967, nonwhites represented 7.7 percent of all persons enrolled in part A of the Medicare program. During 1967, however, nonwhites represented only 5.7 percent of Medicare beneficiaries treated in hospitals and only 2.8 percent of Medicare beneficiaries treated in ECFs.

TITLE VI COMPLIANCE ACTIVITIES OF HEW
DURING EARLY DAYS OF MEDICARE

In February 1966 OEHO was established within the Public Health Service to administer title VI with respect to medical institutions. With enactment of the Medicare program in 1965, HEW needed to approve many hospitals and other facilities for participation in Medicare in a short period of time. OEHO made a crash effort to approve applications of all hospitals by July 1, 1966, and all ECFs by January 1, 1967, the dates these institutions could begin participating in the Medicare program under provisions of the act. OEHO hired about 60 consultants to assist a staff of about 500 persons who were temporarily assigned to them from the Social Security Administration, the Public Health Service, the Welfare Administration,[1] and other organizations within HEW.

At the outset, OEHO decided that the best leverage for enforcement of title VI compliance was for HEW to adopt a policy that no hospital or ECF would be certified for Medicare until OEHO had assurance that the facility was in compliance with title VI. To assist in making this determination, a questionnaire was sent to hospitals requesting background data and information--such as patient admission policies, patient censuses, and the nondiscriminatory practices followed by the facility--which would indicate whether a hospital was discriminating on the basis of race, color, or national origin. Because of the large workload that developed when the Medicare program was enacted, OEHO visited only about 2,700 of the 6,600 hospitals that initially applied to participate in the program.

Many hospitals were cleared on the basis of statements of assurance of compliance and background data submitted to OEHO by representatives of the institutions. Because of this compliance procedure, OEHO worked mainly to develop a nondiscriminatory policy and a public announcement of that policy by each hospital.

---

[1] The program activities of the Welfare Administration were assigned to the newly established Social and Rehabilitation Service in August 1967.

OEHO found that, by July 1966, about 6,400 of the 6,600 hospitals complied with title VI. OEHO efforts were directed at the remaining 200 hospitals until October 1966. By that time about 150 of the 200 hospitals had complied. OEHO was then able to direct its compliance activities toward ECFs.

A questionnaire, similar to the one sent to hospitals, was sent to ECFs seeking to participate in the Medicare program. Because OEHO's staff had been reduced by this time, few onsite visits were made to ECFs. Most ECFs were cleared on the basis of data submitted to OEHO by representatives of the institutions, and OEHO's main emphasis was on the development and public announcement of a nondiscriminatory policy by each ECF.

An HEW official told us that OEHO intended to make followup inspections of hospitals and ECFs to ensure their continuing compliance with title VI. In November 1967--before OEHO could begin reviewing these institutions--the Secretary, HEW, transferred title VI enforcement responsibilities from OEHO to OCR.

From November 1966 through November 1968, HEW cited 54 medical institutions for not complying with title VI despite HEW's efforts to get the institutions to voluntarily correct the problems. HEW advised the institutions that administrative proceedings were being initiated to terminate their participation in all federally assisted programs. Notices were sent to 42 institutions during the period November 1966 through February 1967 and to the remaining 12 institutions during the period October 1967 through November 1968. As of January 1972 proceedings had not been initiated against any additional institutions.

The results of the actions taken against the 54 institutions were, as follows:

--During calendar years 1967 through 1969, HEW terminated 16 institutions' participation in federally assisted programs. Subsequently 14 of the institutions corrected the civil rights deficiencies, reapplied, and were approved to participate in federally assisted programs. The two remaining inistitutions closed (one in 1969 and the other in 1971).

--Proceedings against 25 institutions were dropped during calendar years 1967 through 1969, because the institutions took corrective actions to end discrimination after receiving HEW's notices rather than have their participation in federally assisted programs terminated.

--Seven institutions voluntarily withdrew their Medicare applications during the period January through April 1967, rather than submit to Federal nondiscrimination requirements. After determining that these seven institutions were not in other federally assisted programs, HEW dropped proceedings against them. Later, all seven of these institutions corrected their civil rights deficiencies, reapplied, and were accepted for Medicare.

--Proceedings were dropped against three State mental health institutions (one in 1969 and two in 1971) after the institutions took corrective actions ordered by the U.S. district court to end discrimination. After investigating the three institutions, HEW initiated formal administrative compliance proceedings in January 1967. A hearing was held in April 1967, and the hearing examiner rendered his initial decision in October 1967 that the State and its three mental institutions were violating title VI and the applicable regulations. In November 1967 a civil complaint was filed in the district court by the State against HEW. About the same time, a class action was filed in the district court by patients of the institutions who sought an injunction against discrimination in the operations of mental health facilities by the State. The two cases were consolidated in the district court. In February 1969 the State was found guilty of discrimination and ordered to desegregate the three facilities within 12 months. During the time of the district court proceedings, HEW's administrative proceedings were deferred. Action on applications by the State for new assistance to the three institutions was also deferred, but Federal assistance continued on applications which had previously been approved.

--Formal administrative proceedings against three mental health institutions in another State were incomplete as of January 31, 1972. Proceedings were initiated against these institutions in December 1967. Two of the institutions were integrated early in 1968, and a plan was established for gradually integrating the third. Accomplishment of the plan was contingent, in part, on the repair and renovation of several buildings. Construction delays and other problems delayed completion of the work on these buildings. As of January 1972, six of the seven patient dormitories had been renovated and integrated. Renovation of the seventh building and total integration of the institution were expected to be completed by April 1972. OCR officials could not explain to us why they did not require integration of the seven buildings at once. Records maintained by OCR and by HEW's General Counsel's office also did not show why the decision was made to allow gradual integration of the one institution. Since December 1967, when HEW initiated administrative proceedings, all three institutions have been allowed to participate in federally assisted programs.

RECENT COMPLIANCE ACTIVITIES BY
OFFICE FOR CIVIL RIGHTS

HEW regulations require OCR to periodically review the practices being followed by recipients of Federal funds to determine whether they are complying with title VI. OCR's Health and Social Services Division, which is responsible for enforcing title VI compliance by health and welfare facilities and agencies, had nine civil rights specialists in its Washington headquarters in July 1971. An OCR official informed us that the work of the headquarters staff consisted mainly of developing and disseminating civil rights policies and monitoring the activities of the regional offices.

OCR regulations do not provide specific time intervals in which it must make compliance reviews. An OCR official advised us that regional civil rights specialists made onsite inspections of medical institutions when considered necessary on the basis of (1) desk reviews of compliance reports submitted by the institutions, (2) complaints, and (3) the degree of reliance it believed could be placed on State reviews of civil rights activities of medical institutions. The official stated that, with only about 50 civil rights specialists nationwide, the Health and Social Services Division could not possibly make annual onsite compliance reviews of the thousands of suppliers of health and welfare services. Therefore OCR must rely heavily on reviews made by State and local review agencies, he said.

HEW officials advised us that, during the 12-month period ended December 31, 1971, OCR made slightly over 1,700 visits to State and local agencies to monitor their compliance activities, including these agencies' reviews of the compliance status of hospitals and nursing homes used in the Medicaid program. During this same period, OCR made 950 reviews of hospitals and ECFs to determine their compliance status and slightly over 300 of these were onsite reviews.

OCR activities in Atlanta and Birmingham

The Atlanta regional office of OCR is responsible for ensuring title VI compliance in Alabama, Florida, Georgia,

27-401 O - 74 - 15

Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee. Its Health and Social Services Branch--responsible for enforcement of title VI in health and welfare facilities and agencies--employed 10 civil rights specialists in July 1971. The number of specialists had been increased from five to 10 in mid-1971 so that each State could be covered by at least one specialist.

During fiscal years 1970 and 1971, the OCR regional office approved three hospitals and eight ECFs in the Atlanta and Birmingham areas--that either had applied for the first time or had applied because of a change in ownership--for Medicare. OCR officials visited the three hospitals and two of the ECFs to examine admission practices, waiting room arrangements, bed-assignment practices, etc. OCR approved the remaining six ECFs without making a visit, relying on reviews conducted by the State or on data submitted by the ECFs.

In the Atlanta and Birmingham areas, OCR makes all initial reviews to approve hospitals and ECFs for participation in the Medicare program. OCR also makes periodic followup reviews of hospitals; however, OCR has arranged to have the Georgia and Alabama Departments of Health make followup reviews of ECFs.

Of the 24 hospitals in Medicare at the time our fieldwork was completed in these areas, 23 had been visited by OCR--20 before they were approved for Medicare and three shortly after they were approved for Medicare. OCR approved four hospitals for the program, without visiting them, on the basis of reviews of data furnished by the hospitals at the time of initial application. One hospital had not yet been visited at the time our fieldwork was completed. After approval, one-time followup visits were made to 15 of the 23 hospitals which had initially been visited; eight were routine visits and seven were related to specific complaints of discrimination.

At the time our fieldwork was completed, 20 ECFs (nine in Atlanta and 11 in Birmingham) were under Medicare. None had been visited by OCR at the time of initial approval; only half have been visited since then. All 20, however, had been reviewed by the State agencies to ensure continued

civil rights compliance. OCR visited 10 ECFs in the Birmingham area to test the adequacy of the State agency's review procedures. At the time we completed our fieldwork, OCR had not visited any ECFs in the Atlanta area to test the State agency review procedures.

In August 1971 OCR was negotiating agreements with both the Alabama and Georgia Departments of Health to make periodic title VI reviews of hospitals participating in Medicare and Medicaid. OCR was also negotiating with Alabama to improve the scope of the State's reviews of ECFs. We examined the review procedures to be incorporated into these agreements, and we believe that, if properly implemented, they should assist in determining compliance by these facilities.

Each of the 20 ECFs had been visited at least once by representatives of the State Departments of Health during fiscal years 1970 or 1971. State agency reviews disclosed only minor problems which, according to the related reports, had been quickly resolved.

According to an OCR regional official, not all institutions were visited at the time of their applications to participate in Medicare because of the large workload that developed when the Medicare program began. Also decisions concerning participation had to be made quickly and consequently many institutions--especially ECFs--had been cleared on the basis of background data furnished by the institutions and assurances of compliance executed by the institutions. Subsequently many of these facilities were not visited because the civil rights specialists were busy reviewing the civil rights activities of State agencies and approving title VI compliance reports for additional facilities applying to participate in federally assisted health and welfare programs.

OCR records covering the period July 1966 to June 1971 contained 39 charges of discrimination against hospitals participating in the Medicare program in the Atlanta and Birmingham areas. No such complaints had been received against the ECFs participating in Medicare. The charges were directed against 14 hospitals, and most of them involved discrimination by the hospitals against patients or

minority-group physicians. Examples included (1) refusal to admit patients for treatment, (2) segregating minority-group patients from others after admission, (3) inability of minority-group physicians to obtain staff privileges, and (4) unequal treatment given to minority-group professional members by hospital administrative officials.

Each of the 14 hospitals was visited by OCR at least once during its investigations of the 39 complaints. After visits to the hospitals 28 complaints were resolved; without visits six were resolved. OCR records did not show whether the remaining five complaints had been resolved.

Concerning the 34 resolved complaints, the charges of discrimination either could not be substantiated or were substantiated and corrective action was promised by the hospitals. None of the hospitals were removed from participation in the Medicare program.

OCR activities in Wayne County

The Chicago regional office of OCR is responsible for ensuring title VI compliance in Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin. Its Health and Social Services Branch employed six civil rights specialists in July 1971.

During fiscal year 1970 and 1971, the OCR regional office approved 12 ECFs and two hospitals in Wayne County for Medicare. OCR officials did not visit any of the institutions before approving them. According to an OCR official, the institutions were approved on the basis of OCR's review of the compliance reports submitted by the hospitals or ECFs and, in some instances, on the basis of additional information requested by OCR.

In September 1970 the OCR regional office completed a review of civil rights compliance activities in Michigan. OCR found that Michigan was not making title VI compliance reviews of hospitals but that the county departments of social services made annual compliance reviews of nursing homes and ECFs. The data obtained by the counties is sent to the Michigan Department of Social Services.

An OCR official advised us that, because the State had not visited hospitals and relied entirely on the counties to make title VI compliance reviews of nursing homes and ECFs, a number of such institutions were visited by OCR to test compliance. OCR selected 11 hospitals and 15 ECFs or nursing homes in Wayne County. As a result of its review of State activities and visits to hospitals, ECFs, and nursing homes, OCR--in its September 1970 report--made several recommendations to State officials for improving Michigan's civil rights activities, including

--designating someone to coordinate all State agency activities related to compliance with title VI and giving him the authority needed to effectively implement the State's plan for title VI compliance and

--establishing procedures for annual onsite reviews of all hospitals for title VI compliance.

OCR records covering the period July 1966 to June 1971 contained no charges of discrimination against medical institutions in Wayne County in admitting or caring for patients or in granting staff privileges to physicians.

OCR activities in Los Angeles County

The San Francisco regional office of OCR is responsible for ensuring title VI compliance in California, Arizona, Hawaii, and Nevada. Its Health and Social Services Branch employed four civil rights specialists in July 1971.

During fiscal years 1970 and 1971, the OCR regional office approved 29 hospitals and 151 ECFs in Los Angeles County for Medicare. OCR did not visit any of these institutions before it approved them.

According to a regional OCR official, an experienced secretary is responsible for reviewing all compliance reports and attempting to resolve any issues with representatives of the institutions. If these issues cannot be resolved by the secretary, the case is given to a civil rights specialist. In Los Angeles County all issues are resolved by telephone or through official correspondence with the

institutions. Because California reviews all medical institutions annually to ensure compliance with licensing requirements and with all Federal requirements under the Medicare and Medicaid programs--including title VI, this OCR official told us that it relied on the State to conduct onsite reviews unless a complaint had been received about an institution. He said that one exception to this in Los Angeles County occurred in 1969 when OCR regional officials visited six selected ECFs.

In California the State Department of Health Care Services is responsible for ensuring title VI compliance of all Medicaid providers which are also often Medicare providers. Through interagency agreements, onsite reviews of facilities were made by the State Department of Public Health. For Los Angeles County the State Department of Public Health has contracted with the County Health Department to inspect hospitals, ECFs, and nursing homes.

According to a Los Angeles County Health Department official, title VI compliance reviews are made as part of the county's annual onsite review effort to ensure compliance by hospitals, ECFs, and nursing homes with State licensing requirements and with all Federal requirements under the Medicare and Medicaid programs. Because of numerous other factors evaluated during these onsite reviews--such as sanitation, safety conditions, and adequacy of nursing services--title VI compliance has not been emphasized. The county has not instituted any specific procedures to ensure title VI compliance. No violations of title VI requirements have ever been identified during onsite inspections in Los Angeles County.

In letters dated July 14, 1971, OCR advised the Directors of the State Departments of Health Care Services and of Public Health that OCR had found that (1) no one had been assigned specific responsibility for coordinating the implementation of title VI within each of these State departments, (2) the Department of Health Care Services did not have a system for evaluating the compliance work of the Department of Public Health, and (3) in turn, the Department of Public Health did not have a system for ensuring that local health departments, hospitals, ECFs, and other providers of medical services were complying with title VI. OCR requested both departments to implement corrective actions by September 12, 1971.

In their replies, both State departments agreed to take corrective actions. An OCR official told us that, as of January 31, 1972, few corrective actions had been implemented and that OCR planned to work closely with both State departments to obtain satisfactory results.

OCR records showed that, from July 1966 to June 1971, it had received charges of discrimination against six hospitals and two ECFs in Los Angeles County in the granting of staff privileges to minority-group physicians or in admitting and treating minority-group patients. Six of the complaints could not be substantiated. For the remaining two complaints, OCR substantiated the charge and was able to persuade the institution to correct the situation so that neither institution was denied participation in federally assisted programs.

One case involved an ECF--which had no black patients--denying admission to a black woman on the basis of her race. After discussion and correspondence between OCR and the owners of the ECF during the period February to August 1970, the administrator was replaced and the ECF agreed to actively seek out minority-group patients. Starting August 1970, the ECF was required to submit monthly reports of the race, color, and national origin of all patients referred and admitted. Reports were still being required by OCR in January 1972.

In the other case OCR concluded that a community mental health center was insensitive and unresponsive to the needs of minority groups. As a result of OCR's efforts, the center took action to (1) obtain representation of minority groups on its board of trustees, (2) recruit minority-group medical and paramedical staff, and (3) initiate outreach activities for minority patients. In addition, OCR required the center to submit reports on the progress in these areas every 4 months from July 1971 through July 1972. In February 1972 an OCR official advised us that reports from the center had been received on schedule and that he was satisfied with the reported results.

CONTROLS OVER PAYMENTS FOR EMERGENCY SERVICES PROVIDED BY HOSPITALS THAT DO NOT PARTICIPATE FULLY IN MEDICARE

Some hospitals participate in Medicare only when providing care to patients in emergency situations when no other hospital is conveniently available. These are referred to as "emergency hospitals."

An "emergency hospital" is defined by the Medicare legislation as an institution which (1) is licensed if its State or local law provides for licensing of hospitals, (2) furnishes care by or under the supervision of a physician, and (3) provides 24-hour licensed nursing service under the supervision of a full-time registered nurse. Emergency hospitals, however, need not comply with other conditions established by Medicare for hospitals or with the provisions of title VI.

During the early stages of Medicare, concern was expressed by health-care leaders that a large concentration of claims for emergency services in some areas of the South was an indication that some hospitals--which were not in compliance with title VI--were securing reimbursement for routine services provided to Medicare beneficiaries under the guise of emergency services.

We reviewed the procedures followed by the Social Security Administration to control reimbursements for services provided by emergency hospitals within the jurisdiction of HEW's regional office in Atlanta, Georgia. This region covers eight of the Southern States, and these States account for 23 percent of the Nation's emergency hospitals. The Social Security Administration's procedures seemed adequate to ensure that reimbursement for emergency services was made only when a bona fide medical emergency existed and use of a fully participating hospital was not feasible because of the circumstances of the case.

The procedures for payment provide that the Social Security Administration district office located nearest the emergency hospital determine whether a fully participating hospital was as near or nearer than the emergency hospital and whether space and needed services were available in that hospital at

the time the emergency occurred. This information--together with the claim file--is forwarded for review to the HEW regional office. The procedures provide that, if the claim is approved on the basis that space or needed service was not available in a fully participating hospital, a Public Health Service physician will then examine the clinical records accompanying the claim to determine whether a bona fide medical emergency existed. The claims are then sent to the Medicare part A intermediary where (1) approved claims are paid and (2) rejected claims are subject to reconsideration.

Those having rejected claims are advised of the reasons and the procedures to follow if the patient wants the claim to be reconsidered. If a reconsideration is requested, the claim file and any additional medical information furnished by the hospital or the physician are forwarded to the Social Security Administration's Bureau of Hearings and Appeals in Rockville, Maryland, where a final decision is made on the case.

We examined 140 claims for emergency Medicare services provided by six emergency hospitals. OCR records showed that five of these six hospitals were not in compliance with title VI and could not be accepted as fully participating hospitals in Medicare. No information was available in OCR records to indicate whether the sixth hospital was complying with title VI.

Our examination of these 140 claims shows that

--68 claims were approved for payment after review by the Social Security Administration district office and the HEW regional office;

--seven claims were initially rejected but approved upon reconsideration;

--51 claims were rejected in total because (1) space or needed service was available in an accessible and fully participating hospital at the time the emergency occurred or (2) after examining the patients' clinical records, Public Health Service physicians determined that an emergency requiring hospitalization did not exist; and

--14 claims were rejected, in part, because Public Health Service physicians determined that the emergency condition had subsided to a point where the patients could have been moved to other hospitals. HEW rejected those parts of the claims covering services provided after this point.

CHAPTER 4

ACCESS TO MEDICAL SERVICES BY BLACKS IN THE ATLANTA AND BIRMINGHAM AREAS

OCR and State agency reviews in the Atlanta and Birmingham areas revealed little evidence of discrimination on the basis of race, color, or national origin in the admission or care of patients or in the granting of staff privileges to physicians by the 24 hospitals and 20 ECFs participating in the Medicare and Medicaid programs. In these areas our interviews with black and white persons--including physicians, nurses, patients, and administrative personnel at these institutions, plus representatives of local medical societies and various community service organizations--produced no new evidence of overt discrimination.

Hospitals and ECFs under Medicare and Medicaid have policies to admit all patients regardless of race, color, or national origin, and most of them have admitted black and white patients at one time or another. Nevertheless, black patients were clustered in a few hospitals and ECFs.

A patient census taken for us by the hospitals and ECFs in the Atlanta and Birmingham areas in 1971[1] showed a definite pattern of usage of certain medical institutions by black patients. From this pattern it seems reasonable to conclude that a dual system of medical facilities existed even if not intended--one group for white patients and another group for black patients.

---

[1] A patient census was taken for us by each of the 24 hospitals for each day of the period July 19 to 26, 1971. From this we determined an average daily census. Each of the 20 ECFs took a patient census for us on July 19, 1971. When we visited the hospitals and ECFs to pick up the data, we also toured them to confirm the reasonableness of the census data furnished.

Reasons given to us in interviews in these two areas for the concentration of black patients in certain hospitals were that

--the black patients preferred to use these hospitals for convenience and because of their familiarity with the hospital from prior association,

--the patients' physicians preferred to use these hospitals,

--the hospitals were located in areas heavily populated by blacks, and

--many black patients did not have their own physicians so they had to use the outpatient clinics of the State- or county-owned hospitals to gain admission to these hospitals.

Listings of physicians having staff privileges obtained from each of the 24 hospitals show that black physicians have been able to obtain staff privileges at most hospitals in the Atlanta and Birmingham areas, but at many hospitals--particularly those treating predominantly white patients--few black physicians had staff privileges.

The small numbers of black physicians at some hospitals may have been due to the following reasons.

--In July 1971 only 78 black physicians were practicing at hospitals in the Atlanta area which had a population of about 1.4 million, including over 300,000 black persons (or one black physician for every 3,846 black persons); only 15 black physicians were practicing at hospitals in Birmingham which had a population of over 300,000, including over 125,000 blacks (or one black physician for every 8,333 black persons).

--Black physicians having staff privileges at hospitals treating predominantly white patients advised us that they seldom used these privileges because of (1) loyalty to predominantly black-patient hospitals where they also had staff privileges, (2) the desire to have

their patients near their offices, or (3) the time and expense of making rounds at several hospitals.

--Black physicians with staff privileges at only those hospitals treating predominantly black patients advised us that they were not interested in obtaining staff privileges at predominantly white-patient hospitals for the same reasons mentioned above. Several of these physicians said that they had applied for staff privileges at white-patient hospitals years ago, were rejected, and were no longer interested in practicing at those hospitals.

The persons whom we interviewed generally agreed that little difference existed between the quality of medical care or services provided to blacks and whites.

CONCENTRATION OF BLACK PATIENTS IN CERTAIN HOSPITALS AND ECFs

The patient census taken for us at the 24 hospitals and 20 ECFs that were participating in Medicare in the Atlanta and Birmingham areas showed that 67 percent of the black patients had been treated at five institutions. One hospital and six ECFs had no black patients. In addition, as shown below, another four hospitals and nine ECFs had five or fewer black patients.

	Number of patients		
	White	Black	Total
Atlanta area institutions:			
A (hospital)	210	4	214
B "	35	2	37
C "	19	1	20
D (ECF)	182	2	184
E "	164	2	166
F "	90	4	94
G "	67	1	68
H "	25	1	26
Birmingham area institutions:			
I (hospital)	146	5	151
J (ECF)	65	4	69
K "	38	1	39
L "	35	1	36
M "	14	3	17
Total	1,090	31	1,121

Three of the 15 hospitals in the Atlanta area were treating 81 percent of all black patients. One hospital (having 20 patients) had no black patients. At the remaining 11 hospitals, from 2 to 13 percent of all patients being treated were black patients.

One hospital with an average daily census of 117 patients had no white patients. The hospital was constructed under a Hill-Burton[1] grant in 1949 to serve black patients with the ability to pay for their care. The hospital has been a concern of HEW at various times since passage of the 1964 Civil Rights Act. HEW officials have advised us, however, that they have been unable to prove that the hospital practices any form of discrimination.

Of the nine ECFs in the Atlanta area, one was treating 75 percent of the black patients. This ECF had 116 patients and only one was white. On the other hand, one religiously affiliated ECF had 101 patients and none were black.

Of the nine participating hospitals in the Birmingham area, one (a State-owned hospital) was treating 49 percent of the black patients. Another hospital, with an average daily census of 43, had all black patients. At the remaining seven hospitals, 3 to 21 percent of all patients being treated were black patients.

Of the black patients in ECFs in the Birmingham area, 91 percent were being treated in two of the 11 ECFs. One of these ECFs had 43 black patients and no white patients; the other had 46 black patients and one white patient. Five of the ECFs--providing care to 400 patients--had no black patients.

---

[1]The Hill-Burton program provides Federal grants or loans and loan guarantees with interest subsidies for the construction or modernization of hospitals and other health-care facilities.

REASONS FOR BLACK PATIENTS' BEING CLUSTERED IN CERTAIN HOSPITALS AND ECFs

We interviewed physicians; patients; hospital and ECF officials; and representatives of civil rights organizations, medical societies, and welfare organizations to obtain reasons for the heavy concentration of black patients in certain hospitals and ECFs. The disproportionate number of black patients being treated by only a few of the hospitals and ECFs, they believe, is not the result of current discriminatory policies or practices but is the result of (1) personal preference by black patients and their physicians, (2) convenience of the institutions to the black community, and (3) traditional use of State- or county-owned hospitals by black patients without personal physicians.

Preferences of black patients and their physicians

The most frequent reasons given by black patients we interviewed for being in a particular hospital or ECF were (1) it was convenient to them or had been used previously, (2) their physician had selected it, and (3) it had provided free medical care to them before they became eligible for Medicare or Medicaid benefits. Most patients said that the institutions in which they were confined were selected with full knowledge that, under the Medicare and Medicaid programs, they could have selected any medical facility of their choice.

Physicians have told us that it is a general practice in their profession for the patient to select a physician and for the physician to select the medical facility. Black physicians have told us that they generally confine their use of staff privileges to hospitals where the patient loads have been totally or predominantly black. This was done principally, they said, for their convenience to limit their hospital rounds to a few hospitals.

Black physicians with staff privileges at several hospitals--including hospitals where the patients treated were predominantly white--admit almost all of their patients to hospitals treating predominantly black persons, they said. In Birmingham, for example, of the 15 black physicians who

had staff privileges at Medicare-approved hospitals, 14 had privileges at the one hospital where only black patients were being treated at the time of the patient census. Of these 14 physicians, four also had staff privileges at hospitals where predominantly white patients were being treated, including one physician who had patient admission privileges at seven hospitals in the city. These four physicians said they rarely admitted patients to any hospital other than the one where the patient load was totally black.

Some black physicians in the Atlanta and Birmingham areas practiced at hospitals which had traditionally served a greater number of black patients, even though other hospitals at which the physicians had staff privileges were more conveniently located. They preferred to practice, they said, at the predominantly black-patient hospitals for a variety of reasons--including tradition, loyalty, and preference of their patients to use those hospitals. In Birmingham, for example, the hospital occupied totally by black patients was the only one where black physicians could practice prior to passage of the 1964 Civil Rights Act. Two black physicians told us that they preferred to continue to practice at this hospital out of loyalty and because the hospital was experiencing financial problems and needed patients.

Of the 11 black physicians we interviewed who had staff privileges at only those hospitals treating predominantly black patients, 10 told us they were not interested in obtaining staff privileges at predominantly white-patient hospitals. The other physician said that he has applied at two predominantly white-patient hospitals over the past few years. Also, from 1968 to 1970 he submitted three applications to one hospital but was told by hospital staff that they had never received any of his applications. He told us that he applied at the other hospital in 1969 but was told in 1971 that the hospital had not yet acted on his application. This physician believes that he may have been discriminated against.

Three of the 10 black physicians--who told us they were not interested in obtaining staff privileges at hospitals treating predominantly white patients--said that they had applied for staff privileges at white-patient hospitals

several years ago but were told by the hospitals that (1) the hospital was already overcrowded and could not handle the additional patient load which would be generated by granting admitting privileges to additional physicians or (2) the hospitals had no need for additional general practitioners. Two of these black physicians believed that they had been refused admission privileges because of their race.

A black physician told us about a particular case where two black and three white physicians had applied for staff privileges in 1970 at a hospital where the patient load had traditionally been predominantly white. All five applications had been deferred because of overcrowded conditions, and none of the applicants had been granted staff privileges at the time of our fieldwork. We interviewed one of the black physicians who had applied; his application was still pending, he said, and he did not consider the hospital's action to be discriminatory.

At hospitals where few black patients were treated, administrators told us that physicians having staff privileges had few black patients. Others said few black patients lived in the areas served by the hospitals.

Because the selection of a hospital is often based on the desire of the attending physician rather than on the desire of the patient, black physicians in the Atlanta and Birmingham areas may be contributing to the existing patterns of hospital use by black patients (1) by not persisting in their efforts to obtain staff privileges at hospitals treating predominantly white patients and (2) by seldom using their staff privileges at white-patient hospitals when they have such privileges.

People generally use institutions near where they live

Those institutions in areas containing high concentrations of the black population generally received the highest usage by black patients. The same relationship exists in predominantly white population areas.

27-401 O - 74 - 16

Atlanta area

The three hospitals treating 81 percent of the black hospital patients in the Atlanta area during the patient census made for us are in census tracts[1] where black persons represent more than 90 percent of the population. The hospital with no black patients and the three hospitals with five or fewer black patients (see A, B, and C on p. 33) are in census tracts where less than 5 percent of the population is black.

The ECF treating 75 percent of the black patients is in a census tract where black persons represent over 93 percent of the population. The ECF with no black patients and four of the five ECFs with five or fewer black patients (see D, E, G, and H on p. 33) are in census tracts where less than 5 percent of the population is black. The other ECF with five or fewer black patients (see F on p. 33) is on the border of two census tracts--one having a black population of 1 percent and the other having a black population of 49 percent.

Birmingham area

The hospital treating only black patients during the patient census conducted for us in the Birmingham area is in a census tract where black persons represent 97 percent of the population. The State-owned hospital treating 49 percent of Birmingham's black patients is in a census tract having a black population of 28 percent. The remaining seven hospitals in Birmingham were located in census tracts where black persons represented from 0 to 22 percent of the population. The hospital with five or less black patients (see I on p. 33) is in a census tract where only one black person lives.

The patient census data for ECFs in Birmingham did not conform to the mix of black and white persons in the census

---

[1] Information gathered by the U.S. Census Bureau is reported by tracts to permit small-area analysis. These are called census tracts. The population information for these census tracts came from the 1970 census.

tracts where the ECFs are located. The two ECFs treating 91 percent of black ECF patients are in census tracts where only 10 to 12 percent of the populations are black. On the other hand one ECF with no black patients and two with fewer than five black patients (see J and M on p. 33) are in a census tract where 22 percent of the population is black. Another ECF with no black patients and one with fewer than five black patients (see K on p. 33) are in census tracts where about 10 to 12 percent of the populations are black.

The major reason two ECFs were treating most of the black patients, in our opinion, was that they were black owned. At one ECF all patients had to be admitted by the black staff physician. At the other ECF patients are attended by a black physician who visits there 1 day a week and is on call at any time.

Several black physicians in Birmingham advised us that blacks--more so than whites--had not yet accepted the nursing home or ECF as a means of obtaining care less intensive than that provided in hospitals and often viewed such facilities as places to set aside unwanted elderly people. According to these physicians, blacks often prefer to care for members of their families at home for illnesses not requiring confinement to a hospital and those who do seek nursing-home or ECF care generally cluster in certain facilities by choice to be in the company of other black persons.

Black patients without personal physicians have traditionally used State- or county-owned hospitals

Officials of civil rights organizations advised us that many poor black persons did not have their own physicians. Consequently they have used outpatient clinics of State- or county-owned hospitals to receive needed medical treatment. When further care has been found necessary--by the examining intern or resident physician--the patients have been admitted to these hospitals. Other reasons given for the heavier use by black persons of government-owned hospitals over other hospitals were that they (1) provided medical care at little or no cost to low-income patients and that much of the local black population was in this category, (2) had been the hospitals generally used by the aged and indigent before the

Medicare and Medicaid programs were established, (3) were in or near predominantly black communities.

The county-owned hospital in Atlanta provides medical care at little or no cost to indigent patients, and all patients are admitted through its outpatient clinic and emergency room. The hospital is a teaching hospital,[1] and all patients are admitted by staff physicians and interns. None of the staff physicians have private medical practices.

During 1 day of the 1-week census period, 1,798 patients--of which 1,378, or about 77 percent, were black--visited the hospital's outpatient clinic and emergency room. During this 1-week period, 58 percent of all black patients hospitalized in the Atlanta area were confined in this one hospital.

In this connection, we noted that, under a Model Cities grant,[2] an agency of the city operates a bus in one of the large black communities and the bus passes this hospital. The bus fare is 10 cents compared with 40 cents for the regular bus fare in Atlanta. Therefore it is convenient and economical for black patients to use this hospital for needed medical services.

In Birmingham, black patients extensively used the one State-owned hospital that provided medical care at little or

---

[1]The term "teaching hospital" has been defined by the Association of American Medical Colleges as any hospital having a program of graduate medical education (one which trains residents and interns) whether or not the hospital is related directly to a medical school.

[2]Established under title I of the Demonstration Cities and Metropolitan Development Act of 1966, the Model Cities Program was designed to demonstrate how the living environment and general welfare of people living in slum and blighted neighborhoods could be substantially improved in cities of all sizes through a comprehensive attack on the social, economic, and physical problems by a concentrated and coordinated Federal, State, and local effort.

no cost to indigent patients. This hospital is also a teaching hospital, and all patients are admitted by staff physicians through its outpatient clinics and emergency room. According to the hospital administrator, poor persons and persons who do not have their own private physicians come to the State-owned hospital for medical treatment because they are not able to obtain it elsewhere.

During the 1-week census period, this hospital accounted for 49 percent of all black patients in hospitals in Birmingham. On 1 day, this hospital received 386 patients in its outpatient clinic and emergency room and 256 of them, or about 66 percent, were black.

Other than the two government-owned hospitals in Atlanta and Birmingham, patients could be admitted to a hospital only by a physician having staff privileges at that hospital.

CHAPTER 5

ACCESS TO MEDICAL SERVICES BY NONWHITES IN WAYNE COUNTY

In reviews of hospitals in Wayne County, OCR has found no evidence of discrimination. OCR and State agency reviews have also shown nursing homes and ECFs under Medicare or Medicaid in Wayne County to be in compliance with title VI. Our interviews in Wayne County with administrators, 10 black physicians, and 20 black patients at 12 hospitals and five ECFs or nursing homes and with officials of local civil rights organizations, State and local social service organizations, and medical societies substantiated that compliance with title VI was being attained.

In a 1966 study of 19 hospitals in the Detroit area,[1] the Michigan Civil Rights Commission found little overt racial discrimination and concluded that of most significance was the extent of change and improvement that had taken place in hospitals over the period of a few years. The study pointed out that (1) most hospital administrators were aware of their responsibilities in promoting equality of opportunity and (2) administrators had shown a willingness to consider community expectations and adopt aggressive and affirmative programs designed to help overcome past inequities.

In a 1966 study of 16 licensed nursing homes in Wayne County, however, the commission found that many of these facilities seldom had black patients and some had never had a black patient referred to them. The commission concluded that the four major sources of nursing-home referrals--the county welfare department and three local government-owned hospitals--contributed to an extreme racial imbalance of patients in many nursing homes.

---

[1]The population of Detroit represents about 57 percent of Wayne County's population (1.51 million of 2.67 million). About 92 percent of Wayne County's black persons live in Detroit.

An official of the Michigan Civil Rights Commission told us in June 1971 that, during the past few years, the commission had received no charges of discrimination in providing services to patients or in granting staff privileges to physicians against medical institutions in Wayne County.

In 1970 OCR made reviews of 11 hospitals and 15 ECFs or nursing homes in Wayne County. OCR observed no discriminatory practices in hospitals. Nonwhite persons were being served commensurate with the minority population in each hospital's locale. However, many of the ECFs or nursing homes had few or no minority-group patients. OCR directed the Wayne County Department of Social Services to reexamine its referral practices to ensure that patients of minority groups were not being restricted in their access to ECFs or nursing homes.

The 12 hospitals and five ECFs or nursing homes which we visited had policies of admitting patients regardless of race, color, or national origin. Nevertheless, patient counts taken at these 17 institutions--and others throughout Wayne County--showed that some were used almost exclusively by whites and others were used almost exclusively by nonwhites.

Nonwhites have used city- and county-owned hospitals more extensively than most other nearby hospitals. Reasons given to us in interviews in Wayne County for the heavier use by nonwhites of these government-owned hospitals are:

--They are open to anyone in need of medical treatment regardless of their ability to pay and much of the black population in Wayne County has low incomes.

--Because many nonwhites do not have their own family physicians, they go to the city- or county-owned hospitals, outpatient clinics, or emergency departments for their care and when further care is found necessary, they are admitted to these hospitals.

--Nonwhite patients often are not aware that Medicare and Medicaid benefits are payable to other participating hospitals.

Many hospitals have limited numbers of black physicians on their staffs; however, the consensus of the 10 black physicians whom we interviewed is that the trend in Wayne County is toward acceptance of physicians on hospital staffs on the basis of ability, not race. There is, however, a shortage of black physicians in Wayne County and a shortage of any physicians practicing in the Detroit inner-city area which has a high percentage of black persons. Wayne County had a black population of nearly 725,000 but had only about 200 black physicians in 1971--or one black physician for each 3,625 black persons. Fewer than 60 black physicians practiced in the Detroit inner-city area. Black physicians represented only about 4 percent of the physicians on the staffs of the 12 hospitals we visited.

Several black physicians have told us that black general practitioners have problems getting privileges to admit patients at many hospitals because the hospitals admit only specialists to their staffs. This practice by hospitals of limiting new staff appointments to specialists was mentioned as a problem in the 1966 Michigan Civil Rights Commission study but was reported to be of equal concern to white as well as black physicians.

The persons whom we interviewed have generally agreed that white and nonwhite patients are treated equally at medical institutions in Wayne County.

USE OF HOSPITALS BY NONWHITES

Statistics compiled by HEW in 1969 on the basis of a 1-day census at 59 hospitals participating in the Medicare program in Wayne County showed that

--nonwhites represented under 5 percent of the patients at 11 hospitals, including one that had all whites among its 237 patients, and

--whites represented under 5 percent of the patients at five hospitals, including three hospitals that had only nonwhites among their 222 patients.

We visited six hospitals--including a city-owned hospital--in the Detroit inner city where about 80 percent

of the population is black. The following table shows the racial mix of the patients at the six hospitals on the day of our visits.

	Patient load				
		White		Nonwhite	
Hospital	Total	Number	Percent	Number	Percent
A (city owned)	471	71	15.1	400	84.9
B	103	39	37.9	64	62.1
C	357	164	45.9	193	54.1
D	746	481	64.5	265	35.5
E	585	409	69.9	176	30.1
F	90	85	94.4	5	5.6
Total	2,352	1,249	53.1	1,103	46.9

The city-owned hospital (A) had the highest percentage of nonwhite patients, and only hospital F had a small number of nonwhite patients. We asked an official of hospital F why the hospital had so few nonwhite patients; he said that nonwhites living in this locale were generally treated at neighborhood clinics staffed by general practitioners and that this hospital limited admissions to referrals from members of the medical staff, who were all specialists.

At the city-owned hospital, patients could be admitted only through the outpatient clinic or emergency room; usually admission was by an intern or a resident physician. Although a patient could be referred to this hospital by a private physician, the physician could not admit or treat his patient there.

We also visited six hospitals--including a county-owned hospital--in an area of suburban Wayne County where only about 5 percent of the population is black. The following table shows the racial mix of the patients at these six hospitals on the day of our visits.

Hospital	Patient load				
	Total	White		Nonwhite	
		Number	Percent	Number	Percent
G (county owned)	358	261	72.9	97	27.1
H	257	210	81.7	47	18.3
I	22	21	95.5	1	4.5
J	214	207	96.7	7	3.3
K	435	431	99.1	4	.9
L	204	204	100.0	0	0
Total	1,490	1,334	89.5	156	10.5

The county-owned hospital (G) had the highest percentage of nonwhite patients. The only other hospital with a significant number of nonwhite patients in this suburban area heavily populated by whites was hospital H which is on the border of a community with a black population of 45 percent.

We asked 10 black patients at hospital A and 10 black patients at hospital G why they had selected the government-owned hospitals. Of these patients, 17 said that, because they had no family physicians, they had come to the outpatient clinics to see physicians and were then admitted to the hospitals. Most patients gave more than one reason for using the government-owned hospital; these other reasons are shown below.

Other reasons given for using government-owned hospital	Number of patients responding
Preferred hospital because of familiarity from previous use	9
Preferred hospital because it was convenient	3
Had no money and knew these hospitals would treat them	5
Brought to hospital by police or government-owned ambulance	7
Referred to hospital by someone else	5
Were not aware that Medicare or Medicaid coverage was accepted at other hospitals	11

USE OF ECFs AND NURSING HOMES BY NONWHITES

In 1969 HEW compiled statistics on 35 ECFs in Wayne County which showed that

--six ECFs with 796 patients had no nonwhite patients;

--one ECF with 486 patients had only one nonwhite patient;

--at five other ECFs, nonwhites represented less than 5 percent of the patients; and

--one ECF had only one white among its 55 patients.

In Michigan, county departments of social services make annual onsite reviews of the compliance by nursing homes and ECFs with title VI. The Michigan Department of Social Services compiles a report on the basis of the results of these reviews. Its 1971 report showed no instances of noncompliance with title VI by the 400 nursing homes and ECFs in the State.

The report showed that, of all nonwhite patients treated in nursing homes in Michigan, 84 percent were in Wayne County nursing homes. Although nonwhites represented only about 8 percent of all nursing-home patients in Michigan, they represented about 23 percent of all nursing-home patients in Wayne County. For the 112 nursing homes in Wayne County, 21 had no nonwhite patients and an additional 32 had five or fewer nonwhite patients each. These 53 nursing homes had only 87 nonwhites among 4,670 total patients--less than 2 percent--whereas 57 nursing homes in Wayne County had 2,048 nonwhites among 6,152 total patients--about 33 percent. The remaining two nursing homes had 121 patients, but the report did not show a breakdown between white and nonwhite patients for these facilities. None of the 110 nursing homes in Wayne County for which a breakdown of white and nonwhite patients was reported were treating only nonwhite patients.

To obtain reasons for concentrations in certain ECFs and nursing homes of one racial group, we visited one ECF and one nursing home in the Detroit inner-city area and two

ECFs and one nursing home in a suburban area of Wayne County. The racial mix of the patients at the five institutions on the day of our visits was, as follows:

	Patient load				
		White		Nonwhite	
Facility	Total	Number	Percent	Number	Percent
Detroit inner-city area:					
A	101	97	96.0	4	4.0
B	476	470	98.7	6	1.3
Suburban Wayne County:					
C (county owned)	221	150	67.9	71	32.1
D	87	69	79.3	18	20.7
E	90	83	92.2	7	7.8
	975	869		106	

According to officials of facilities A and B, the homes are religiously affiliated and most of their patients are referred by churches or people previously treated there. Very few referrals are from the government-owned hospitals or from the county welfare department.

The administrator of facility A said that the facility had few nonwhite patients because (1) few nonwhites were referred there, (2) nonwhites preferred to stay at home with their families rather than use a nursing home, and (3) the black community had a general misunderstanding about the type of services provided by the facility.

An official of facility B told us that this facility did not discriminate although the patient mix might imply that it did. He showed us advertisements in local newspapers stating that applicants were accepted by the facility regardless of race, color, creed, national origin, or financial means but said that they received very few applications as a result of these advertisements. He attributed the virtual absence of nonwhite applicants to a belief that nonwhite people preferred to live with other nonwhites.

The three facilities in suburban Wayne County get most of their patients from the county-owned hospital and the county welfare department. Facility C is a county-owned ECF on the grounds of the county-owned hospital complex in an area with a small black population. (See G on p. 46.) Most of its patients are transferred from the county-owned hospital which had nearly the same percentage of nonwhite patients. The population of the suburban community in which facility D is located has a black population of 45 percent. Facility E is in an almost all-white suburban section of Wayne County.

CHAPTER 6

ACCESS TO MEDICAL SERVICES BY MEMBERS OF MINORITY GROUPS IN LOS ANGELES COUNTY

Hospitals and ECFs in or near the minority-group communities in which our review was concentrated in Los Angeles County were in compliance with title VI. Except for two complaints which had been substantiated and acted upon by OCR (see p.), we found no instances in which patients had been refused admittance or otherwise discriminated against or in which physicians had been refused staff privileges at hospitals because of race, color, or national origin.

Some minority-group physicians told us, however, that subtle forms of discrimination existed in the granting of hospital staff privileges but that such discrimination could not be proved. Some members of minority-group organizations and some minority-group patients told us that subtle discrimination also existed in the provision of services to minority patients.

Although not in violation of title VI, many hospitals, ECFs, and nursing homes in Los Angeles County served relatively few minority-group patients. This is apparently attributable to

--the tendency for minorities to use those institutions in or near the areas in which they reside and

--a disproportionate use of county-owned hospitals by members of minority groups.

These matters are discussed in greater detail below.

ADMISSION AND CARE OF PATIENTS

All of the 30 hospitals and 16 of the 18 ECFs we visited were treating patients of minority groups. Three of the ECFs--including the two not treating minority-group members and the one treating only members of a minority group--catered

to certain religious, ethnic, or economic groups. According to OCR, however, those ECFs were not in violation of title VI.

We toured all 48 institutions and, in the 45 which were treating both majority- and minority-group patients, we saw no indication of segregation of patients or differences in services afforded patients of minority groups. We also interviewed several admitting personnel at nine of the institutions, including three persons who were members of minority groups, and were told that they knew of no instances in which individuals had been denied access to the institutions because of race, color, or national origin.

To obtain their views regarding discrimination by health institutions, we interviewed 39 patients, 44 physicians, and 27 nurses whose ethnic characteristics were, as follows:

Ethnic characteristic	Number of Patients	Number of Physicians	Number of Nurses
Black	21	19	6
Oriental	0	9	2
Spanish surname	7	8	10
White	11	8	9
Total	39	44	27

None of the 39 patients advised us of any specific instances of discrimination; however, two black patients felt that an overtone of discrimination existed in the attitude of hospital staffs. None of the physicians informed us of difficulty in having patients admitted to an institution because of race, color, or national origin. The nurses told us that they had not observed any difference in the services provided to minority patients and were unaware of any policy by any institution to exclude patients because of their race, color, or national origin.

One black physician advised us, however, of a nursing home which had segregated minorities by room. He informed the home that, if it did not end the practice, he would stop making referrals there; the nursing home corrected the situation.

Officials whom we interviewed--representing 34 civil rights, health, welfare, and other community organizations--had differing opinions as to whether discrimination actually existed. Views of some of the organizations whose officials believed that discrimination in admission or care of patients existed included:

--An official of a postgraduate medical school in the highest black-populated area of Los Angeles has said that a rapport often does not exist between white hospital staff and black patients because the staff does not understand the cultural or economic background of the black persons.

--Officials of a new county-owned hospital to be opened in the highest black-populated area of Los Angeles in March 1972 have advised us that, especially in southern California, discrimination is very subtle and impossible to describe in specific terms. It takes the form of general discriminatory overtones behind the actions of whites and may not necessarily be a conscious effort.

--A community organization in the section of Los Angeles most heavily populated with Spanish-surnamed individuals reported in 1970 that many health service staff members were insensitive to the problems of the Spanish-speaking patient and needed to be educated in Mexican-American culture.

HOSPITAL STAFF PRIVILEGES FOR MINORITY PHYSICIANS

According to regional OCR officials, the granting of hospital staff privileges to physicians is of major importance when considering whether hospitals discriminate in admissions or services and they found no indication that physicians had any difficulty in having minority patients admitted to hospitals once they obtained staff privileges. Also, because patients were admitted to most hospitals by their physicians, hospitals could effectively exclude or control admission of minority patients by discriminating in the granting of staff privileges. Although minorities were significantly underrepresented on hospital staffs, they

believed this was partially due to a general shortage of minority-group physicians. Minority-group physicians--especially blacks--were apt to serve patients of their own race, they said.

At 28 of the 30 hospitals visited, data was available on the ethnic breakdown of physicians having staff privileges. Each of the 28 hospitals had granted staff privileges to physicians of minority groups; the range was from 5 percent of the total physicians at two hospitals outside the large minority population areas to 68 percent of the total physicians at one hospital in the most heavily populated black area in Los Angeles County.

Oriental and Spanish-surnamed physicians we interviewed said that they had found no difficulty in obtaining staff privileges. Eight of the 19 black physicians, however, believed that subtle forms of discrimination existed in the granting of staff privileges.

According to four black physicians, complaints recieved by OCR reflected just a sample of existing discriminatory practices because many physicians who might have requested investigations of discrimination were interested in practicing medicine and not in pursuing civil rights issues. One of these physicians said that (1) minority-group physicians often simply avoided seeking privileges at hospitals they suspected of discrimination and (2) even when those physicians who did apply were denied staff privileges for seemingly racial reasons, they found it simpler or less humiliating to ignore the matter.

Another black physician told us that he had been dismissed from a hospital staff for not adequately maintaining his Medicare and Medicaid records but that he believed race had played a part in his dismissal. He felt that a white physician would have been given a second chance under similar circumstances. He had not referred the matter to OCR because he was attempting to be readmitted to the staff and did not want adverse attention.

OCR had received complaints from minority-group physicians who charged that three hospitals in Los Angeles County had rejected their applications for staff privileges

27-401 O - 74 - 17

on the basis of race or national origin. In each case OCR found that the applications had been rejected for reasons unrelated to the applicants' race or national origin.

Officials of two of the three hospitals contended that they were already overstaffed and therefore accepted only those applicants (1) whose medical speciality was in short supply, (2) whose medical capabilities were outstanding, or (3) who were associated in a partnership or group practice with someone who already had staff privileges. The hospitals were complying with title VI, OCR concluded, because their policies were applied consistently regardless of the race, color, or national origin of the physician and some minority-group physicians had been granted privileges.

Black physicians believed such policies were discriminatory because the physicians on the staffs of these hospitals were predominantly white and they would therefore likely be associated in practice only with other white physicians. Furthermore, they maintained that blacks were less likely to have medical specialities to offer hospitals because a larger proportion of black physicians were general practitioners than were their white counterparts.

OCR officials advised us that, although such admission policies placed minority-group physicians at a disadvantage, they were not dicriminatory if applied uniformly regardless of race, color, or national origin.

MEMBERS OF MINORITY GROUPS USE INSTITUTIONS NEAR THEIR HOMES

Information extracted from compliance reports--submitted to HEW on the basis of a 1-day census in 1969 by 160 hospitals and 284 ECFs in Los Angeles County--showed that many hospitals and ECFs in Los Angeles County treated few minority-group patients, as follows:

Percent of minority-group patients	Hospitals		ECFs	
	Number	Percent	Number	Percent
0 to 9.9	53	33	213	75
10 to 49.9	88	55	61	22
50 to 89.9	13	8	6	2
90 to 100	6	4	4	1
Total	160	100	284	100

Each of the 19 hospitals in which 50 percent or more of the patients were from minority groups was in or near areas heavily populated by such groups. Four of the 141 hospitals which had reported that less than 50 percent of the patients were from minority groups were within the two largest minority-group population areas in Los Angeles County. We visited three of these four hospitals and found that the minority-group representation had changed at two of them after 1969; minority-group members represented 100 percent of the total patients at one hospital and 88 percent of the total patients at the second hospital. The third--which had 22 percent of its patients from minority groups--was established to serve employees of a large railroad company rather than the general community.

Five of the 10 ECFs in which 50 percent or more of the patients were from minority groups were within the two largest minority-group population areas in Los Angeles; the other five were in areas having minority-group populations of over 30 percent. Four of the 274 ECFs in which less than 50 percent of the patients were from minority groups were within the two largest minority-group population areas in Los Angeles County. We visited two of these four ECFs and learned that they were established to serve particular

ethnic or economic groups. (See facilities B and C on p. 57.)

Bureau of the Census statistics show that the two largest minority groups in Los Angeles County are black and Spanish-surnamed persons. These two minority groups account for 88 percent of the total minority population in the county. A Community Action Agency representative has advised us that South Los Angeles is the largest black community and that East Los Angeles is the largest Spanish-surnamed community in the county.

South Los Angeles area

According to a 1965 Bureau of the Census special report, the South Los Angeles area--which includes the neighborhoods of Central Los Angeles, Avalon, Exposition, Florence, Green Meadows, Watts, and Willowbrook--had a black population of 259,980 representing about 81 percent of the area's population of 320,830.

A 1970 report of a postgraduate medical school serving much of the area showed that the area's two major health problems were (1) a shortage of medical manpower and (2) a lack of medical institutions.

The South Los Angeles area had only nine general hospitals providing 719 beds. We visited seven of these hospitals plus four other hospitals within 1-1/2 miles of South Los Angeles. The following table shows the racial mix of the patients at these 11 hospitals on the day of our visits.

Hospital	Number of patients					Percentage of minority patients to total patients
	Total	White	Black	Spanish surnamed	Other minority	
South Los Angeles area:						
A	8	1	7	0	0	88
B	53	1	52	0	0	98
C	41	3	32	6	0	93
D	29	12	13	4	0	59
E	22	2	20	0	0	91
F	31	3	28	0	0	90
G	126	58	43	25	0	54
Adjacent areas:						
H	192	115	51	22	4	40
I	158	93	49	7	9	41
J	332	283	28	12	9	15
K	408	346	39	23	0	15
Total	1,400	917	362	99	22	35

The hospitals in the South Los Angeles area had a heavy minority-group patient load. The nearby hospitals which we visited, although treating minority-group patients, had predominantly white patients.

We also visited four ECFs in the South Los Angeles area and three others within 1-1/2 miles of that area. The following table shows the racial mix of the patients at these seven facilities on the day of our visits.

ECF	Number of patients					Percentage of minority patients to total patients
	Total	White	Black	Spanish surnamed	Other minority	
South Los Angeles area:						
A	94	9	83	2	0	90
B	55	15	35	4	1	73
C	78	20	58	0	0	74
D	90	8	78	2	2	91
Adjacent areas:						
E	108	102	2	4	0	6
F	98	88	4	2	4	10
G	127	121	3	2	1	5
Total	650	363	263	16	8	44

ECFs in the South Los Angeles are--like the hospitals--had heavy minority-group patient loads; ECFs in the adjacent areas had significantly lower percentages of minority patients.

East Los Angeles area

A 1965 Bureau of the Census special report showed that the East Los Angeles area--which includes the neighborhoods of City Terrace, East Los Angeles, and Boyle Heights--had a total population of 178,333, of which 134,870, or about 76 percent, had Spanish surnames. This minority group consisted primarily of persons of Mexican descent. Spanish is the primary language spoken by many residents of the area.

According to a 1970 Health Task Force report[1] some of the health problems in the East Los Angeles area were (1) difficulty in receiving proper medical treatment because a language barrier frequently existed between staff and patient, (2) unawareness by the population of the medical services available, (3) drug abuse, and (4) lack of medical manpower.

The East Los Angeles area had nine general hospitals with 2,932 beds; of these, 2,105 beds were in the Los Angeles County/University of Southern California Medical Center, the largest general hospital in Los Angeles County and one of the largest in the United States. We visited all nine hospitals and four others within 1-1/2 miles of the East Los Angeles area. We did not obtain a 1-day patient census at the large county/university hospital; however, for fiscal year 1970 members of minority groups represented 54 percent of that hospital's total inpatients.

The following table shows the racial mix of the patients at the other 12 hospitals on the day of our visits.

	Number of patients					Percentage of minority patients to total patients
Hospital	Total	White	Black	Spanish surnamed	Other minority	
East Los Angeles area:						
A	25	1	15	9	0	96
B	34	6	1	27	0	82
C	86	10	3	73	0	88
D	80	5	0	75	0	94
E	26	1	0	25	0	96
F	104	81	9	14	0	22
G	5	0	0	5	0	100
H	242	85	36	85	36	65
Adjacent area:						
I	153	93	0	59	1	39
J	6	1	0	5	0	83
K	40	5	0	9	26	88
L	53	17	3	28	5	68
Total	854	305	67	414	68	64

[1]The study was funded primarily under a grant from HEW.

Seven of the eight hospitals in the East Los Angeles area had heavy minority-group patient loads. The other hospital--with a 22-percent minority-group patient load--was the one established to serve employees of a large railroad company. (See p. 55.) The nearby hospitals which we visited also had high percentages of minority-group patients.

We also visited four ECFs in the East Los Angeles area and one ECF within 1-1/2 miles of the area. A table showing the racial mix of the patients at these facilities on the day of our visits follows.

	Number of patients					Percentage of minority patients to total patients
ECF	Total	White	Black	Spanish surnamed	Other minority	
East Los Angeles area:						
A	92	16	3	73	0	83
B	80	80	0	0	0	0
C	103	103	0	0	0	0
D	33	15	0	16	2	55
Adjacent area:						
E	81	1	0	0	80	99
Total	389	215	3	89	82	45

Institutions B, C, and E were established to serve special religious or ethnic groups or had policies which restricted admission to people of means. Each had publicly announced its policy to serve all people, regardless of race, color, or national origin.

According to the administrator at B, ECF care was provided to any person who assigned assets of at least $30,000 to the home. He advised us that black, Oriental, or Spanish-surnamed persons had never applied for admission.

Facility C was established by and for members of a religious faith who wished to preserve their cultural and religious values, and the home gave priority to members of that faith. The administrator advised us that the home had never had an applicant of another religious faith or a black, Oriental, or Spanish-surnamed applicant.

The 80 minority-group patients at facility E were Japanese. The ECF was constructed through contributions from the Japanese community and was geared to meet the language, dietary, and social needs of Japanese patients. The administrator would not refuse admission to anyone, he said, but might try to discourage a non-Oriental by showing him the oriental atmosphere of the facility. Two Spanish-surnamed patients had been admitted during the facility's 2-year history, he advised.

According to an OCR official, none of these facilities were in violation of title VI, because their policies did not preclude admission on the basis of race, color, or national origin. He stated, however, that such admission policies effectively limited the numbers of patients of races, colors, or national origins--uncommon to the ethnic, religious, or economic character of these ECFs--and thereby defeated the objectives of title VI.

DISPROPORTIONATE USE OF COUNTY HOSPITALS BY MINORITIES

A disproportionate share of minority-group patients received health care from county health facilities and often bypassed other facilities more conveniently located. Persons whom we interviewed attributed this to one or more of the following reasons.

1. Most patients in private facilities are admitted by a private physician, and, because of an acute shortage of physicians in the ghetto areas where much of the minority population resides, these persons turn to the county facilities for help.

2. Proportionately more minority-group patients are poor than nonminority patients and must obtain services from the county system or must rely on the Medicaid program to finance their health care. Many private physicians, disgruntled with California's Medicaid program, refused to treat Medicaid patients, or discouraged them, and thereby added to the shortage of available physicians.

3. County hospitals made special efforts to accommodate minority-group patients. Many of these patients were not aware that care could be obtained through private physicians and hospitals under the Medicare and Medicaid programs.

Ethnic composition of patients in county hospitals

The facilities of the Los Angeles County Department of Hospitals were established primarily for the care of indigent people. The department has 6,025 beds in eight hospitals or about 23 percent of all hospital beds in the county.

We visited two large county facilities--the University of Southern California Medical Center and the Harbor General Hospital. An example of the ethnic composition of inpatients at these facilities is shown by the following data reported by the facilities.

Group	Medical Center patients in fiscal year 1970		Harbor General Hospital patients during 8-day period in September 1969	
	Number	Percent	Number	Percent
White	48,364	46	479	37
Black	31,070	30	334	26
Spanish surname	23,884	23	144	11
Other minority	1,090	1	108	8
Unknown	-	-	237	18
Total	104,408	100	1,302	100

County hospital representatives advised us that similar statistics were not available for all other hospitals in the county system but that the ethnic composition of inpatients at these two hospitals was probably typical.

Medical center

The University of Southern California Medical Center is in the East Los Angeles area where Spanish-surnamed individuals represented the largest minority group. In contrast to most other hospitals in that area, its largest minority group of patients was black. (See table on p. 58.)

The medical center treats patients from all areas of Los Angeles County. Its outpatient clinic provides medical treatment to those whose illnesses do not require hospitalization. During fiscal year 1970 about 440,000 persons visited its outpatient clinic. Statistics showing the majority- and minority-group composition of outpatients were not available; however, our observation of a crowded outpatient waiting room over a 2-day period indicated that most of the patients were black or were persons of Spanish descent.

The medical center is only 3 miles northeast of the border of the South Los Angeles area which has a high percentage of black persons, and it appears that many persons from South Los Angeles bypass other hospitals to receive treatment there. Of 10 randomly selected black outpatients we interviewed who would give us their addresses, five were from South Los Angeles.

Harbor General Hospital

There were medical facilities in the vicinity of Harbor General Hospital which members of minority groups appeared to bypass. Harbor General is about 7 miles south of the boundaries of the South Los Angeles area.

We visited four hospitals within a 6-mile radius of Harbor General. The racial mix of the patients at these hospitals on the day of our visits is shown in the following table.

Hospital	Number of patients					Percentage of minority patients to total patients
	Total	White	Black	Spanish surnamed	Other minority	
A	75	65	1	4	5	13
B	125	108	0	15	2	14
C	110	91	2	11	6	17
D	35	21	1	12	1	40
Total	345	285	4	42	14	17

Hospital A was about 2 miles from Harbor General, and minority groups represented 38 percent of the population of the city in which it was located. The area surrounding hospital B, about 6 miles from Harbor General, had a population of 7-percent black residents and 24-percent Spanish-surnamed residents. An official of hospital B said that it was a hospital goal to serve a more affluent white community about 5 miles to the west.

Although 403 physicians had staff privileges at hospitals A, B, and D, no black physicians and only six Spanish-surnamed physicians had privileges at these three hospitals. The assistant administrator at hospital C refused to disclose the race of the physicians having privileges at that hospital.

Shortage of physicians exists in South Los Angeles area

In June 1970, Los Angeles County had about 13,500 licensed physicians, of which nearly 10,000 were members of the Los Angeles County Medical Association. This represented about 140 member physicians for 100,000 persons. A California regional medical program report showed--in two Los Angeles County health districts covering most of the South Los Angeles area--the number of member physicians for 100,000 persons in 1967 to be 48 and 44, respectively. The county health districts in the South and East Los Angeles areas were those ranked by the Los Angeles County Health Department as having the highest health needs in the county. According to an official of the Los Angeles County Health Department, the South Los Angeles area health districts were generally characterized by a high population density and poor economic conditions which made it more profitable for physicians to practice elsewhere.

A former officer of the National Medical Association told us that a general shortage of minority physicians was another contributing reason for the shortage of physicians in the South Los Angeles area. He estimated that about 530, or only 4 percent, of the licensed physicians in the county were black.

Physician rejection of Medicaid patients adds to shortage of physicians for minorities

Medicaid is a grant-in-aid program in which the Federal Government shares in costs incurred by States in providing medical assistance to individuals who are unable to pay for such care.

County officials reported that minorities made up 31 percent of Los Angeles County's population but that, because a substantial portion were poor, they made up 40 percent of those eligible for Medicaid. Black persons made up 13 percent of the county's population and 21 percent of the population eligible for Medicaid. Spanish-surnamed individuals comprised 16 percent of the county's population and 17 percent of the population eligible for Medicaid.

On December 15, 1970, the Department of Health Care Services--which administers Medicaid in California--imposed a 10-percent cutback in Medicaid fees to physicians. One of the county hospitals reported that, during the following 4 months, it experienced a 26-percent increase in Medicaid outpatients compared with the same period in the preceding year. The president of an intern and resident association at this same county hospital reported, in February 1971, that cutbacks in physician fees under the Medicaid program had resulted in a deluge of patients being rejected by private physicians. During the period February 1 to March 20, 1971, social workers at this hospital interviewed 4,894 patients and found that 418, or 9 percent, had come to the county hospital because they had been refused care as Medicaid patients by private physicians. Three physicians told us that they refused to accept Medicaid beneficiaries as new patients or had set maximum limits on the number of Medicaid patients they would treat.

A group practice comprising 28 physicians refused to accept any Medicaid beneficiaries as new patients and sent letters advising them to find private physicians elsewhere or go to county hospitals. Members of the medical group advised us that this action was provoked by the December 15, 1970, cutback in Medicaid fees. Although the Medicaid fee cutbacks were rescinded on July 1, 1971, the physicians in the medical group said they planned to continue to reject

Medicaid patients and refer them to county hospitals because they felt the cutback was just one example of many arbitrary and inequitable administrative practices of that program.

County hospitals have made special efforts to accommodate minority-group patients

Although county hospitals have made special efforts to accommodate patients of minority groups from surrounding areas, some private hospitals have done very little to accommodate them or to meet their special needs once admitted. Also patients of minority groups are often unaware of their eligibility to obtain services at private hospitals under the Medicare and Medicaid programs.

The administrative director of the largest county hospital advised us that officials at that hospital recognized the importance of meeting the special needs of minority groups--such as language and cultural differences--and had taken action to provide specialized services. For example, at that hospital all departments were provided with a directory showing the location of members of the staff who--in addition to their regular hospital duties--serve as foreign language interpreters for 37 languages. The hospital was also conducting an experimental project of setting aside one entire floor of the building to serve East Los Angeles residents--most of whom are Spanish surnamed--by staffing that floor with many Spanish-speaking physicians and other health personnel. This project was being funded, in part, by Federal grant funds of about $1 million from the Office of Economic Opportunity and the Department of Housing and Urban Development.

Both county hospitals we visited--which had large percentages of minority patients (see p. 61)--had public information brochures containing pictures of minority-group staff and patients. On the other hand, a private hospital we visited--in an area where about 38 percent of the residents were members of minority groups--had only about 13 percent minority patients at the time of our visit. The administrator told us that the hospital was only 50-percent occupied and needed additional patients but had tried very little to attract or provide special services to members of

minority groups. According to OCR officials, even recognizing that patients generally cannot gain admittance to private hospitals without physician referrals, public statements by those hospitals of their nondiscriminatory policies are healthy reminders to the community and hospital staffs.

Reasons given by 39 patients (see table on p. 51) whom we interviewed for using county hospitals were, as follows (most patients gave more than one reason):

	Number of patients responding
Were not aware that Medicare or Medicaid coverage was accepted at private hospitals	21
Preferred hospital because of familiarity from previous use	11
Preferred hospital because they believed it would provide the best available care	5
Preferred hospital because it was convenient	3
Had no money and knew these hospitals would treat them	8
Referred to a county hospital or denied service by a private physician or health facility	14
Referred to hospital by someone else	4
Brought to hospital by government-owned ambulance	4

According to a representative of the Los Angeles County Department of Public Social Services--the agency responsible for determining eligibility and enrolling individuals in the Medicaid program--at the time of enrollment, recipients were given several brochures explaining the program's benefits including hospitalization services available. However, we noted that a brochure still being provided to recipients as late as August 1971 contained information indicating that a recipient could not stay in a noncounty hospital for more than 8 days, a provision which had been revoked in April 1970.

Regional OCR officials are aware that many minorities are using county rather than private facilities. This, in their opinion, is tantamount to the concept of separate but

equal facilities and is not appropriate. The officials offer the following comments: Major changes are needed in the Medicaid program to make the same level and quality of medicine available to all. In gaining access to the health system, discrimination against the poor is prevalent but cannot be dealt with by OCR under title VI. Past racial discrimination in such areas as employment and housing have placed members of minority groups in an economically disadvantaged position and, as a consequence, in a poorer state of general health. To deal with the subtle forms of discrimination existing today, it may be necessary to modify the law so that instances such as gross underrepresentation of minority patients in a hospital compared with community population are considered prima facie evidence sufficient for OCR to compel a facility to take affirmative action to increase the number of its minority patients or demonstrate why more minority patients are not served.

CHAPTER 7

SCOPE OF REVIEW

Our review was made to determine the extent to which HEW enforces the provisions of title VI of the Civil Rights Act of 1964. We examined the procedures and practices OCR follows to enforce title VI including (1) making initial title VI clearance for hospitals, ECFs, and nursing homes wanting to participate in the Medicare or Medicaid programs, (2) making continuing compliance reviews of these institutions, (3) monitoring the State agencies' reviews of hospitals and other facilities requiring title VI compliance, and (4) investigating complaints of title VI violations.

Our review was made during the period May through October 1971, at the OCR headquarters in Washington, D.C., and at three OCR regional offices in Atlanta, Georgia; Chicago,Illinois; and San Francisco, California. We visited 66 hospitals, 41 ECFs, and two nursing homes participating in the Medicare and/or Medicaid programs in the Atlanta and Birmingham areas, in Wayne County, and in Los Angeles County.

At the OCR offices, we reviewed assurance-of-compliance statements received from hospitals and ECFs, investigation reports of civil rights complaints, and reports of the activities of State agencies assigned the responsibility for reviewing title VI compliance. At each of the hospitals and other facilities, we obtained admission policies and a patient census, interviewed administrative and admitting personnel, and made a tour of the institution to see if any signs of discrimination were visible. We interviewed 79 physicians, 48 nurses, 80 patients, and representatives of 73 interested organizations including civil rights groups, medical societies, and community service organizations regarding the availability and quality of medical treatment and services afforded to minority patients, as follows:

27-401 O - 74 - 18

	Number of			
	Physicians	Nurses	Patients	Organization officials
Atlanta	15	21	14	8
Birmingham	10	–	7	9
Wayne County	10	–	20	22
Los Angeles	44	27	39	34
Total	79	48	80	73

The 73 organizations contacted in our review were, as follows:

Atlanta

Atlanta Medical Association
Fulton County Office of Family and Children Services
Georgia Department of Public Health
Metropolitan Atlanta Council for Health
Metropolitan Atlanta Summit Leadership Congress
National Association for the Advancement of Colored People
National Welfare Rights Organization
Prudential Life Insurance Company

Birmingham

Alabama Christian Movement
Alabama Welfare Rights Organization
Birmingham Metropolitan Council of National Association for the Advancement of Colored People
Birmingham Regional Hospital Council
Community Service Council of Jefferson County
Jefferson County Department of Health
Jefferson County Department of Pensions and Security
Jefferson County Medical Society
Mineral District Medical Society

Detroit

Black Medical Society, Wayne State University
College of Nursing, Wayne State University
Committee on Hospital Utilization
Community Relations Service, Department of Justice

Detroit City Health Department
Detroit Community Relations Committee
Detroit Urban League
Eastside Voice of Independence
Greater Detroit Area Hospital Council
Indians North American Foundation
Lafayette Clinic, Wayne State University
Latin Americans for Social and Economic Development
Medical Committee for Human Rights
Michigan Civil Rights Commission
Michigan Nursing Home Association
Michigan State Medical Society
National Association for the Advancement of Colored People, Hospital Committee
School of Public Health, University of Michigan
United Community Service
Wayne County Medical Society
Welfare Rights Organization
Wolverine State Medical Society

Los Angeles

Black Nurses Recruitment Program
Blue Cross of Southern California
California Medical Association
California Department of Human Resources Development
California Department of Public Health
California State College at Los Angeles, Nurses Training Program
Council on Bio-Medical Careers
Council of Black Nurses
Charles Drew Medical Society
Drew Post Graduate Medical School
East Los Angeles Health Task Force
Economic and Youth Opportunities Agency
Harbor Health Task Force
Joint Commission on Accreditation of Hospitals
Los Angeles County:
    Department of Hospitals
    Department of Public Social Services
    Health Department
    Department of Mental Hygiene
Los Angeles County Medical Association
Los Angeles Urban League

Medical Committee on Human Rights
National Association for the Advancement of Colored People
National Medical Association
Regional Medical Programs
Rio Hondo Health Task Force
Security Pacific National Bank (Economic Research Department)
Southern California Comprehensive Health Planning Council
Commission on Civil Rights
Equal Employment Opportunity Commission
Department of Commerce, Bureau of the Census
Department of Housing and Urban Development, Model Cities Program
Department of Labor, Bureau of Labor Statistics
United Way
Welfare Planning Council

APPENDIX I

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON THE JUDICIARY
WASHINGTON, D.C. 20515

June 3, 1971

The Honorable Elmer B. Staats
Comptroller General of the United States
General Accounting Office Building
Washington, D.C. 20548

Dear Mr. Staats:

In the interest of fulfilling the Committee's oversight responsibilities with respect to civil rights legislation, we are planning to examine the enforcement of Title VI of the Civil Rights Act of 1964 with respect to selected Federal programs. To assist the Committee in this endeavor, we would appreciate having the General Accounting Office make a review and provide a report on certain aspects of the Hill-Burton health facilities construction and modernization program and the Medicare-Medicaid programs of the Department of Health, Education, and Welfare.

With respect to the Hill-Burton program, it is requested that your Office review the policies and practices followed by the Department of Health, Education, and Welfare and selected State agencies in: 1) establishing service planning areas in formulating the State plans for facilities construction; and 2) approving construction projects--to determine if there are inherent factors in performing such functions which may make it difficult for certain communities to obtain Federal funds for health facilities, particularly where the communities may be largely composed of minority groups. For example, we would be interested in: 1) an evaluation of the criteria used in establishing State-wide service planning areas under the Hill-Burton program; and 2) an analysis of the composition of service areas with consideration given to the location of medical facilities and minority areas; and 3) an explanation as to why priority areas may have been passed over in approving construction projects.

APPENDIX I

With respect to the Medicare-Medicaid programs, the Committee would be interested in an analysis of available data in selected areas in order to obtain information as to whether the benefits of the Medicare and Medicaid programs are being made available to minority groups to the same degree as to others. In this regard, examination into the Department of Health, Education, and Welfare's Office of Civil Rights compliance monitoring activities might be helpful in determining whether hospitals, extended care facilities, and nursing homes participating in the Medicare and Medicaid programs are complying with Title VI.

These matters have been discussed with your staff. Any other suggestions you or your staff may have in fulfilling our objective will be appreciated.

Your report on these programs would be most helpful if it could be available to the Committee by December, 1971.

Sincerely yours,

Emanuel Celler
Chairman
House Committee on the Judiciary

EC:jh

APPENDIX II

PRINCIPAL OFFICIALS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE RESPONSIBLE FOR THE ADMINISTRATION OF THE ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
Elliot L. Richardson	June 1970	Present
Robert H. Finch	Jan. 1969	June 1970
Wilbur J. Cohen	Mar. 1968	Jan. 1969
John W. Gardner	Aug. 1965	Mar. 1968
DIRECTOR, OFFICE FOR CIVIL RIGHTS:		
J. Stanley Pottinger	Feb. 1970	Present
Leon Panetta	Mar. 1969	Feb. 1970
Dr. Lloyd Henderson (acting)	Jan. 1969	Mar. 1969
Mrs. Ruby Martin	Apr. 1968	Jan. 1969
F. Peter LiBassi	Jan. 1966	Apr. 1968
COMMISSIONER OF SOCIAL SECURITY:		
Robert M. Ball	Apr. 1962	Present
ADMINISTRATOR, SOCIAL AND REHABILITATION SERVICE:		
John D. Twiname	Mar. 1970	Present
Mary E. Switzer	Aug. 1967	Mar. 1970

U.S. GAO, Wash., D.C.

Appendix 2

Leadership Conference on Civil Rights,
Washington, D.C., October 2, 1973.

Hon. Jerome Waldie,
U.S. House of Representatives,
Cannon Office Building, Washington, D.C.

Dear Congressman Waldie: At the hearing on September 24, 1973, during the testimony of the witnesses from the American Public Health Association, you indicated that you were interested in information demonstrating racially discriminatory practices other than in the South. After the hearing I indicated to you that I did have such information, including information from Los Angeles County, and would send it to you. Please consider the following:

The Los Angeles County data to which I refer was gathered in a one week survey of all California hospitals by the Regional Medical Program in March 1968. I arranged to have certain information extracted from the data tapes, relating to service to the poor (including MediCal beneficiaries) and minorities from Los Angeles County. A similar study exists for a one week period in March 1970, but the RMP program refused to permit me to obtain the similar information in 1970 because they "contracted" with the hospitals not to release the information on a per hospital basis.[1] A public health student working for my program extracted certain studies and made charts for me from the "programs" run on my directions.

One of the program runs which he charted involved the number of black and Mexican-American patients as a percentage of total admissions in 21 Hill-Burton hospitals in Los Angeles County for that week. The reason Hill-Burton hospitals were selected stems from the fact of their construction under that Federal program, with the obligations not to discriminate on the basis of race (See *Simkins* v. *Moses Cone Memorial Hospital*, 323 F.2d 959), to afford a reasonable volume of service to persons unable to pay (See *Euresti* v. *Steiner*, 458 F.2d 1115; *Cook* v. *Ochsner*, 319 F. Supp. 603), and to afford services to all persons in the territorial area of the facility. (The latter requirement has recently been interpreted by the Court in a later stage of the *Cook* case to require participation by Hill-Burton hospitals in the Medicaid program.)

The racial census for the 21 hospitals for that one week period in March 1968 was as follows:

---

[1] The RMP program, as you are aware, is federally-funded. It appears unconscionable to us that data it collects can be restricted by a private agreement with hospitals, themselves constructed with public money and/or tax exempt and/or licensed by the State to perform a community function. The 1970 data would have been most important for several reasons to us: (1) the information as to race and payment mechanism was more exact; (2) Harbor General did not give this data to the 1968 survey, thus seriously limiting an over-all analysis of comparing service in non-profit and public hospitals; (3) comparative as well as more recent data might confirm or clarify many of our suspicions as to the practices at these hospitals.

Hospital	Total admission	Total black and Chicano	Percentage minority
Glendale Adventist	297	8	3.7
White Memorial	270	122	45.1
Presbyterian Intercommunity	143	0	0
Bev. Comm., Montebello		(1)	
Little Co. Mary	226	12	5.3
Memorial Hospital, Long Beach	501	24	4.8
California Hospital, Los Angeles	319	94	29.5
Inter. Comm. Hospital	251	0	0
Memorial Hospital, Glendale	180	0	0
St. Luke	176	13	7.4
Huntington Memorial	319	18	5.6
Cedars	302	18	5.9
Sinai	181	1	.5
St. John's	307	4	1.3
Holy Cross		(1)	
St. Monica	284	14	4.9
St. Joseph's	432	0	0
Centinela Valley	206	1	.4
Daniel Freeman	263	17	6.4
Valley Presbyterian	235	0	0
Queen of Angels	293	51	17.4
St. Francis	447	25	5.6

[1] No data.

As you are well aware, Los Angeles County is enormous, with unincorporated areas and separate cities interspersed with Los Angeles City. The projected population figures with which we were working in 1970 showed some 7 million people in the County, some 752,727 of whom were black (or 10.8%) and 2.8 million in Los Angeles City, some 503,606 black (or 17.9%). Note that only two of the Hill-Burton hospitals on this list (White Memorial and California Hospital) had a greater percentage of minority patients (black and Mexican-Americans combined) than the City population of blacks, and only one other (Queen of Angels) had a greater percentage of combined minorities than the black percentage for the City.[2]

While some of these hospitals may be in areas which have only a small minority population, many are near areas which have a large minority population, and still serve very few minorities. For example, note that Huntington Memorial which is located in Pasedena, served a minority population which was only 5.6%. When we look at only its black patients, the percentage was 3% minority. In 1970 the black population of Pasadena was 16% of that City's total population, and combining the populations of Pasadena and Altadena,[3] the black percentage was 18%. During that one week in March 1968, 13% of the patients from this area in all hospitals were black. (There were 449 patients, 353 white and 60 black). Of the 353 white patients, only 13 went to L.A. County General Hospital, but of the 60 black patients, 28 went to L.A. County General.

Inglewood had a population 11.2% black. The two Hill-Burton hospitals in Ingelwood had a very small percentage of black patients: Centinela Valley had only 1 out of 206 (or 0.4%) and Daniel Freeman's had a combined minority population of 17 out of 263 total patients (a maximum of 6.4%, all 17, thus being black).

[2] I am preparing this letter from the data extracted in reports by my student assistant. The basic print-outs I purchased are available. One of these demonstrates the great distance the poor on Medi-Cal travel, from all over the county, to L.A. County General.

[3] Altadena, contiguous to Pasadena, has a population over 27% black. It had one small (22 bed) non-profit hospital (Altadena Community) which had no black patients that week. In addition to Huntington Memorial (with 385 beds) Pasadena had one 86 bed non-profit (Pasadena Community) which had a 9% black patient census, one 125 private, largely long term facility (Las Encina) with no black patients, and St. Luke's, a 161 bed non-profit, with 6% of its patients that week being black.

Since these reports were prepared the 1970 census has become available, and it is possible for us to prepare an analysis of the census tracts from which all these 21 hospitals constructed with Federal funds drew their patients that one week, as well as the census tracts which are a reasonable travel distance to the hospitals. Of course, it would be even more helpful if RMP would permit us to purchase the 1970 data and any similar data from more recent surveys.

Los Angeles is not the only Northern City which has an extensive amount of available data to analyse hospital service to minorities. Over the years numerous studies have been done of the Chicago and Cook County area. One of the many studies to which I would refer you is "Slum Medicine: Chicago's Apartheid Health System," DeVise et al., Community and Family Study Center, University of Chicago, Jan. 1, 1969. It (and other more recent studies in the Chicago area) demonstrate a similar pattern as I discerned from the incomplete data I had from Los Angeles. Black patients travel a far greater distance, even when they are able to pay (personally or under the Medicaid program) and are treated by a very few hospitals. The question such a dual hospital system presents, both in the South and the North, is what are the obligations of OCR, and its parent HEW, to change this picture.

I hope this letter gives you at least some of the information you requested. The Office for Civil Rights could, of course, obtain far more data, from a greater number of cities, both from its official position and the size of its health and welfare staff, i.e. 89 positions as compared to the less than one position[4] on the NHeLP staff which has been devoted to the subject.

Sincerely yours,

MARILYN G. ROSE.

LEADERSHIP CONFERENCE ON CIVIL RIGHTS,
Washington, D.C., January 8, 1974.

Hon. MCCLORY,
U.S. House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN MCCLORY: After I testified at the hearings in September 1973 on the practices of HEW in the area of enforcement of Title VI of the Civil Rights Act of 1964, I sent to you certain materials you requested concerning the identification of Chicago area hospitals running away to the suburbs. At that time I wrote to the Chicago Lawyers' Committee, which was involved with meeting the problems engendered by that run-away, in order to ascertain the current status of the matter. I have received the enclosed letter, and transmit it to for your information.

Sincerely yours,

MARILYN G. ROSE.

COMPREHENSIVE RESEARCH AND DEVELOPMENT,
Chicago, Ill., December 10, 1973.

MARILYN ROSE,
National Health Law Program,
Washington, D.C.

DEAR MS. ROSE: I'm really very sorry to have taken so long in answering your letter. The information requested by Congressman McClory is as follows:

St. George Hospital Corporation—for its part—agreed under pressure from H.E.W. to admit some blacks to its board, to do long-range planning jointly with the community organizations, to meet civil rights law hiring and promotion standards through an affirmative action plan, and, most important, to resume the expansion plan for Englewood Hospital (the plan that had been cancelled in 1969).

St. George's agreements were negotiated during 1972, and announced in early 1973. The Lawyers Committee for Civil Rights Under Law rendered invaluable assistance in this process.

---

[4] In four years a very small percentage of my time, with some student assistance, has been involved with the pure question of racial discrimination as a barrier to access for the poor into the health system. My imagination "runneth over" with what I would do with 89 positions devoted to the subject.

For its part the State of Illinois agreed to make inner-city hospital modernization the top priority for Hill-Burton funds and to require community representation on boards of hospitals that receive Hill-Burton grants. There is only one loose end—the state still has not reformed its planning method so that south side poverty areas and well-off southwest suburbs are still included in the same planning area. Several hospital construction proposals for the southwest suburbs are currently pending and they may benefit as St. George did in 1969 from this anomaly of the Plan. (To be clearer—that planning area has a large "bed need" because of the hospital shortage in the inner-city part of the area but the expansion proposals are for the suburban part).

We would be willing to supply Rep. McClory with further details if he wishes.

Yours very truly,

EDWARD L. PALMER.

LEADERSHIP CONFERENCE ON CIVIL RIGHTS,
Washington, D.C., September 24, 1973.

Hon. DONALD EDWARDS,
Hon. ROBERT MCCLORY,
Civil and Constitutional Rights Subcommittee, House Committee on Judiciary, Rayburn Office Building, Washington, D.C.

DEAR CONGRESSMEN EDWARDS AND MCCLORY: As promised to Congressman McClory on September 17, 1973 with reference to the Illinois "run-away" hospital situation which I described in my testimony, I am enclosing copies of a complaint filed by a consumer organization and two newspaper articles describing the situation.

Sincerely yours,

MARILYN G. ROSE,
Chairperson, Health Task Force.

Enclosures.

COMPREHENSIVE RESEARCH AND DEVELOPMENT,
Chicago, Ill., January 26, 1972.

RICHARD FRIEDMAN, *Regional Director,*
FRANK ELLIS, *Public Health Service,*
U.S. Department of Health, Education, and Welfare, 300 South Wacker Drive, Chicago, Ill.

DEAR SIRS: Attached is a letter containing a complaint and request for action concerning the distribution of Hill-Burton funds to Palos Community Hospital and the Illinois Hill-Burton Plan on which the grant is based. We are requesting a full hearing and a suspension of further payments because the grant and Plan are incompatible with federal Hill-Burton rules.

We are also attaching a full study of the "Hospital Facilities Crisis in South Central Chicago", and appendices as follows:

I. Tables showing the residence and race of patients discharged from South Central area hospitals; the population data for the South Central communities; hospital utilization of South Central area residents; and population of the Hill-Burton planning area in question.
II. Maps of the COMPRAND planning area and the Hill-Burton planning area.
III. The Englewood Hospital-St. George's Hospital merger document.
IV. An excerpt from the Palos Community Hospital Hill-Burton application.
V. Membership list of the Illinois Advisory Hospital Council.

The Consumer Assembly is the formally constituted body representing health consumers in COMPRAND, the recognized sub-area Comprehensive Health Planning Agency for far south side Chicago.

Yours truly,

Rev. KEITH DAVIS,
President, Consumer Assembly.

CONSUMER ASSEMBLY,
COMPREHENSIVE RESEARCH AND DEVELOPMENT,
Chicago, Ill.

RICHARD FRIEDMAN, *Regional Director,*
FRANK ELLIS, *Public Health Service,*
Department of Health, Education, and Welfare,
Chicago, Ill.

DEAR SIRS: The Consumer Assembly of Research and Development (COMPRAND), a recognized sub-area health planning organization, submits to you the following complaint and request for action:

Hill-Burton funds are being distributed to Palos Community Hospital under conditions incompatible with § 291c(a)(3) of Subchapter 4 of The Public Health Service Act (42 U.S.C. § 291c(a)(3); Regs. § 53.12 of Part 23-2 of the Health Grants Manuel; and §§ 2000d et seq. of the Civil Rights Act (42 U.S.C. §§ 2000d et seq.). COMPRAND requests a full hearing concerning this matter and a suspension of further payments to Palos Community Hospital until this matter is resolved.

In April and June of 1969, St. George Hospital, 449 Winnecona Parkway, Chicago, Illinois, applied for Hill-Burton funds to construct a replacement facility to be known as Palos Community Hospital and to be located in Palos Heights, Illinois. A grant of $840,000 was made pursuant to this application and an additional grant of $168,000 was made pursuant to a revised application submitted in December of 1969. St. George is located in the south central area of Chicago which has a non-white population of 88.2% as of 1970 (of which the vast majority is Black) and a median income of $7,518 per family, and Palos Community Hospital is being built in Palos Heights which has a non-white population of less than 1% and a median income $11,392. The population density of the area in which St. George is located is far higher than that of Palos Heights. The site of Palos Community Hospital is 13 miles from that of St. George Hospital. Data for these claims is drawn from the following studies of the Hospital Planning Council for Metropolitan Chicago: A Profile of District 4 (1965), and Discharge Study (1970).

COMPRAND Consumer Assembly is seeking to improve health care facilities in South Central Chicago. The closing of St. George Hospital which has functioned at 77% of capacity and which draws 61% of its patients from the COMPRAND area (see attached map) would markedly decrease the facilities available to the people in this area. Palos Community Hospital, the "replacement" facility, is 13 miles away and County Hospital, where many patients from this area go already, is over an hour away by public transportation and already has severely strained facilities.

Use of federal funds to facilitate a move from a densely populated low income urban area to a sparsely populated middle income suburban area is contrary to 42 U.S.C. § 291 c(a)(3) which provides:

> "The Surgeon General, with the approval of the Federal Hospital Council and the Secretary of Health, Education and Welfare, shall by general regulations provide—
>
> (a) The general manner in which the State agency shall determine the priority of projects based on the relative need of different areas lacking adequate facilities of various types for which assistance is available under this part, giving special consideration * * *
>
> (3) In the case of projects for modernization of facilities, to facilities serving densely populated areas * * *."

St. George was able to justify the construction of Palos Community as a replacement facility because they are in the same planning area: Area 4.

However, this area is unrealistically large, extending from the Adlai E. Stevenson Expressway on the north to Palos Park, Palos, Robbins, and Blue Island on the south, and from Archer Avenue on the west to Halsted and State Streets on the east; it has a 1970 population of 906,401 persons. A map and census summary are appended. The 1960 population of Area 4 was almost totally white. Such boundaries clearly violate Regs. Sec. 53.12 in Part 23-2 of the Health Grants Manual which provides:

> The Service area is a very important factor in planning, and should be outlined with care. It should not be too large in area and should not contain too many diversified hospital communities. On the other hand, it should contain sufficient population and at least one community large enough to support a desirable minimum size facility * * *. Patient source data are extremely valuable and serve as the springboard for delineation of service

areas. Conclusions reached through the application of patient origin data must frequently be adjusted to compensate for inequities arising from the existing pattern of facilities. Studies of the socio-economic, trade, geographic, transportation and time distance, and other factors should also be considered in adjusting area boundaries * * *. Area boundaries should not be established to coincide with city, town, or county lines unless such political subdivisions represent the most logical service areas for planning health facilities and services.

(Compare page 39 of the Illinois State Survey and Plan for the Construction of Hospitals and Medical Facilities Fiscal Year 1971:

"Area boundaries should follow established boundaries of governmental units or of defined census-taking units so that accurate population and other demographic and socioeconomic data can be readily compiled.)

Moreover, St. George Hospital is not even located within this oversized planning area, but was included in it, without consideration of its surrounding population, for planning purposes only.

Federal funds then are being disbursed pursuant to a State plan which is wholly inconsistent with Federal standards. The misshapen area map is the basis on which state-administered federal funds are being used to help a hospital move out of a Black area where the majority of its patients now come from, into a White area which is geographically inaccessible to most of its patients. We submit that this constitutes a denial on account of race of the benefits of a program receiving federal financial assistance and is therefore also a violation of § 2000d of the Civil Rights Act (42 U.S.C. § 2000d). We ask (1) that a hearing be held as soon as possible to determine whether Hill-Burton funds should have been granted for Palos Community Hospital and (2) that until such a determination is made, no further funds be dispersed under that grant.

Respectfully submitted,

Rev. Keith Davis,
Chairman, Consumer Assembly,
Otis Flynn,
Herbert Odom, D.D.S.,
for Englewood branch, Consumer Assembly.

Hospital Facilities Crisis in South Central Chicago

(A Report for the Consumer Assembly of COMPRAND—The Comprehensive Health Planning Agency for the Far South Side)

Recently uncovered evidence indicates that two South Side hospitals have engaged in a series of transactions involving millions of dollars that:

1. Deprive the community of badly needed hospital services and medical personnel.
2. Use profits accumulated from providing health care to South Side residents to construct a new hospital in the suburbs while closing needed facilities on the South Side.
3. Misuse Federal tax revenues in a highly irregular transfer of federal funds originally designated to be used for the renovation and improvement of an inner-city hospital facility.

Evidence also suggests that the State of Illinois and Federal Hill-Burton agencies cooperated in transferring the $1,008,000 approved for sorely needed renovation at the inner-city Englewood Hospital to assist construction of the suburban Palos Community Hospital. Gerrymandering of Hill-Burton planning areas made this possible.

The hospitals, St. George and Englewood, are operated by the Order of the Hospitals of St. Joseph, headquartered in Canada. It is interesting that both of these hospitals had, until recently, considerable experience with community complaints that they discriminated against non-whites. The corporation which operates these hospitals is building its new facility on a hill surrounded by lush woods in the midst of the sparsely populated southwest suburbs, far from the people of the inner-city ghetto.

St. George, one of the few hospitals serving the south central community of Chicago, will soon shut its doors and cut off services to the residents of this area. It is an old, outmoded facility. Instead of being replaced by expansion

and modernization of Englewood Hospital, which at one time had expansion plans and dropped them, it is being "replaced" in Palos Heights.

The St. George Hospital is building Palos Community Hospital in the far southwest suburbs, but is justifying it partly as a "replacement" for St. George. Federal hospital construction grants under the Hill-Burton program have been awarded to the Palos project, with the replacement justification a key to that award. Nevertheless, St. George serves a population of Chicago's South Side that is primarily black and suffering from a desparate shortage of hospital and other medical resources. The real "replacement" for St. George will inevitably be an added burden on over-taxed inner-city hospitals, including Cook County and the few that still remain in south central communities.

This hospital closing raises fundamental issues for health planning in Chicago and nationally, gut issues that the people of the South Side will demand be resolved. They are:

1. Community participation in decision-making about hospital facilities—the annual state hospital licensing process, the health planning process, and decision-making by the boards of directors of the particular community hospitals.

2. Reversal of inequitable procedures of the Federal Hill-Burton program—gerrymandered Hill-Burton planning areas which presently allow a facility in the far suburbs to be considered a replacement for inner-city beds . . . negligence on the part of the federal agency in the review of state grant procedures.

All involved in the decisions which have brought about removal of St. George resources to the suburbs must answer to the community—to put all the facts on the table, to rectify the situation and to insure that it is not repeated elsewhere. Responsible parties certainly must include members of the St. George Hospital Corporation board of directors, and the federal and state Hill-Burton agencies. There is no representation for inner-city minorities on the State Hospital Advisory Council, which has made the decisions on the state plan and the specific grants outlined here. The "review and comment" agency which gave the go-ahead to the Palos project was the Northeastern Illinois Planning Commission—a historically suburban oriented agency which is guilty of agreeing to a plan which relocates needed inner-city health care facilities in the midst of affluent suburbia, a location with little or no access by public transportation and almost totally inaccessible to the population it should serve if it is *in fact* a replacement facility.

Others who should be reacting to these disclosures include the planning agencies which play a role in hospital licensing and facilities planning: the state Department of Public Health licensure branch, the Chicago Hospital Council, the Joint Commission on Accreditation of Hospitals, the Health and Hospitals Governing Commission of Cook County, and the state and regional Comprehensive Health Planning agencies.

It is often said in defense of hospitals departing for the suburbs that the "patients have moved first, the physicians have followed them, and the hospitals can't operate without medical staff." As the south central area has undergone racial change in the past 20 years. St. George and other hospitals have made the transition to serving a predominantly black patient population.

Fully 61% of St. George patient discharges, as reported by the authoritative study of all hospital discharges in February 1970 (see Table 1, attached), are drawn from the far South Side planning area, known as COMPRAND. A slight majority of St. George patients are black (Table 2). Nevertheless, to an alarming extent, residents of these neighborhoods are forced into the overcrowded facilities of Cook County Hospital (almost as large a number of patients use County as use the six nearest community hospitals—Table 4).

The departure of St. George can only aggravate that situation. It cannot be emphasized too strongly that County Hospital operates near or at capacity, and marginal increases in its burdens can have catastrophic effects. Moreover, the community has no guarantee of continued operations from the remaining hospitals, with exception of St. Bernard where expansion plans have been drawn and reviewed favorably by community planning organizations.

Although St. George Hospital was an old and deteriorating facility, its 11,500 emergency room cases in 1970, an increase of 16 percent over the previous year, and its over 80 percent annual occupancy rate for its 122 beds, show that the services provided by the hospital were vitally needed in the community.

In its rationale for closing, the St. George Hospital administration indicated that its patient load could be carried by its sister hospitals, Englewood Community and St. Bernard. Without the additional weight of the St. George case load, St. Bernard had a patient load increase of about 13 percent over the past two years, with a 12 percent increase over the 1969 figure and a 14 percent increase over 1968. In 1970, St. Bernard Hospital treated more than 23,149 emergency cases.

According to its own publicity information, St. Bernard's operated at better than 86 percent occupancy for its 200 beds with an average patient stay of 12.8 days. Construction of the edifice which houses St. Bernard's Hospital was completed on November 21, 1905.

Englewood Hospital, 6001 South Green Street, is the oldest hospital in Englewood, having been organized in 1894, in a converted apartment house in the community. The present building was erected in 1905. The hospital currently has 169 beds and an average medical-surgical and pediatric occupancy in excess of 90 percent. Englewood Hospital had 9,570 Emergency Room cases in 1970, of which 1,130 resulted in hospital admissions. Figures for 1971 are expected to reveal even higher rates. Financial data indicates that Englewood has operated quite profitably over the past few years. In fact, the hospital has done so well that it was able to transfer at least $750,000 from its reserves to further construction of the Palos hospital.

HISTORY OF THE CLOSING OF ST. GEORGE

1. In July, 1968, Englewood Hospital applied for Hill-Burton assistance for modernization and expansion.

2. On January 20, 1969, a telegram was sent to the hospital notifying it of the State Department of Public Health acceptance of their application. A tentative grant of $1,008,000 was awarded, subject the concurrence of Hill-Burton officials at the regional office of the U.S. Department of Health, Education and Welfare. Federal approval has invariably been given to state grant decisions.

3. Eight days later, on January 28, the Board of Directors of St. George authorized application to Hill-Burton for a grant to aid the construction of Palos Community Hospital. The application for Palos was submitted in April, and stated St. George would close when Palos opens.

4. On June 23, 1969, when St. George submitted a supplementary application for the Hill-Burton funds, it also submitted a letter from Englewood Hospital declaiming its intent to merge with St. George. There is no indication of how long merger discussions had been going on, but it can be assumed that the topic had been discussed for some considerable time. That supplementary application noted that $1,500,000 "income earned during construction" through the regular operations of both Englewood and St. George (half from each) hospitals would be transferred to meet construction costs at Palos.

5. In October, the Hill-Burton grant for Palos was awarded in the amount of $840,000.

6. On December 15, the merger of Englewood into St. George was consumated. St. George acquired the assets and assumed the debts of Englewood, which operated subsequently as the Englewood Hospital Division of St. George. The merger agreement provides explicitly that the merged corporation would continue to operate both hospitals, contingent only on an adequate supply of patients (agreement is attached in appendix). However, on January 13, 1970, St. George officials reaffirmed to the state their firm intent to close.

7. The construction contract for Palos was also signed on December 15, (with a target date for completion of June 23, 1971.)

8. On December 29, 1969, a revised Part 2 application was submitted for supplementary Hill-Burton support. It indicated a further transfer of $90,000 from Englewood Hospital Division accounts toward Palos construction costs.

9. On April 2, 1970, the State agency approved an additional grant for Palos of $168,000, bringing the total for Palos to the exactly identical amount which was to have been granted for modernization of Englewood Hospital, i.e. $1,008,000.

10. To date, three installments of the $1,008,000 have been paid, with one final check for $252,000 as yet unpaid. It will presumably be requested early in February 1972.

As a result of the merger into St. George, Englewood withdrew its application for Hill-Burton money for modernization. Although in a formal sense it is not that original $1,008,000 that is now being spent at Palos, in reality Hill-Burton has co-operated with the St. George-Englewood board in depriving the Englewood community of that modernization money and spending it in the affluent southwest suburbs.

It is able to do that because its grant formula is based on a gerrymandered set of maps which places Palos and the whole far southwest area in the same planning area as southwest side Chicago all the way up to Englewood. This planning area, called A–4 in the Hill-Burton plans officially is a priority, inner-city area, with first call on federal money. When the Hill-Burton area boundaries were done in 1965, St. George was located outside area A–4. Subsequently, it was added to the A–4 hospital list "For Planning Purposes" without attaching the population of its neighborhood to A–4. This arbitrary decision has allowed Palos Community Hospital to be constructed as if it were a replacement facility for St. George. Federal guidelines for Hill-Burton state that area planning should reflect actual community conditions; these have obviously been violated.

The diversion of Hill-Burton funds is only half of the story. In addition to the federal $1,008,000, over $750,000 in current operating surpluses from Englewood has been transferred with no strings attached for use in Palos construction. Thus, patients at Englewood hospital have been subsidizing construction at Palos. Only a statement from the St. George Board of Directors can give us the precise amount of cash transferred.

WHAT IS TO BE DONE

1. We call on the St. George Board of Directors to give the community a firm assurance that Englewood Hospital will not go the way of St. George; that it will remain in the community and will be modernized to meet community needs.

2. We call on the St. George Board to commit at least an amount equal to the cash transferred from Englewood operation revenues to Palos construction to be returned for modernization at Englewood.

3. We call on the St. George Board to back up their commitment to continued operation of Englewood by admitting community representation onto the Board.

4. We call on the Federal Hill-Burton agency to suspend payment of the final check to Palos on the grounds that it has been granted in line with a state plan that violates the federal guidelines for state plans, and that it convene a formal administrative proceeding to rectify the situation.

5. We call on the Federal Hill-Burton agency to order the state Hill-Burton agency to re-draw planning area boundaries to insure high priority for the South Central area of Chicago as a meaningful planning area.

6. We call on the Federal Hill-Burton agency to order the state Hill-Burton agency to revise the state plan to insure the same high priority for all inner-city areas of Chicago.

7. We call on the State Department of Public Health and the state legislature to revise annual hospital licensing procedures to take account of community needs and to force continued service of existing hospitals to their surrounding communities.

8. We call on all hospital planning agencies to provide concrete assurance to the public that their plans and proposals are responsive to the need for community hospitals in shortage areas.

CONSUMER ASSEMBLY,
Englewood Branch.

27-401 O - 74 - 19

TABLE I.—RESIDENCE AREAS OF PATIENTS DISCHARGED AT SOUTH CENTRAL HOSPITALS

CA	Englewood	St. Bernards	St. George	Evangelical	Central Community	Holy Cross
43 South Shore	12	7	8	12		
44 Chatham	10	18	18	6	1	
45 Avalon Park	4	4	1	3		
46 South Chicago	3	6	4	2		2
47 Burnside		3				
48 Calumet Heights	1	2	1			2
49 Roseland	10	5	7	8		5
50 Pullman	4	1		3		1
51 South Deering	1		1			1
52 East Side				1		
53 West Pullman	15	6	5	1		1
54 Riverdale	1	2	2	2		1
55 Hegewisch		1				
67 West Englewood	51	36	12	32	22	68
68 Englewood	108	67	20	38		6
69 Greater Grand Crossing	19	28	21	7		1
71 Auburn-Gresham	40	32	52	14	3	17
72 Beverly	3	6	7	2	1	7
73 Washington Heights	14	6	12	7		3
75 Morgan Park	4	2	4	1	2	6
Comprand area	300	232	175	139	30	120
Percent	61	62	61	42	13	11
Other Southwest side	110	63	52	131	147	708
Mid-South	19	41	9	34		2
All other	59	36	51	30	55	241
Total, all areas	488	372	287	334	231	1,072
Total, percent	100	100	100	100	100	100

Source: February 1970 Discharge Study, Hospital Planning Council of Metropolitan Chicago with support of comprehensive health planning.

TABLE II.—HOSPITAL UTILIZATION BY RACE

Hospital	White cases	Percent	Nonwhite cases	Percent	Total known cases	Percent	Unknown cases	Percent
Englewood	210	43.0	275	56.4	485	99.4	3	6.0
St. Bernard's	147	39.5	215	57.8	362	97.3	10	2.7
St. George	141	49.1	146	50.9	287	100.0		
Total	498	43.4	636	55.4	1,134	98.8	13	1.2

Source: February 1970 Discharge Study, Hospital Planning Council of Metropolitan Chicago with support of comprehensive health planning.

TABLE III.—POPULATION AND INFANT DEATH RATES, SOUTH CENTRAL COMMUNITY AREAS

Community area	Population, 1970	Percent nonwhite	Infant death rate per 1,000 live births
44 Chatham	47,287	98.0	35.1
67 West Englewood	61,910	49.0	38.6
68 Englewood	89,713	97.0	38.0
69 Greater Grand Crossing	54,414	98.5	38.5
71 Auburn-Gresham	68,854	69.1	35.7
Total (average)	321,178	82.2	37.1

Note: City average—Infant death rate 29.5 per 1,000 live births, Chicago Board of Health, 1969 occurence statistics.

Source: February 1970 discharge study, Hospital Planning Council of Metropolitan Chicago with support of comprehensive health planning.

TABLE IV.—SOUTH CENTRAL COMMUNITY AREAS PATIENT LOADS TO LOCAL HOSPITALS AND TO COUNTY HOSPITAL

	Chatham (44)	West Engle-wood (67)	Engle-wood (68)	Greater Gr. Crossing (69)	Auburn Gresham (71)	South central total
6 nearby hospitals	53	221	239	81	158	752
Cook County Hospital	72	91	332	121	86	702
All hospitals of metropolitan Chicago area	540	667	1,110	632	693	3,642

Note: 6 nearby hospitals: Englewood, St. Bernard's, St. George, Central Community Evangelical, Holy Cross.

Source: February 1970, Discharge Study, Hospital Planning Council of Metropolitan Chicago with support of comprehensive health planning.

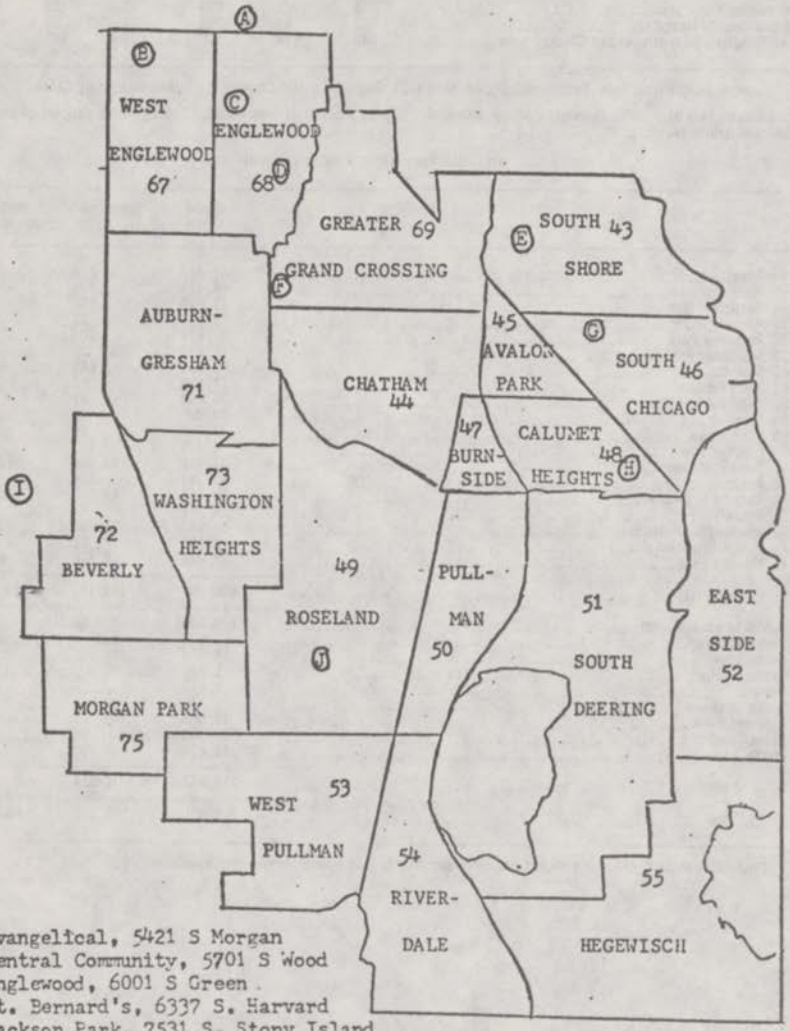
HILL-BURTON AREA 4 POPULATION

	Total 1970	Nonwhite 1970	Nonwhite change 60 to 70
49 Roseland	62,512	34,670	+21,312
53 West Pullman	40,318	6,779	+7,710
56 Garfield Ridge	42,998	3,686	+912
57 Archer Heights	11,134	23	+22
58 Brighton Park	35,618	204	+133
59 McKinley Park	15,632	36	+13
61 New City	60,817	2,645	+2,389
62 West Elsden	14,059	22	+17
63 Gage Park	26,698	41	+19
64 Clearing	24,488	64	+44
65 West Lawn	18,597	68	+51
66 Chicago Lawn	48,435	137	+84
67 West Englewood	61,910	30,246	+23,313
70 Ashburn	47,161	578	+544
71 Auburn Gresham	68,854	47,537	+47,399
72 Beverly	26,771	87	+64
73 Washington Heights	36,540	27,437	+23,661
74 Mount Greenwood	23,186	21	−2
75 Morgan Park	31,016	14,846	+5,016
Subtotal	696,744	169,127	+131,701
Lyons Township—Part	(20,654)	66	+1
Bedford Park	573		
Bridgeview	8,756		
Hickory Hills	1,827		
Justice	9,473		
South Stickney Township	25		
Calumet Park	10,069	72	+34
Palos Township	33,100	96	
Worth Township	155,834	780	+663
Subtotal	219,857	1,014	+698
Total	906,401	170,141	+132,399

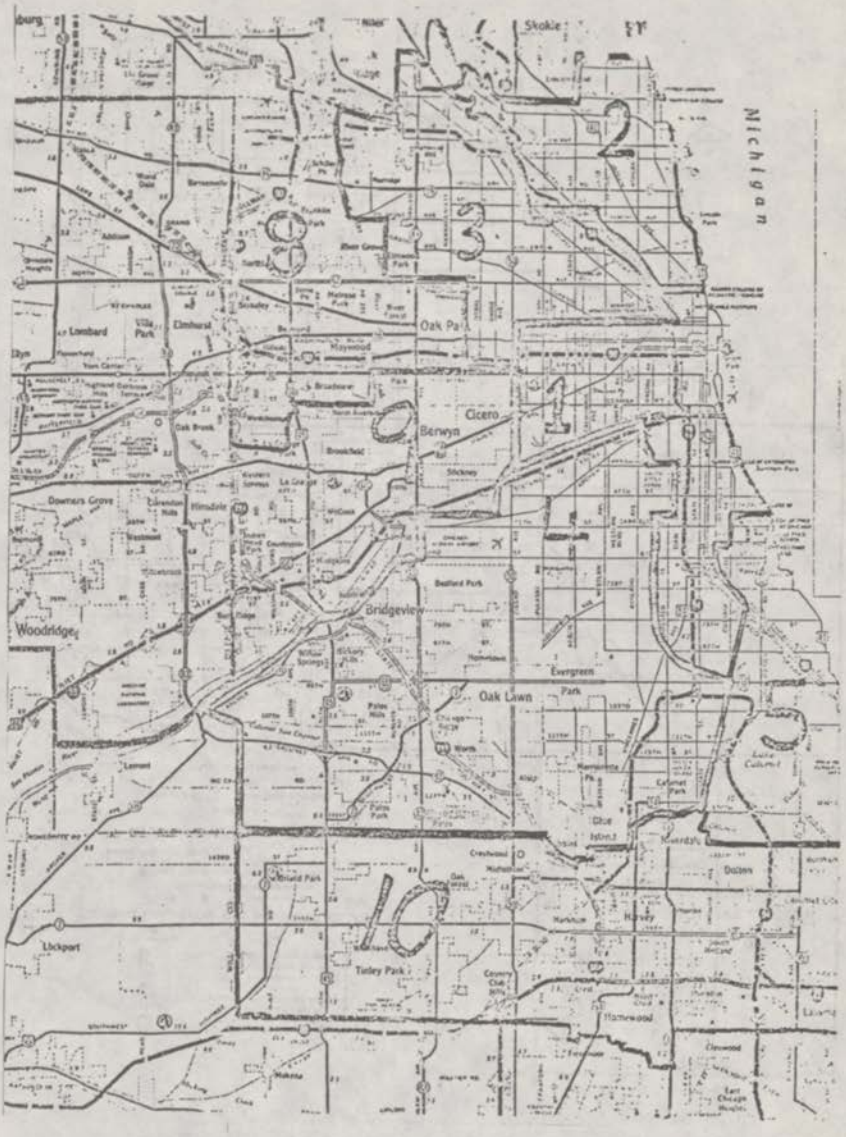
Note: Nonwhite figures for suburbs are estimates due to incomplete census data available.

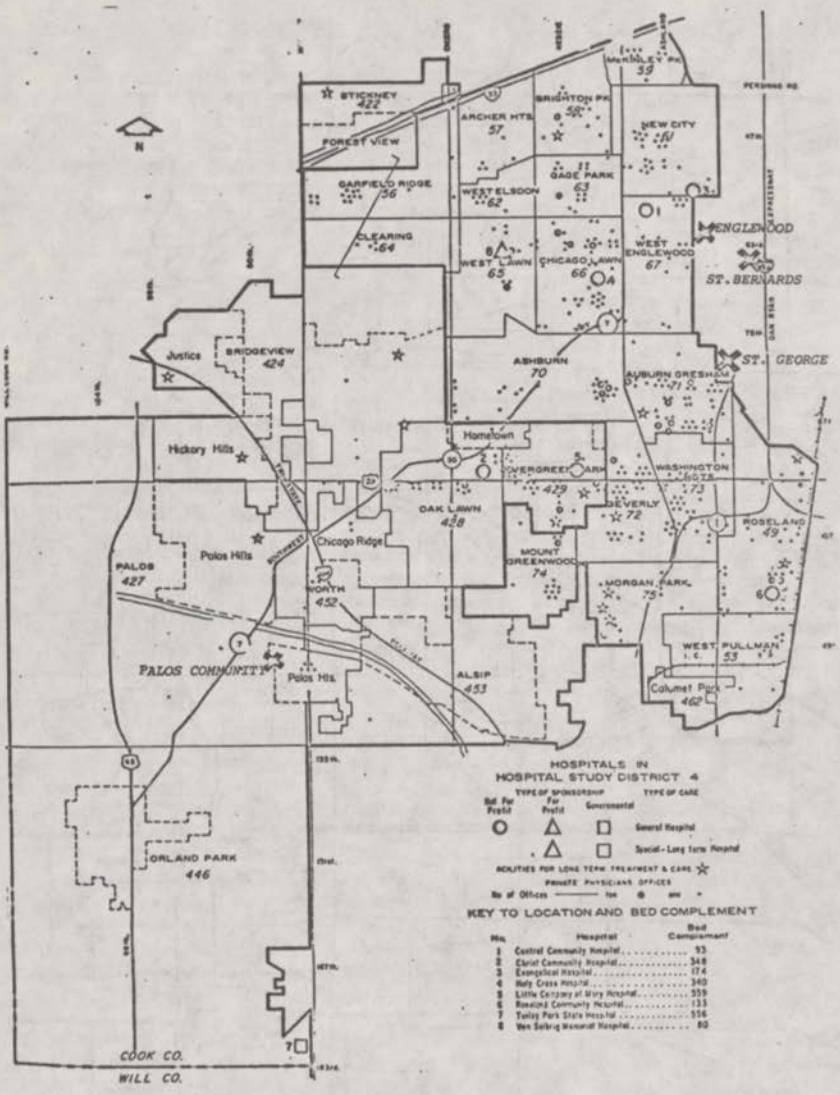
MAP OF COMPRAND AREA

COMMUNITY AREAS AND HOSPITALS



A Evangelical, 5421 S Morgan
B Central Community, 5701 S Wood
C Englewood, 6001 S Green
D St. Bernard's, 6337 S. Harvard
E Jackson Park, 7531 S. Stony Island
F St. George, 449 W. Winnecona
G South Shore, 8015 S. Luella
H South Chicago Community, 2320 E. 93
I Little Company of Mary, 2800 W. 95
J Roseland Community, 45 W. 111


Skokie
Niles
Lombard
Villa Park
Elmhurst
Oak Park
Maywood
Cicero
Berwyn
Oak Brook
Brookfield
Downers Grove
Hinsdale
Bridgeview
Woodridge
Evergreen Park
Oak Lawn
Lemont
Lockport
Tinley Park
Homewood
Dolton
Harvey
Calumet Park
Blue Island
Crestwood
Oak Forest
Orland Park
Palos Hills
Palos Park
Bedford Park
Stickney
Hometown
Lake Calumet
East Chicago
Michigan



Plan of Merger

ARTICLE I—PARTIES TO THE MERGER

The Englewood Hospital Association, an Illinois not-for-profit corporation (hereinafter called "Englewood") shall be merged into St. George's Hospital, also an Illinois not-for-profit corporation (hereinafter called "St. George"). The term, "Surviving Corporation," as hereinafter used, means St. George when the merger has been effected.

ARTICLE II—TERMS AND CONDITIONS OF THE MERGER

1. Englewood shall be merged into St. George, which, when the merger has been effected, shall be the Surviving Corporation, under the name "St. George Hospital."

2. The Surviving Corporation shall have all the rights, privileges, immunities and powers and shall be subject to all the duties and liabilities of a corporation organized under the General Not-For-Profit Corporation Act of the State of Illinois.

3. The Surviving Corporation shall possess all the rights, privileges, immunities and franchises of each of the merging corporations; and all property, real, personal and mixed, and all debts due on whatever account, and all other choses in action, and all and every other interest, of or belonging to or due to each of the corporations so merged, shall be taken and deemed to be transferred to and vested in the Surviving Corporation without further act or deed; and the title to any real estate, or any interest therein, vested in either of such corporations, shall not revert or be in any way impaired by reason of the merger.

4. The Surviving Corporation shall be responsible and liable for all the liabilities and obligations of each of the corporations so merged; and any claim existing or action or proceeding pending by or against either of such corporations may be prosecuted to judgment as if the merger had not taken place, or the Surviving Corporation may be substituted in its place. Neither the rights or creditors nor any liens upon the property of either of the corportations shall be impaired by the merger.

5. The Surviving Corporation shall construct a new hospital of approximately 250-bed capacity, near the intersection of 80th Avenue and McCarthy Road in the City of Palo Heights, Illinois.

6. The Surviving Corporation shall (a) continue to operate under the name of St. George, the hospital now operated by St. George at 449 West Winneconna Parkway, Chicago, Illinois; (b) continue to operate under the name of Englewood, the hospital now operated by Englewood at 60th and Green Streets, Chicago, Illinois; and (c) operate the hospital to be constructed in Palos Heights, Illinois, under the name of Palos Community Hospital. The obligation to operate the aforesaid hospitals shall be conditioned upon the Surviving Corporation being able to attract and maintain a census of patients in each such hospital in such number as may be necessary to make each hospital self-sustaining.

ARTICLE III—ARTICLES OF INCORPORATION OF THE SURVIVING CORPORATION

The Articles of Incorporation of the Surviving Corporation, as amended, shall, when the merger has been effected, be further amended to read as set forth in Exhibit 1 attached hereto.

ARTICLE IV—DIRECTORS, OFFICERS, AND MEDICAL STAFF OF SURVIVING CORPORATION

1. The board of directors of the Surviving Corporation, who shall hold office for the terms indicated, and until their respective successors shall have been elected, and their names and classes are as follows:

Name	Class	Term ending

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

READ INSTRUCTIONS BEFORE COMPLETING THIS FORM

APPLICATION FOR PROJECT CONSTRUCTION — PART 2. FINANCIAL INFORMATION

TYPE OF PROGRAM (Check one)
☒ HOSPITAL AND MEDICAL FACILITIES
Title VI, PHS Act, as amended
☐ FACILITIES FOR THE MENTALLY RETARDED
Title I, Part C, P.L. 88-164
☐ COMMUNITY MENTAL HEALTH CENTERS
Title II, P.L. 88-164

1. PROJECT NUMBER(S) (Assigned by State Agency)
ILL - 268
2. NAME OF PROJECT
Palos Community Hospital
3. ADDRESS (City, County, State)
80th Avenue and 123rd Street (McCarthy
Palos Heights (Cook County) Illinois

FINANCIAL RESOURCES FOR CONSTRUCTION

A. CASH, AND NEGOTIABLE AND NON-NEGOTIABLE SECURITIES		$ 2,474,117.00
B. PLEDGES FACE VALUE $ 165,000.00 ESTIMATED CASH VALUE (By Bank or Lending Agency)		$ 165,000.00
C. CONTINGENT GIFTS AND BEQUESTS		$
D. BONDS AUTHORIZED BUT NOT YET SOLD		$
E. MORTGAGES		$ 4,500,000.00
F. APPROPRIATIONS: STATE	$	
LOCAL	$	$
TOTAL		
G. OTHER (Specify) Loan from	$	
rious Hospitals of St. Joseph	1,000,000.00	
paid to architect and	$	
nso of testing of the soil	221,200.00	
me to be earned during	$	
struction period.	1,500,000.00	
		$ 2,721,200.00
H. TOTAL		$ 9,860,317.00

Health Facilities Planning & Construction Service
JUN 26 1969
Region V - Chicago

APPLICANT'S CERTIFICATION: The applicant hereby certifies that the foregoing statements are correct to the best of its knowledge and belief.

LEGAL NAME OF APPLICANT	SIGNATURE OF RESPONSIBLE OFFICER	DATE
St. George Hospital An Illinois Corporation 449 North Winnetonka Parkway Chicago, Illinois 60620	Clair M. Rodkey	6-23-69
	NAME AND TITLE OF RESPONSIBLE OFFICER (Type or print) Clair M. Rodkey, Chairman St. George Hospital Corporation	

FOR STATE AGENCY USE ONLY

ON THE BASIS OF THE INFORMATION CONTAINED HEREIN AND THE DATA OR OTHER INFORMATION AVAILABLE TO THE STATE AGENCY, THE LATTER HEREBY CERTIFIES THAT IN ITS OPINION:

A. The applicant can, and if its application is approved, will raise money for construction of the facility and for its maintenance and operation when completed in the amounts and from the sources set forth in the application.

B. All legal requirements for raising these funds have been met.

OFFICIAL NAME OF STATE AGENCY	SIGNATURE OF RESPONSIBLE OFFICER	DATE
Illinois Department of Public Health	Franklin D. Yoder	6-26-69
	NAME AND TITLE OF RESPONSIBLE OFFICER (Type or print) Franklin D. Yoder, M.D., Director	

SECTION II.—ADVISORY HOSPITAL COUNCIL IN THE DEPARTMENT OF PUBLIC HEALTH

(Chairman: Franklin D. Yoder, M.D., Director of Public Health)

A. Representatives of Public Agencies

Robert E. Lanier, Special Assistant to the Director, Department of Mental Health, Room 401, State Office Building, Springfield, Illinois 62706.

Henry A. Holle, M.D., Medical Director, Illinois Department of Public Aid, Room 900, 209 West Jackson Boulevard, Chicago, Illinois 60606.

B. Representatives of Non-governmental Groups

1. Individuals in the field of hospital administration

Leonard P. Goudy, Administrator, Proctor Community Hospital, 5409 North Knoxville Avenue, Peoria, Illinois 60614, (Hospital Administrator) (1974).
George K. Hendrix, Executive Director, Memorial Hospital, 1st and Miller Streets, Springfield, Illinois 62701. (Hospital Administrator) (1974).
David M. Kinzer, Executive Vice-President, Illinois Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois 60611, (Hospital Association Executive Vice President) (1972).
Reverend John Weishar, Diocesan Director of Catholic Hospitals, Catholic Diocese of Peoria, 1121 First National Bank Building, Peoria, Illinois 61602, (Director of Catholic Hospitals) (1973).
William R. Williams, Administrator, Suburban Cook County Tuberculosis Sanitarium, 55th Avenue and County Line Road, Hinsdale, Illinois 60521, (Hospital Administrator) (1971).

2. Individuals in the fields of medicine or dentistry

Francis Bihss, M.D., No. 3 Powder Mill Road, Belleville, Illinois 62223. (Physician) (1972).
Everett Coleman, M.D., The Coleman Clinic, 24–26 North Main Street, Canton, Illinois 61520, (Physician) (1974).
Raymond A. Dougherty, M.D., Link Clinic, Mattoon, Illinois 61938, (Physician) (1971).
Willard Scrivner, M.D., 20 Kingstrom Drive, East St. Louis, Illinois 62202, (Physician) (1973).
Edward C. Thompson, D.D.S., 47 Greencraft, Champaign, Illinois 61822, (Oral Surgeon) (1972).

C. Representatives of Consumers

Odin Anderson, 1325 East 55th Street, Chicago, Illinois 60615, (Educator) (1973).
Horace G. Brown,[1] Shawneetown, Illinois, (Public School Official) (1972).
Francis Hickey, 1239 National Avenue, Rockford, Illinois 61103, (Attorney) (1971).
W. Henderson May, 1139 West Cook Street, Springfield, Illinois 62704, (Association Executive) (1971).
Harris Perlstein, One East Wacker Drive, Room 3712, Chicago, Illinois 60601, (Industrialist) (1973).
Paul Plunkett, Sr., 1105 Locust Road, Wilmette, Illinois 60091, (Attorney) (1971).
Lee Pravatiner, 8025 South Oglesby, Chicago, Illinois 60607, (University employee) (1972).
Mrs. Louis Rubin, 1012 Lundvall, Rockford, Illinois 61107, (Civic Worker) (1971).
H. Clay Tate, R. R. No. 2, Bloomington, Illinois 61701, (Newspaper Editor) (1974).
Mrs. Ann Zercher, 6528 Nokomis, Lincolnwood, Illinois 60645, (Nurse) (1973).
Vacancy (1972) [1]
Vacancy (1973) [1]

SECTION III. METHODS OF ADMINISTRATION

A. Basis

Methods of administration are based upon the provisions and requirements of the following:

(*a*) Public Law 88–433, "Hospital and Medical Facilities Amendments of 1964" (Title VI of the Public Health Service Act, as amended), including amendments under Public Law 91–296;

(*b*) Public Health Service Regulations—Part 53, pertaining to the construction and modernization of hospital and medical facilities;

(*c*) Public Health Service, Health Grants Manual, Part 23–2, January 29, 1968;

(*d*) Illinois Hospital Construction Act (Illinois Revised Statutes, 1969, Chapter 23, Sections 1301–1307);

[1] Resigned after July 1971; no appointment as of this date.

(c) Civil Administrative Code of Illinois (Illinois Revised Statutes, 1969, Chapter 127, Sections 55.01–55.35); and policy and program decisions of the State Agency, consistent with the foregoing, arrived at through consultation with the Public Health Service Regional Office Staff (Health Facilities Planning and Construction Service) and the Illinois Advisory Hospital Council.

1. *Designation of State Administering Agency.*—The Illinois Department of Public Health is the State Agency designated to administer the Program in and for the State of Illinois. The Director of Public Health is the designated Hospital Authority. Within the Department of Public Health, the Division of Health Facilities, an integral part of the Bureau of Personal and Community Health, is responsible for administration of all phases of the Program. An organization chart is provided in the Plan.

2. *Administrative Costs.*—Administrative costs of the Program have thus far been borne by the State of Illinois. However, Public Law 91–296 makes provision for states to use annually "not more than 4 per centum of the state's total allotment for the year, or $100,000, whichever is less" to apply on administration of the Program.

3. *Advisory Hospital Council.*—The Civil Administrative Code of Illinois provides for an Advisory Hospital Council to advise the State Agency on administration of the Program. The membership of the Council is stated elsewhere in this Plan.

The statute provides that this Council shall be comprised of: the Director of Public Health who shall serve as chairman; a representative of the Department of Public Aid, designated by the Director of that Department; a representative of the Department of Mental Health, designated by the Director of that Department; 5 individuals in the field of hospital administration; 5 individuals in the fields of medicine or dentistry; and 12 consumer representatives familiar with the need for the services provided by hospitals and other medical care facilities.

[From the Chicago Tribune, Wednesday, Jan. 26, 1972]

PLAN PROBE OF HOSPITAL PLOT CHARGE

(By Philip Wattley)

Richard Friedman, regional administrator for the Department of Health, Education, and Welfare said last night he would investigate charges that two inner-city hospitals conspired to divert funds for the construction of a suburban hospital.

The Comprehensive Health Planning Agency [COMPRAND], a South Side group, has charged that Englewood and St. George Hospitals conspired to transfer $1,008,000 in funds to help construct the Palos Community Hospital.

The funds originally were to be used to renovate the Englewood Hospital, 6001 S. Green St., according to COMPRAND.

"I'll call for the hospital's files and make a personal review of the situation," Friedman said. "We'll have to see if the regulations were followed and explore the complicated change of corporate structure."

In 1968, Englewood Hospital asked the federal government for a $1,008,000 grant to renovate the facility. It was approved the next year. In December, 1969, St. George Hospital merged with Englewood Hospital, and, according to COMPRAND, Englewood at this point withdrew its request for the grant so the hospital could degenerate to the point of closing.

"This problem arose in 1969," Friedman said. "At that time the guidelines for awarding grants were somewhat different than they are today."

The South Side group charges that if the hospitals close it will create a serious gap in medical care in the Englewood neighborhood. The COMPRAND group said it plans to meet with Friedman at 10 a.m. today and demand a cutoff of federal funds to the hospitals until a complete review of the situation is made.

U.S. AID MOVES HOSPITAL TO SUBURBS

(By Judy Nicol)

The federal government has pledged a million dollars to move a ghetto hospital to the suburbs, and income from a second inner-city hospital is being diverted to pay for the construction, it was charged Tuesday.

The charges were made by COMPRAND, the Comprehensive Health Planning Agency from the Far South Side.

The Department of Health, Education and Welfare has partially financed the removal of St. George Hospital from the Greater Grand Crossing neighborhood, near the south tip of Englewood, to Palos Heights under a law that is supposed to help needy areas, the group said.

Greater Grand Crossing, with a population of 54,415, has a median family income of $8,700 a year.

St. George will close as soon as the Palos Community Hospital is completed, probably within 60 days.

The Englewood neighborhood, with a population of 89,713, has a median family income of $6,450.

Palos Heights, with a population of 9,915, has an estimated income of $15,400 per family.

CHARGES DETAILED

COMPRAND charged Tuesday that:

(1) St. George and Englewood hospitals conspired to transfer $1,008,000, originally approved for the renovation of Englewood, to build Palos Community Hospital.

(2) Englewood withdrew its request for a renovation grant to let the hospital degenerate so that it, too, could close.

(3) At least $750,000 has been transferred from the income of Englewood to build Palos Community Hospital.

(4) State health planning maps are gerrymandered to the disadvantage of poor people.

Dr. Herbert Odom, an Englewood dentist and member of COMPRAND said, "It appears there is a conspiracy between St. George and Englewood to transfer money from Englewood to Palos Heights and to deprive Englewood people of much-needed services."

St. George and Englewood hospitals merged in 1969 under a single board of directors. COMPRAND said this was part of the conspiracy.

CONSPIRACY DENIED

Clair M. Roddewig, president of St. George Hospital Corp., which directs Englewood, St. George's and Palos Community Hospitals, said, "There is no conspiracy."

"St. George is leaving because the accreditation people told us we had to close," he said. "We didn't consider staying in the area because (nearby) St. Bernard Hospital will be enlarged.

"We have taken some surplus funds from Englewood Hospital. I don't know the exact amount.

"Englewood will not close. We will announce renovation plans next week," Roddewig said.

Asked about the renovation plans, S. J. Schroeder, executive director of the St. George Hospital Corp., said financial plans were not concrete.

Schroeder said that the renovation plan was the same as was withdrawn by the hospital two years ago.

One board member of the St. George Hospital Corp., Claire T. Driscoll, said he was completely unaware Tuesday of any renovation plans.

"It (Englewood Hospital) will just go on like old man river," he said.

FINANCIAL COINCIDENCES

COMPRAND bases its conspiracy charges on what it believes to be strange financial coincidences.

In 1968 Englewood Hospital asked the federal government for money to modernize and expand. A tentative grant of $1,008,000 was approved in 1969.

Eight days later, COMPRAND says, St. George Hospital applied for a grant to help build Palos Community Hospital.

In June, 1969, St. George asked for more money and announced its intention to merge with Englewood. An $840,000 grant was awarded in October, 1969.

In December, 1969, the merger took place, and Englewood subsequently withdrew its grant request.

In April, 1970, the Illinois Department of Public Health approved a supplemental grant for Palos Community Hospital that brought the total grant to exactly the sum originally approved for Englewood.

Dr. Odom said that "unless Englewood is fixed up, it will have to close. If they (the hospital corporation) are going to dust off their previously canceled modernization plans it comes as news to the community."

Aden H. Clump, the state public health official in charge of approving the St. George and Englewood requests, said the grant for the removal of St. George to the suburbs was approved by his office.

"They (St. George and Palos Community Hospital) are in the same district," he said. "According to the federal guidelines a hospital can move and use modernization funds for rebuilding in the same area."

Although the federal government has the final authority to approve grant applications, Clump said that "they usually follow our recommendations. They've never turned us down when they had the money."

Clump, in turn, said the state usually follows the recommendations of the local agency. He said, in fact, that he had "never gone against local recommendations."

Local recommendations in 1968 and 1969 were made by the Hospital Planning Council of Metropolitan Chicago, now merged with the Northeastern Illinois Planning Commission.

Hiram Sibley, former head of the planning council and now a professor of health administration at the University of Illinois, said "the issue at that time was that St. George would have to close if it didn't move because it was a fire hazard.

"It could have moved within the city or the suburbs. Nobody on the medical staff wanted to stay in the city.

"Since doctors make the decisions about where they want to practice, that was their right.

"We approved the request because another hospital was needed in the south west area, and they had the medical staff to make it a good hospital, plus a location with transportation in all directions."

Sibley said no public hearings were held. "That used to bother me," he said, "but our attorneys told us we were not a public agency so we shouldn't have public hearings."

He said he believed the Englewood grant request was withdrawn because "they, like St. George, has decided they were going to phase themselves out of business."

"This obviously leaves a big gap (in medical services)," he said. "The question is, who's going to fill the gap. I have been frustrated for years over these gaps. There has not been anyone to whom we could turn to fill gaps."

The federal Hill-Burton Act, which was set up to help finance hospital construction, "has been a complete failure in the city of Chicago," Sibley said.

The reason that St. George managed to "replace" itself 13 miles away is because the federal districts are "gerrymandered," COMPRAND charges.

Pierre DeVise, a sociologist who drew the lines, denies the gerrymandering charge. The boundaries were drawn to reflect where a hospital's patients come from, he said.

In 1965, when the last lines were drawn, St. George and Englewood's patients came largely from outside the community of Englewood.

Therefore, Englewood Hospital and St. George Hospital, in the same district as Cook County Hospital, were moved "for planning purposes" into the Palos Heights district, DeVise said.

APPENDIX 3

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF THE SECRETARY,
Washington, D.C., October 31, 1973.

Hon. DON EDWARDS,
Chairman, Subcommittee No. 4, Committee on the Judiciary, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: Thank you again for the opportunity to appear before the Subcommittee and respond to the General Accounting Office Report on compliance by hospitals and other facilities under Medicare and Medicaid with the non-discrimination provisions of Title VI of the Civil Rights Act of 1964.

I am returning a copy of the October 1 hearing transcript with editorial corrections and, on separate pages, responses to certain committee questions. A requested copy of the 1969 survey of hospitals is included. In addition, I have included copies of questionnaires used for the 1969 survey of hospitals and extended care facilities as well as those being used for the current survey which we hope to complete by the end of June, 1974.

I think you also will be interested to know that our Office is preparing a brochure and a poster emphasizing the rights of recipients of care at medicaid and medicare facilities to be free of discriminatory treatment. The subject also will be stressed by my staff at upcoming meetings with the National Urban League and the Leadership Conference on Civil Rights and we will make available the brochures and posters for distribution by these organizations.

I hope this information is helpful. Please let me know if I can be of further assistance.

Sincerely yours,

PETER E. HOLMES,
Director, Office for Civil Rights.

Response to Representative Edwards' request, page 182

Taking the GAO points in order:

During the current fiscal year the Office for Civil Rights anticipates conducting several in-depth reviews of nursing home referral processes.

As indicated in Mr. Holmes testimony on page 176, a greater effort needs to be made in the area of educating potential recipients of federally-assisted health care to their rights to non-discriminatory treatment. The Office for Civil Rights currently is preparing a fact sheet/brochure and posters for distribution to health care institutions *and* interested civil rights organizations.

The reporting checklist or form for skilled nursing facilities has been developed. As indicated in the GAO statement of Mr. Ahart, page 5.

Questions concerning the model ombudsmen units, which function under the Bureau of Health Services Research, should be directed to Mr. Allan Forman, Director Ombudsmen Demonstration Program, Room 1581, Parklawn Bldg., 5600 Fishers Lane, Rockville, Md., 20852. Mr. Forman's telephone number is 443-4923.

Response to Representative Drinan's question, page 181

The pre-award procedure developed by the Chicago Regional Office for Civil Rights is being refined as that office continues to review Federal contract and grant awards to medical facilities for possible violations of the non-discrimination provisions of Title VI. It is not, at this time, being used nationwide. Assuming its continued success in the Chicago region, it is anticipated that a similar procedure will be utilized by all Regional offices.

Response to Representative Drinan's question, page 181

Page B VIII–a of the Health and Social Services "Enforcement plan" which has been made available to the subcommittee outlines the purpose of the new survey. Copies of newly structured questionnaires for hospitals and nursing homes also have been given to the subcommittee. Filled-out questionnaires will provide valuable information for use in determining the Title VI compliance status of an individual facility. Questions common to the 1969 survey (copies of the 1969 questionnaires also have been furnished the subcommittee have been retained and will enable OCR to make comparisons and evaluate nationwide changes between 1969 and 1973. The expanded 1973 quesionnaires seek new information concerning a medical facility's ability to communicate with non-English speaking patients, the geographic area served by the facility and its methods of seeking patient payment.

Response to Representative Drinan's question, page 182

The Office for Civil Rights does not make evaluations of the quality of medical services offered by a health-care institution. Where medical service quality is indicated by complainants or those being interviewed, the Office for Civil Rights refers the matter to the appropriate Department Agency such as the National Institute of Health or the Medical Services Administration of the Public Health Service.

Response to Representative McClory's question, page 178

According to officials of the Health Resources Administration, more than 100 grants or contracts have been approved for programs intended to bring disadvantaged Americans into health career fields. Under the National Institute of Health, two programs are aimed at financially assisting minorities to advance in health service careers. One, however, the Minority Access to Research Careers (MARC) currently is being phased out despite considerable support for the program from officials of predominantly Black colleges and universities. More specific information should come from Dr. Charles Miller, of MARC. A second program is the Minority Schools Bio-Medical Support Grants. The grants go to colleges and junior colleges where the majority of students are members of minority groups. Generally, money is provided to pay a teacher's salary while he or she does research in which students are involved. The institution can use the money that it formerly paid the teacher to hire a temporary replacement. Additional information should come from Dr. Robert J. Gibbs, of NIH's Division of Research Resources where he is Chief of the General Research Support Branch.

Response to Representative Drinan's question, page 181 and 182

National statistics are not available on the number of private physicians who have stopped serving Medicaid patients. Nor is there information on the number of hospitals that have stopped serving Medicaid patients. Based on OCR experience in reviewing hospital facilities, however, there is no discernible national trend by hospitals to withdraw from medicaid. The financial problem associated with empty beds make it unlikely that many hospitals would want to eliminate this source of income. Some communities maintain lists of approved Medicaid vendors. Where such lists had been maintained over a period of time, a physician-vendor name not appearing on a later list might indicate that physician had stopped serving medicaid patients.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF THE SECRETARY,
October 30, 1973.

Memorandum to: Peter E. Holmes, Director, OCR.
From: Theodore A. Miles, Assistant General Counsel, OCR.
Subject: Effect of Title VI on Employment Practices in Health and Social Service Programs.

In light of the July 5, 1973, revision of the Department's Title VI Regulation, particularly 45 CFR Section 80.3(c)(3) concerning employment practices under Title VI of the Civil Rights Act of 1964, we have reviewed the law applicable to our jurisdiction over employment practices in health and social service facilities. The regulation as revised states that discrimination on the ground of race, color, or national origin in employment practices which excludes individuals from participation in, denies them the benefits of, or subjects them to discrimination in any Federally assisted program is prohibited. (Such discrimination is deemed subject to the same remedies as discrimination in a program where the primary purpose is employment, as per section 80.3(c)(1).) Discrimination in employment practices is prohibited "to the extent necessary to assure equality of opportunity to, and nondiscriminatory treatment of, beneficiaries."

The regulation was promulgated in conformity with section 601 of Title VI of the Civil Rights Act of 1964:

> SEC. 601. No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

In its health and social services monitoring activities under Title VI as in its other Title VI functions, OCR has as its sole concern the equal delivery of Federally assisted programs or activities to the intended beneficiaries. The Office may, however, have to deal with employment practices, as well as with a myriad of other factors, in order to discharge its statutory responsibilities to the beneficiaries.

The only specific provision dealing with employment in Title VI is section 604:

> SEC. 604. Nothing contained in this title shall be construed to authorize action under this title by any department or agency with respect to any employment practice of any employer, employment agency, or labor organization except where a primary objective of the Federal financial assistance is to provide employment.

While it was sometimes argued in past cases that section 604 prohibited correction of employment discrimination in programs with a primary purpose other than to provide employment, regardless of the effect on beneficiaries, that approach seems now to have been discarded by the courts.

The question of the boundaries of Title VI employment jurisdiction was specifically considered by Judge Wisdom in *United States* v. *Jefferson County Board of Education*, 327 F.2d 836 (5th Cir. 1966); *aff'd en banc*, 380 F.2d 385 (1967); *cert. denied, sub. nom. Caddo Parrish* v. *United States*, 389 U.S. 840.

The *Jefferson* case speaks directly to the issue of interpretation of section 604. *Jefferson* specifically approved HEW faculty desegregation guidelines. Speaking to the argument that section 604 forbids action to eliminate discrimination in hiring and assignment of faculty even when such discrimination results in discrimination against program beneficiaries, the court said, ". . . it is the school children who are beneficiaries of Federal assistance to the public schools . . . to the extent that teacher discrimination jeopardizes the success of desegregation, it is unlawful wholly aside from its effect upon individual teachers," 372 F.2d at 883.

This view comports with the general rule that remedial statutes should be liberally construed, their exceptions, therefore, strictly construed. It is also consistent with the legislative history of Title VI. As the majority opinion in *Jefferson* pointed out, section 604 was not designed to limit the protection of program beneficiaries given by section 601:

> Section 604 was not a part of the original House Bill. Senator Humphrey, while introducing the Act explained: "[The] Commissioner might also be justified in requiring elimination of racial discrimination in em-

ployment or assignment of teachers, at least where such discrimination affected the educational opportunities of students. See *Braxton* v. *Board of Public Instruction of Duval County*, 326 F.2d 616 (5th Cir. 1964)," 110 Cong. Rec. p. 6345. That was in March 1964. In June 1964, in explaining the amendments Senator Humphrey said, "this provision is in line with the provisions of section 602 and serves to spell out more precisely the declared scope of coverage of the title." In the same speech he stated (110 C.R. 12414): "We have made no changes of substance in Title VI." This explanation plainly indicates that the amendment was not intended as a statutory bar to faculty integration in schools receiving federal aid. 372 F.2d at 882.

Judge Wisdom in *Jefferson* disagreed with the school boards' contention that Title VI does not apply to employment practices of schools by saying:

> In the broadest application this argument would allow racial discrimination in the hiring, discharge and assignment of teachers. In its narrowest application this argument would allow discrimination in hiring and discharging but not in assigning teachers, an inexplicable anomaly. There is no merit to this argument. 372 F.2d 883.

It must be emphasized that *Jefferson* points out that section 601 protects *beneficiaries* of Federal financial assistance from discrimination and that section 604 does not limit this right. Therefore, discriminatory employment practices which affect beneficiaries are violations of section 601 notwithstanding section 604.

In *United States* v. *John S. Frazer*, 317 F. Supp. 1079 (1970), the Justice Department charged that Alabama was discriminating on racial grounds in its state personnel practices, including hiring, recruitment, promotion, and demotion. Although the decision was not on section 601 grounds, the court found against Alabama and in so deciding said, citing *Jefferson supra:*

> It is true that Section 604 of Title VI makes it clear that Title VI was not intended to be applicable to the employment practices of recipients of federal assistance "except where a primary objective of the Federal assistance is to provide employment" *or where discrimination in employment causes discrimination to the beneficiaries.* (Emphasis added) 317 F. Supp. 1083.

Thus, the court, in addition to determining the right of the Attorney General to bring the action, interpreted section 604 as not preventing action under section 601 where, as a result of employment practices by recipients, the beneficiaries of Federal financial assistance suffer discrimination.

Judge Butzner, in the well known case of *Taylor* v. *Cohen*, 405 F.2d 277 at 281 (4th Cir. 1968), while rejecting a school district's bid for an injunction against HEW enforcement action under section 601, interpreted Title VI as going just as far as the Constitution in ensuring civil rights. Thus we must conclude a wide range of discrimination violates section 601.

The elimination of discrimination in employment practices was found by Judge Johnson, in *Marable* v. *Alabama Mental Health Board*, 297 F. Supp. 291 (1969), to be so related to nondiscriminatory care of patients as to give standing to the latter to bring an action where the professional and subprofessional staffs of state mental institutions were segregated:

> The Mental Health Board also challenges plaintiffs' standing to raise the issue of discrimination in employment practices, including the pay rates of subprofessional personnel. We agree that plaintiffs do not have standing to challenge the practices as potential employees, but we must conclude that they do have standing because of the secondary effects on plaintiffs as patients of the discrimination against staff personnel.
>
> Plaintiffs stand in the same relationship to the hospital staff as students in the public schools stand to their teachers. In the latter connection, this Court has stated:
>
> "It is no longer open to question that faculty and staff desegregation is an integral part of any public school desegregation plan—not because of teachers' employment rights, but because students are entitled to a nonracial education, and assignment of teachers to students

on the basis of race denies students that right." *Lee* v. *Macon County Board of Education*, 267 F. Supp. 458, 472 (M.D. Ala. 1967); aff'd *sub. nom. Wallace* v. *United States* 389 U.S. 215, 88 S.Ct. 415, 19 L. Ed. 2d 422.

The analogy to the School situation emphasizes the point that neither students nor patients, as beneficiaries of Federal financial assistance, may be treated unequally because of discriminatory employment practices.

Thus, as demonstrated above, promulgation of the revised section 80.3(c)(2) merely codifies existing case law regarding discriminatory employment practices which affect beneficiaries.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF THE SECRETARY,
OFFICE FOR CIVIL RIGHTS,
November 9, 1970.

REPORT OF TITLE VI RIGHTS COMPLIANCE SURVEY OF HOSPITALS AND EXTENDED CARE FACILITIES—1969

INTRODUCTION

In July of 1969, all hospitals and extended care facilities participating in the Medicare program or receiving other types of Federal financial assistance were requested to submit reports reflecting their current compliance status with the requirements of Title VI of the Civil Rights Act of 1964. The information contained in these reports included such areas as admission policies, patient room assignments, utilization of services and facilities, physician and dentist staff privileges, and training programs for residents, interns, nurses, and paramedical personnel. The individual reports for 6,539 hospitals and 4,401 extended care facilities have now been reviewed and edited and the information has been summarized on a state, regional, and national basis. This information is included in the tables appended to this report. The major purpose in requesting the reports from each facility was to enable us to make a compliance assessment for each hospital and extended care facility and to identify those requiring further investigation, on-site review, or consultation to eliminate policies or practices which might result in discrimination because of race, color, or national origin. Each such situation is being looked into as rapidly as available staff will permit. This effort is being augmented by State Health and Welfare Departments which utilize these facilities in serving beneficiaries of federally assisted programs. Similar reports were received from hospitals in the Fall of 1966 and from extended care facilities in the Spring of 1967. By comparing pertinent items in these earlier reports with the 1969 reports, we can measure the change which has taken place on a state, regional and national basis in improving access and services to minority groups in hospitals and extended care facilities. The tables included with this report provide the comparable data.

While in general, these comparative statistics reflect gratifying improvement in services to minority groups, the area of utilization of extended care facilities by minority groups still gives cause for concern. Although there was an increase of 82% in the number of extended care facilities serving minority patients and an increase of 75% in the actual number of minority patients served, minority patients still constitute only 5.2% of the total patient load in these facilities. It is recognized because of their geographical location, there are many extended care facilities which will have no minority patients on any given day. However, analysis of the reports showed that there are still a substantial number of such facilities located in racially mixed areas which continue to serve patients exclusively of one race. This is true despite the fact that these facilities have adopted and published open admission policies. This emphasizes the importance of our intensive work with hospitals, welfare agencies and other referral sources to see that discriminatory referral patterns are changed.

In the case of hospitals substantial increases in the number of hospitals serving minority patients and also increases in the number of minority patients served indicate that there is no major problem regarding access. However, some reports give rise to a question as to whether race is playing a factor in room assignment. These situations will receive priority attention and where necessary corrective action will be taken.

27-401 O - 74 - 20

This report presents highlights and summary analysis of national data by race covering hospital patients census, physician and dental staff privileges, interns and residents, student nurse training, and other hospital training programs for 1966 and 1969; extended care facilities patient census for 1967 and 1969. Separate data by race covering each of the above mentioned areas of concern is presented in table 1–12 by national, region and State totals of 1966–67 and 1969.[1]

[1] Excludes Hawaii, Guam, Puerto Rico, and Virgin Islands.

TABLES

Data by State and Region

HOSPITALS—PATIENT CENSUS

Table 1. Number of hospitals and number of patients by race—1966 Reports.[1]
Table 2. Number of hospitals and number of patients by race—1969 Reports.[1]

HOSPITALS—STAFF PRIVILEGES

Table 3. Number of hospitals reporting Staff privileges and number of staff by race of staff physician or dentist—1966 Reports.
Table 4. Number of hospitals reporting Staff privileges and number of staff by race of staff physician or dentist—1969 Reports.

HOSPITALS—INTERNS AND RESIDENTS

Table 5. Number of hospitals reporting interns and residents and number of interns and residents by race—1966 Reports.
Table 6. Number of hospitals reporting interns and residents and number of interns and residents by race—1969 Reports.

HOSPITALS—STUDENT NURSES

Table 7. Number of hospitals reporting student nurses and number of student nurses by race—1966 Reports.
Table 8. Number of hospitals reporting student nurses and number of student nurses by race—1969 Reports.

HOSPITALS—OTHER TRAINING PROGRAMS

Table 9. Number of hospitals reporting other training program and number of trainees by race—1966 Reports.
Table 10. Number of hospitals reporting other training program and number of trainees by race—1969 Reports.

EXTENDED CARE FACILITIES

Table 11. Number of facilities and number of patients by race of patients—1967 Reports.[1]
Table 12. Number of facilities and number of patients by race of patients—1969 Reports.[1]

Highlights

24 percent increase in the number of hospitals serving patients of the minority groups[2] (See summary on page 5 and tables 1 and 2).
12 percent increase in the number of hospitals serving Negro patients.
9 percent increase in the number of Negro patients.

---

[1] The term "race" is interpreted to mean "race, color, or national origin."
[2] *"Minority Groups"* for purpose of this report include Negro, American Indian, Oriental and Spanish-Surnamed Americans. *Oriental* includes Chinese, Japanese, Korean, Vietnamese, and others of Oriental origin. *Spanish-Surnamed American* includes Mexican, Puerto Rican, Cuban and others of Latin American origin.

Staff Privileges

61 percent increase in number of hospitals with minority group physicians and dentists on the hospital staff (Summary on page 7 and tables 3 and 4).

27 percent increase in number of hospitals with Negro physicians and dentists on hospital staff.

22 percent increase in the number of staff positions filled by Negroes.[3]

Interns and Residents

60 percent increase in minority group interns and residents (See summary on page 8 and tables 5 and 6).

22 percent increase in Negro interns and residents.

Student Nurses

24 percent increase in number of hospitals with Negro student nurses in training (see summary on page 9 and tables 7 and 8).

27 percent increase in the number of Negro student nurses.

Other Hospital Training

73 percent increase in the number of hospitals with Negroes in other types of training (See summary on page 10 and tables 9 and 10).

Extended Care Facilities

82 percent increase in number of ECFs serving patients of the minority group (See summary on page 11 and tables 11 and 12).

104 percent increase in number of ECFs serving Negro patients.

75 percent increase in number of minority patients in ECFs.

67 percent increase in number of Negro patients in ECFs.

Hospital Patient Census

The completed reports from 6,539 hospitals in 1969 show an in-patient population of 1,052,926. Patients of the minority groups [4] were reported by 4,878 hospitals, or nearly 75 percent of the hospitals which represents an increase of more than 24 percent over the 3,930 hospitals reporting patients of the minority groups in 1966.[5] The number of hospitals with Negro patients increased from 3,592 or 56 percent in 1966 to 4,051 hospitals or approximately 62 percent in 1969. The number of Negro patients increased from 121,854 in 1966 to 133,138 in 1969 for an increase of 9 percent while the total patient increase was slightly less at 8 percent. The number of hospitals reporting patients of Oriental ancestry increased from 700 to 917 in 1969 while the number of patients of Oriental ancestry remained relatively the same with 2,949 in 1966 and 2,912 in 1969. Spanish-Surnamed American patients were not fully identified on the reports for 1966. The reports of 1969, however, show 28,603 Spanish-Surnamed American patients in 2,230 hospitals representing 2.7 percent of the hospital population.

---

[3] The number of staff positions filled by Negroes is not the number of Negro physicians holding staff positions because one physician may be on the staff of more than one hospital and consequently, in the summation of reports from these hospitals would be counted more than once.

[4] "*Minority Groups*" for purpose of this report include Negro, American Indian, Oriental and Spanish-Surnamed Americans. *Oriental* includes Chinese, Japanese, Korean, Vietnamese, and others of Oriental origin. *Spanish-Surnamed American* includes Mexican, Puerto Rican, Cuban and others of Latin American origin.

[5] Not all hospitals would be expected to have minority group patients because there are some areas where no minority persons live.

NUMBER OF HOSPITALS AND NUMBER OF PATIENTS BY RACE OF PATIENTS[1]

	1966		1969		Percent change
	Number	Percent	Number	Percent	
Number of hospitals:					
Total	6,393	100.0	6,539	100.0	+2.3
With minority patients	3,930	61.4	4,878	74.6	+24.1
With Negro patients	3,592	56.1	4,051	61.9	+12.7
With Indian patients	655	10.2	789	12.1	+20.4
With Oriental patients	700	10.9	917	14.0	+31.0
With Spanish-surnamed American patients [2]	92	1.4	2,230	34.1	+2,323.0
Number of patients:					
Total	975,019	100.0	1,052,926	100.0	+8.0
Minority	129,217	13.2	168,207	15.9	+30.0
Negro	121,854	12.4	133,138	12.6	+8.9
Indian	3,129	.3	3,554	.3	+13.5
Oriental	2,949	.3	2,912	.2	−1.2
Spanish-surnamed American	1,285	.2	28,603	2.7	+2,126.0

[1] The term "race" is interpreted to mean "race, color, or national origin."
[2] These figures may not accurately reflect the number of Spanish-surnamed Americans utilizing hospital services since this group was not fully identified in the initial reports as belonging to one of the relevant minority groups.

Staff Privileges

The number of physicians and dentists on the staff of the hospital including those otherwise classified who are permitted to attend and render service to their patients in the hospital was reported by race or national origin of the physician or dentist. The total number of physicians and dentist reported with such staff privileges increased by approximately 23 percent from 483,000 in 1966 to 593,000 in 1969. Staff positions in which Negroes served increased by 22 percent from 8,297 in 1966 to 10,138 in 1969 which was slightly less than the total rate of increase but constituted 1.7 percent of the total staff positions reported for 1966 and 1969. The number of hospitals reporting Negro staff physicians and dentists increased by nearly 27 percent while the total rate of increase was less than 6 percent.

NUMBER OF HOSPITALS REPORTING STAFF PRIVILEGES AND NUMBER OF STAFF[1] BY RACE OF STAFF PHYSICIAN OR DENTIST

	1966		1969		Percent change
	Number	Percent	Number	Percent	
Number of hospitals:					
Total	6,173	100.0	6,539	100.0	+5.9
With minority staff	2,143	34.7	3,451	52.7	+61.0
With Negro staff	1,468	23.8	1,862	28.4	+26.8
Physicians and dentists:					
Total	483,219	100.0	593,276	100.0	+22.7
Minority	13,851	2.9	28,596	4.8	+106.5
Negro	8,297	1.7	10,138	1.7	+22.2

[1] Because physicians and dentists may serve on the staff of more than 1 hospital, the number of such positions include duplication.

Interns and Residents

The number of hospitals reporting interns and residents decreased slightly from 1,143 to 1,129 while the number of hospitals reporting Negro interns and residents increased from 282 to 299. In spite of the decrease in the total number of hospitals reporting such staff, the actual number of interns and residents in these hospitals increased by more than 41 percent. The number of Negro interns and residents increased by nearly 22 percent from 860 in 1966 to 1,047 in 1969.

Negroes occupied a smaller ratio of such positions in 1969 than they did in 1966 in spite of the numerical increase of 187 such positions. Other minorities filled 18 percent of the intern and resident positions in 1969 for an increase of 66 percent. Some of the interns and residents classified as other minorities are foreign doctors temporarily in the United States for training purposes.

NUMBER OF HOSPITALS REPORTING INTERNS AND RESIDENTS AND NUMBER OF INTERNS AND RESIDENTS BY RACE

Hospitals reporting	1966		1969		Percent change
	Number	Percent	Number	Percent	
Interns and residents:					
Total	1,143	100.0	1,129	100.0	−1.2
With 1 or more minority	707	61.9	821	72.7	+16.1
With 1 or more Negroes	282	24.7	299	26.4	+6.0
Total	34,188	100.0	48,325	100.0	+41.4
Minority	6,160	25.3	9,838	20.4	+59.7
Negro	860	3.5	1,047	2.2	+21.7
Other minorities	5,300	21.8	8,791	18.2	+65.9

Student Nurses

The number of student nurses in training reported by these hospitals decreased by nearly 1 percent from 81,670 in 1966 to 81,145 in 1969 while the number of Negro student nurses increased by nearly 27 percent from 2,278 in 1966 to 2,887 in 1969. The number of hospitals reporting Negro student nurses increased by 24 percent from 461 in 1966 to 572 in 1969 while the total number of hospitals reporting student nurses increased by 9 percent. Hospitals reporting Negro student nurses constitute 52 percent of the hospitals reporting student nurse training in 1969. Other minorities had 1,572 student nurses or approximately 2 percent of those reported in 1969.

NUMBER OF HOSPITALS REPORTING STUDENT NURSES AND NUMBER OF STUDENT NURSES BY RACE

Hospitals reporting	1966		1969		Percent change
	Number	Percent	Number	Percent	
Student nurses:[1]					
Total	1,009	100.0	1,102	100.0	+9.2
1 or more Negro nurses	461	45.7	572	51.9	+24.1
Total	81,670	100.0	81,145	100.0	−0.6
Minority	2,608	3.2	4,459	5.5	+71.0
Negro	2,278	2.8	2,887	3.6	+26.7
Other minorities	330	.4	1,572	1.9	+376.4

[1] The number of hospitals reporting student nurse training by minoirty group persons other than Negro was not available.

Other Training[1]

Other training programs reported by hospitals include practical nurses, medical technologists, therapists, Social Workers, dietitions, Administrative Aides, etc. The number of hospitals reporting such training increased by 70 percent from 1,321 in 1966 to 2,252 in 1969 while the number of hospitals reporting persons of the minority group engaged in these training programs increased by 83 percent from 820 in 1966 to 1,515 in 1969. The number of hospitals reporting Negro trainees in these programs increased by 73 percent from 718 in 1966 to 1,241 in 1969.

[3] Other Training includes Practical Nurses, Medical Technologists, Therapists, Social Workers, Dietitions, Administrative Aides, etc.

The number of such trainees more than doubled from 25,913 in 1966 to 67,257 in 1969. Although the number of minority trainees had similar increases, the ratio of minority trainees decreased slightly from 19 percent of the trainees in 1966 to a little less than 19 percent in 1969. The ratio of Negro trainees also dropped from 16 percent in 1966 to 13 percent in 1969.

NUMBER OF HOSPITALS REPORTING OTHER TRAINING[1] PROGRAMS AND NUMBER OF TRAINEES BY RACE

	1966		1969		Percent change
	Number	Percent	Number	Percent	
Hospitals reporting Other training:					
Total	1,321	100.0	2,252	100.0	+70.4
Including minority persons	829	62.7	1,515	67.2	+82.7
Including Negroes	718	54.3	1,241	55.1	+72.8
Other trainees:					
Total	25,193	100.0	67,257	100.0	+166.9
Minority	4,849	19.2	12,655	18.5	+160.9
Negro	4,010	15.9	9,061	13.4	+125.9
Other minority	839	3.3	3,594	5.3	+328.4

[1] Other training includes practical nurses, medical technologists, therapists, social workers, dietitions, administrative aides, etc.

Extended Care Facilities

The completed reports from 4,401 extended care facilities in 1969 show that 395,340 patients were receiving care and that over one-half of these facilities (56.9 percent) had one or more minority patients. The number of extended care facilities caring for minority patients increased from 1,374 in 1967 to 2,504 in 1969, an 82 percent increase. The number of minority patients in these facilities increased by approximately 75 percent from 11,836 in 1967 to 20,668 in 1969. The number of facilities reporting Negro patients increased by 104 percent from 902 in 1967 to 1,840 in 1969 while the increase in the number of Negro patients was a little over 67 percent from 8,392 in 1967 to 14,033 in 1969. Susbstantial increases occurred in the utilization of extended care facilities by all of the specified minority groups: Indians—55 percent; Oriental—51 percent; Spanish-Surnamed Americans—113 percent.

NUMBER OF EXTENDED CARE FACILITIES AND NUMBER OF PATIENTS BY RACE OF PATIENTS

	1967		1969		Percent increase
	Number	Percent	Number	Percent	
Number of extended care facilities Reporting:					
Total	3,748	100.0	4,401	100.0	17.4
Minority	1,374	36.6	2,504	56.9	82.2
Negro	902	24.0	1,840	41.8	104.0
Indian	225	6.0	340	7.7	51.1
Oriental	261	7.0	398	9.0	52.5
Spanish-surnamed American	524	14.0	1,036	23.5	97.7
Number of patients:					
Total	260,983	100.0	395,340	100.0	51.5
All Minorities	11,836	4.5	20,668	5.2	74.6
Negro	8,392	3.2	14,033	3.5	67.2
Indian	506	.2	786	.2	55.3
Oriental	639	.2	969	.2	51.6
Spanish-surnamed American	2,299	.9	4,880	1.2	112.7

TABLE 1.—NUMBER OF HOSPITALS AND NUMBER OF PATIENTS BY RACE, 1966 REPORTS

1969 TITLE VI COMPLIANCE SURVEY—HOSPITALS

State and region	Total		Serving minority patients									
			Total		Negro		Indian		Oriental		Spanish surnamed Americans	
	Hospitals	Patients	Hospitals	Patients	Hospitals	Patients	Hospitals	Patients	Hospitals	Patients	Hospitals	Patients
Total	6,393	975,019	3,930	129,217	3,592	121,854	655	3,129	700	2,949	92	1,285
Region I	372	77,332	193	2,589	184	2,456	21	35	45	98		
Connecticut	55	18,099	46	1,212	45	1,188	1	2	11	22		
Maine	67	6,156	11	27	7	13	5	12	2	2		
Massachusetts	174	41,977	110	1,151	107	1,068	11	15	27	68		
New Hampshire	32	3,663	7	10	6	8	1	1	1	1		
Rhode Island	20	4,390	16	184	16	175	3	5	3	4		
Vermont	24	3,047	3	5	3	4			1	1		
Region II	494	140,667	378	22,068	371	21,211	42	142	104	556	3	159
New Jersey	121	24,028	107	2,760	106	2,735	3	3	17	22		
New York	372	116,639	271	19,308	265	18,476	39	139	87	534	3	159
Region III	456	100,226	358	17,374	356	17,046	11	42	31	286		
Delaware	10	2,926	9	626	9	624	1	1	1	1		
District of Columbia	13	9,725	13	4,768	12	4,504	3	34	5	230		
Maryland	58	12,265	48	3,880	48	3,873	1	1	2	6		
Pennsylvania	170	50,245	148	5,236	148	5,198	4	4	18	34		
Virginia	110	11,608	83	2,117	83	2,111			3	6		
West Virginia	95	13,453	57	747	56	736	2	2	2	9		
Region IV	1,014	137,326	784	34,002	781	33,699	35	172	22	65	3	66
Alabama	142	18,329	113	5,386	112	5,384	1	1	1	1		
Florida	157	19,501	123	3,154	121	3,103	4	5	9	46		
Georgia	138	23,948	111	7,023	111	7,022			1	1		
Kentucky	129	15,733	86	1,523	86	1,447	3	3	6	7	3	66
Mississippi	90	10,682	81	3,504	81	3,481	5	16	2	7		
North Carolina	143	18,876	115	6,201	115	6,058	17	142	1	1		
South Carolina	67	12,367	63	5,248	63	5,244	2	2	2	2		
Tennessee	148	17,890	92	1,963	92	1,960	3	3				

Region V	1, 235	232, 957	676	23, 691	627	22, 931	123	468	87	267	16	25
Illinois	320	64, 879	202	10, 296	199	10, 100	18	38	34	158		
Indiana	123	23, 554	62	2, 230	61	2, 221	1	1	6	8		
Michigan	180	43, 550	108	4, 844	94	4, 727	25	84	13	29	2	4
Minnesota	173	22, 309	47	371	33	186	36	165	11	19	1	1
Ohio	242	50, 768	183	4, 984	182	4, 950	4	5	17	29		
Wisconsin	197	27, 987	79	966	58	747	39	175	6	24	13	20
Region VI	991	84, 198	647	14, 135	606	13, 516	93	472	19	23	25	124
Arkansas	98	7, 285	57	930	56	926	3	4				
Louisiana	126	17, 406	95	5, 591	95	5, 585	4	5	1	1		
New Mexico	45	2, 906	25	235	19	57	14	166	2	3	1	9
Oklahoma	154	11, 693	99	1, 667	79	1, 375	60	273	1	2	4	17
Texas	568	44, 908	371	5, 712	357	5, 573	12	24	15	17	20	98
Region VII	537	56, 289	190	3, 847	177	3, 647	32	123	29	35	10	42
Iowa	135	11, 433	37	167	34	140	8	13	6	7	3	7
Kansas	140	9, 854	44	552	40	515	7	18	5	7	4	12
Missouri	154	24, 071	82	2, 615	81	2, 597	3	4	13	14		
Nebraska	108	10, 931	27	513	22	395	14	88	5	7	3	23
Region VIII	376	33, 877	134	1, 287	63	453	93	732	28	88	3	14
Colorado	100	12, 512	44	530	32	364	18	109	12	53	1	4
Montana	68	5, 597	25	167	10	20	19	130	4	7	2	10
North Dakota	63	2, 831	15	125	1	2	14	123				
South Dakota	69	5, 468	22	249	3	8	21	240	1	1		
Utah	42	4, 103	16	114	10	34	11	62	7	18		
Wyoming	34	3, 366	12	102	7	25	10	68	4	9		
Region IX	659	89, 292	457	9, 365	370	6, 473	133	671	281	1, 401	21	820
Arizona	67	7, 085	45	858	32	292	27	286	15	135	4	145
California	571	79, 523	398	8, 330	328	6, 078	95	320	262	1, 257	17	675
Nevada	21	2, 684	14	177	10	103	11	65	4	9		
Region X	259	22, 855	113	859	57	422	72	272	54	130	11	35
Alaska												
Idaho	50	2, 869	17	61	6	6	9	41	11	12	2	2
Oregon	89	9, 801	35	282	18	167	26	79	18	85	1	1
Washington	120	10, 185	61	516	33	249	37	152	25	83	8	32

TABLE 2.—NUMBER OF HOSPITALS AND NUMBER OF PATIENTS BY RACE, 1969 REPORTS

State and region	Total		Serving minority patients									
			Total		Negro		Indian		Oriental		Spanish surnamed Americans	
	Hospitals	Patients	Hospitals	Patients	Hospitals	Patients	Hospitals	Patients	Hospitals	Patients	Hospitals	Patients
Total	6,539	1,056,280	4,878	168,207	4,051	133,138	789	3,554	917	2,912	2,230	28,603
Region I	364	70,785	198	2,882	166	2,125	32	78	58	115	105	564
Connecticut	50	12,717	39	1,260	36	915	4	8	12	22	33	315
Maine	60	5,421	13	39	6	13	9	20	1	1	3	5
Massachusetts	179	40,551	121	1,451	101	1,094	17	47	41	88	63	222
New Hampshire	36	3,343	8	12	6	10			1	1	1	
Rhode Island	17	5,873	11	111	11	87	2	3			5	21
Vermont	22	2,880	6	9	6	6			3	3		
Region II	512	171,837	427	30,144	405	21,352	48	383	131	585	299	7,824
New Jersey	127	33,650	112	4,908	112	4,042	3	100	25	50	85	716
New York	385	138,187	315	25,236	293	17,310	45	283	106	535	214	7,108
Region III	573	148,560	460	26,710	446	26,001	27	81	85	178	112	450
Delaware	12	3,528	12	772	12	748	3	4	2	2	7	18
District of Columbia	16	10,409	16	5,244	16	5,173	2	22	8	31	5	18
Maryland	59	17,590	52	3,959	51	3,837	6	18	19	31	15	73
Pennsylvania	301	78,204	223	8,788	215	8,387	12	32	40	65	68	304
Virginia	108	28,012	100	7,352	98	7,298	4	5	10	16	13	35
West Virginia	78	10,817	57	595	54	558			6	33	4	4
Region IV	1,065	145,747	951	35,978	935	34,601	42	179	42	57	98	1,141
Alabama	127	11,334	122	2,450	121	2,437	3	3	2	2	5	8
Florida	182	30,672	170	7,188	161	6,101	3	12	15	22	67	1,053
Georgia	154	22,603	144	6,675	143	6,640	2	4	6	9	11	22
Kentucky	129	14,516	92	1,348	90	1,308	3	36	3	3	1	1
Mississippi	90	10,660	89	3,744	87	3,711	4	8	1	1	2	24
North Carolina	154	23,965	143	6,613	142	6,469	23	111	6	11	4	22
South Carolina	77	12,453	75	4,855	75	4,848	2	3	3	3	1	1
Tennessee	152	19,544	116	3,105	116	3,087	2	2	6	6	7	10

Region V	1, 284	231, 477	861	27, 582	702	24, 676	149	753	164	316	371	1, 837
Illinois	264	52, 413	197	8, 128	191	7, 042	13	53	55	128	110	9, 105
Indiana	129	28, 496	78	2, 452	71	2, 080	8	258	10	20	37	94
Michigan	248	47, 211	215	7, 029	152	6, 500	38	93	35	62	102	374
Minnesota	189	18, 977	66	835	41	575	39	157	17	34	25	69
Ohio	244	57, 837	192	7, 913	189	7, 581	5	47	31	49	56	256
Wisconsin	210	26, 543	113	1, 225	58	898	46	145	16	23	41	159
Region VI	922	88, 236	791	20, 997	665	13, 050	120	512	35	55	412	7, 380
Arkansas	97	6, 474	63	942	62	916	4	5	----	----	3	21
Louisiana	129	13, 557	121	4, 319	120	4, 218	3	24	6	11	16	66
New Mexico	47	2, 922	46	1, 105	20	59	18	96	4	7	44	943
Oklahoma	145	14, 099	117	1, 716	95	1, 152	75	323	4	4	37	237
Texas	504	51, 184	444	2, 915	368	6, 705	20	64	21	33	312	6, 113
Region VII	581	61, 136	260	4, 807	224	4, 272	54	166	36	57	116	312
Iowa	144	11, 934	42	212	38	164	10	12	5	8	16	28
Kansas	157	13, 035	71	829	56	690	13	26	5	10	42	103
Missouri	166	2, 378	107	3, 397	103	3, 192	16	70	22	33	30	102
Nebraska	114	7, 789	40	369	27	226	15	58	4	6	28	79
Region VIII	338	24, 744	185	2, 210	54	359	95	491	32	59	118	1, 301
Colorado	89	9, 263	66	1, 427	30	300	14	61	16	30	66	1, 036
Montana	63	3, 795	33	219	7	10	24	171	3	7	10	31
North Dakota	60	3, 598	23	70	1	1	16	56	----	----	9	13
South Dakota	61	3, 495	26	149	3	3	24	138	2	2	4	6
Utah	38	3, 027	21	227	9	26	12	40	9	18	14	143
Wyoming	27	1, 566	16	118	4	19	5	25	2	2	15	72
Region IX	633	93, 667	575	15, 538	387	6, 258	131	496	275	1, 319	523	7, 465
Arizona	59	4, 519	53	904	28	145	16	148	3	4	47	607
California	555	87, 314	506	14, 456	349	6, 061	109	303	267	1, 301	463	6, 791
Nevada	19	1, 834	16	178	10	52	6	45	5	14	13	67
Region X	267	20, 091	170	1, 359	67	444	91	415	59	171	76	329
Alaska	19	570	17	174	5	8	15	156	2	8	1	2
Idaho	45	2, 032	22	101	4	9	12	28	5	7	16	57
Oregon	85	7, 813	49	324	18	129	21	78	21	46	23	71
Washington	118	9, 676	82	760	40	298	43	153	31	110	31	199

1969 TITLE VI COMPLIANCE SURVEY—HOSPITALS—Continued

TABLE 3.—NUMBER OF HOSPITALS REPORTING STAFF PRIVILEGES AND NUMBER OF STAFF BY RACE OF STAFF PHYSICIAN OR DENTIST, 1966 REPORTS

State and region	Total		Minorities					
			Total		Negro		Other	
	Hospitals	Staff	Hospitals	Staff	Hospitals	Staff	Hospitals	Staff
Total	6,173	483,219	2,143	13,551	1,468	8,297	1,240	5,254
Region I	359	36,364	141	346	79	177	87	169
Connecticut	52	8,617	32	109	24	63	18	46
Maine	66	2,364	15	23	3	5	12	18
Massachusetts	171	20,367	69	154	43	94	35	60
New Hampshire	30	1,334	9	12	1	1	8	11
Rhode Island	17	2,558	9	25	4	5	8	20
Vermont	23	1,124	7	23	4	9	6	14
Region II	467	75,107	266	2,386	218	1,327	161	1,059
New Jersey	111	14,851	71	324	60	265	33	59
New York	356	60,256	195	2,062	158	1,062	128	1,000
Region III	425	41,561	208	1,617	145	1,273	113	344
Delaware	10	929	6	26	4	16	3	10
District of Columbia	11	4,945	10	543	10	499	5	44
Maryland	52	7,163	28	251	21	200	17	51
Pennsylvania	154	16,945	82	389	59	283	44	106
Virginia	107	8,768	55	349	41	259	23	90
West Virginia	91	2,811	27	59	10	16	21	43
Region IV	970	53,198	252	1,147	227	3,042	41	105
Alabama	135	7,114	26	210	23	199	3	11
Florida	150	12,642	40	119	36	110	4	9
Georgia	133	6,572	33	228	30	215	5	13
Kentucky	120	7,932	32	127	22	86	16	41
Mississippi	84	1,903	24	53	23	52	1	1
North Carolina	140	6,092	48	198	48	193	4	5
South Carolina	65	2,502	24	73	23	72	1	1
Tennessee	143	8,441	25	139	22	115	7	24
Region V	1,220	90,384	467	2,750	304	1,967	268	783
Illinois	309	23,784	124	629	89	413	65	216
Indiana	119	8,298	46	257	25	201	19	56
Michigan	180	15,232	82	904	64	742	41	162
Minnesota	173	8,326	37	73	9	13	33	60
Ohio	242	25,588	129	741	97	542	71	199
Wisconsin	197	9,156	49	146	20	56	39	90
Region VI	991	52,491	170	1,007	129	547	64	460
Arkansas	98	2,978	13	40	12	37	2	3
Louisiana	126	5,871	13	30	13	28	1	2
New Mexico	45	1,525	9	25	4	11	7	14
Oklahoma	154	5,888	23	110	18	48	9	62
Texas	568	36,229	112	802	82	423	45	379
Region VII	537	25,414	140	787	88	513	84	274
Iowa	135	5,476	38	91	19	30	24	61
Kansas	140	3,830	22	103	13	77	14	26
Missouri	154	12,044	61	560	48	385	35	175
Nebraska	108	4,064	19	33	8	21	11	12
Region VIII	360	15,199	57	210	14	38	53	172
Colorado	98	9,629	22	113	11	34	18	79
Montana	65	1,220	5	11			5	11
North Dakota	62	1,142	6	12	1	2	6	10
South Dakota	62	798	7	42			7	42
Utah	41	1,912	12	23			12	23
Wyoming	32	498	5	9	2	2	5	7

1969 TITLE VI COMPLIANCE SURVEY—HOSPITALS—Continued

TABLE 3.—NUMBER OF HOSPITALS REPORTING STAFF PRIVILEGES AND NUMBER OF STAFF BY RACE OF STAFF PHYSICIAN OR DENTIST, 1966 REPORTS—Continued

State and region	Total		Minorities					
			Total		Negro		Other	
	Hospitals	Staff	Hospitals	Staff	Hospitals	Staff	Hospitals	Staff
Region IX	605	77,379	376	3,082	238	1,347	310	1,735
Arizona	63	6,106	17	55	10	23	16	32
California	523	70,382	359	3,027	228	1,324	294	1,703
Nevada	19	891						
Region X	239	16,122	66	219	26	66	59	153
Alaska								
Idaho	49	1,035	4	4			4	4
Oregon	83	5,305	23	65	4	12	23	53
Washington	107	9,782	39	150	22	54	32	96

TABLE 4.—NUMBER OF HOSPITALS REPORTING STAFF PRIVILEGES AND NUMBER OF STAFF BY RACE OF STAFF PHYSICIAN OR DENTIST, 1969 REPORTS

State and region	Total		Minorities					
			Total		Negro		Other	
	Hospitals	Staff	Hospitals	Staff	Hospitals	Staff	Hospitals[1]	Staff
Total	6,539	593,276	3,451	28,596	1,862	10,138		18,458
Region I	364	39,049	221	742	107	228		514
Connecticut	50	9,032	40	206	27	87		119
Maine	60	2,319	26	56	8	8		48
Massachusetts	179	22,209	116	327	63	122		205
New Hampshire	36	1,693	15	29	1	1		28
Rhode Island	17	2,672	17	112	6	8		104
Vermont	22	1,124	7	12	2	2		10
Region II	512	86,141	404	5,007	285	1,636		3,371
New Jersey	127	18,417	107	943	84	357		586
New York	385	67,724	297	4,064	201	1,279		2,785
Region III	573	62,491	397	3,631	214	1,597		2,034
Delaware	12	1,119	10	67	4	11		56
District of Columbia	16	7,763	10	872	10	683		189
Maryland	58	10,023	48	810	30	209		601
Pennsylvania	301	28,829	195	993	109	411		582
Virginia	108	11,431	79	623	51	272		351
West Virginia	78	3,326	55	266	10	11		255
Region IV	1,065	71,335	450	2,971	290	1,069		1,902
Alabama	127	7,675	33	151	27	124		27
Florida	182	18,981	112	1,305	56	157		1,148
Georgia	154	9,463	63	552	39	292		260
Kentucky	129	9,098	53	204	22	61		143
Mississippi	90	2,700	33	88	24	51		37
North Carolina	154	10,300	74	342	57	139		203
South Carolina	77	3,783	38	105	36	88		17
Tennessee	152	9,335	44	224	29	157		67
Region V	1,284	109,262	772	6,211	354	2,552		3,659
Illinois	264	24,444	186	1,809	88	689		1,120
Indiana	129	10,933	86	810	30	227		583
Michigan	248	22,260	160	1,536	99	883		653
Minnesota	189	11,664	66	233	13	33		200
Ohio	244	29,447	189	1,508	101	639		869
Wisconsin	210	10,514	85	315	23	81		234

See footnote at end of table.

TABLE 4.—NUMBER OF HOSPITALS REPORTING STAFF PRIVILEGES AND NUMBER OF STAFF BY RACE OF STAFF PHYSICIAN OR DENTIST, 1969 REPORTS—Continued

State and region	Total		Minorities					
			Total		Negro		Other	
	Hospitals	Staff	Hospitals	Staff	Hospitals	Staff	Hospitals[1]	Staff
Region VI	922	54,128	337	2,581	148	613	.....	1,968
Arkansas	97	3,460	15	45	14	33	.....	12
Louisiana	129	8,341	43	220	25	68	.....	152
New Mexico	47	2,315	19	89	3	12	.....	77
Oklahoma	145	6,585	33	157	19	65	.....	92
Texas	504	33,427	227	2,070	87	435	.....	1,635
Region VII	581	29,857	194	1,226	105	512	.....	714
Iowa	144	5,804	46	147	23	42	.....	105
Kansas	157	5,185	37	214	17	78	.....	136
Missouri	166	13,926	85	806	55	373	.....	433
Nebraska	114	4,942	26	59	10	19	.....	40
Region VIII	338	16,450	83	430	21	97	.....	333
Colorado	89	10,106	30	217	16	73	.....	144
Montana	63	1,578	2	2	.....	.....	.....	2
North Dakota	60	1,135	17	35	1	1	.....	34
South Dakota	61	1,033	15	22	1	1	.....	21
Utah	38	2,046	11	143	1	20	.....	123
Wyoming	27	552	8	11	2	2	.....	9
Region IX	633	103,443	483	5,328	301	1,718	.....	3,610
Arizona	59	7,388	33	174	13	32	.....	142
California	555	94,932	446	5,145	286	1,683	.....	3,462
Nevada	19	1,123	4	9	2	3	.....	6
Region X	267	21,120	110	469	37	116	.....	353
Alaska	19	363	4	6	.....	.....	.....	6
Idaho	45	1,087	7	10	.....	.....	.....	10
Oregon	85	7,204	33	101	5	11	.....	90
Washington	118	12,466	66	352	32	105	.....	247

[1] The unduplicated count of hospitals reporting staff positions filled by other minority group physicians or dentists was not available.

TABLE 5.—NUMBER OF HOSPITALS REPORTING INTERNS AND RESIDENTS AND NUMBER OF INTERNS AND RESIDENTS BY RACE, 1966 REPORTS

State and region	Total		Minorities					
			Total		Negro		Other	
	Hospitals	Interns and residents	Hospitals	Interns and residents	Hospitals	Interns and residents	Hospitals	Interns and resident
Total	1,143	34,188	707	6,160	282	860	605	5,300
Region I	108	2,691	69	485	18	27	64	458
Connecticut	28	768	20	189	4	10	20	179
Maine	7	58	3	6	1	1	3	5
Massachusetts	59	1,420	35	250	11	13	31	237
New Hampshire	2	119	1	2	.....	.....	1	2
Rhode Island	7	136	7	20	.....	.....	7	29
Vermont	5	190	3	18	2	3	2	15
Region II	269	9,388	195	2,336	90	292	168	2,044
New Jersey	68	800	46	303	10	11	43	292
New York	201	8,588	149	2,033	80	281	125	1,752

TABLE 5.—NUMBER OF HOSPITALS REPORTING INTERNS AND RESIDENTS AND NUMBER OF INTERNS AND RESIDENTS BY RACE, 1966 REPORTS—Continued

State and region	Total		Minorities					
			Total		Negro		Other	
	Hospitals	Interns and residents	Hospitals	Interns and residents	Hospitals	Interns and residents	Hospitals	Interns and residents
Region III	142	3,763	102	815	36	173	84	642
Delaware	6	87	3	24	1	2	3	22
District of Columbia	9	507	8	161	4	98	5	63
Maryland	25	948	21	172	8	15	17	157
Pennsylvania	65	1,652	41	366	21	54	30	312
Virginia	25	441	23	53	2	4	23	49
West Virginia	12	128	6	39			6	39
Region IV	132	3,204	47	252	18	64	34	188
Alabama	11	409	1	1	1	1		
Florida	45	555	10	25	2	3	8	22
Georgia	16	650	8	42	5	8	5	34
Kentucky	16	358	10	83	2	2	10	81
Mississippi	3	120	2	3	2	3		
North Carolina	19	597	7	19	4	10	4	9
South Carolina	5	158	2	6			2	6
Tennessee	17	357	7	73	2	37	5	36
Region V	224	7,574	151	1,558	64	166	133	1,392
Illinois	64	2,272	48	543	19	47	42	496
Indiana	9	202	6	12	3	5	4	7
Michigan	36	968	22	179	13	36	20	143
Minnesota	23	1,379	12	133	3	9	12	124
Ohio	77	2,223	51	553	20	60	44	493
Wisconsin	15	530	12	138	6	9	11	129
Region VI	71	2,136	24	84	5	6	22	78
Arkansas	3	25						
Louisiana	11	662	5	19	2	2	4	17
New Mexico	3	9	1	1			1	1
Oklahoma	10	269	3	9			3	9
Texas	44	1,171	15	55	3	4	14	51
Region VII	60	1,429	36	252	15	55	32	197
Iowa	10	91	5	9	2	2	4	7
Kansas	4	46	1	5	1	1	1	4
Missouri	36	1,095	25	226	11	51	23	175
Nebraska	10	197	5	12	1	1	4	11
Region VIII	24	739	10	52	2	3	10	49
Colorado	14	510	6	35	1	2	6	33
Montana	1	3						
North Dakota	2	13	2	7			2	7
South Dakota								
Utah	7	213	2	10	1	1	2	9
Wyoming								
Region IX	88	2,532	58	282	32	70	45	212
Arizona	10	225	5	67	4	4	5	63
California	77	2,306	53	215	28	66	40	149
Nevada	1	1						
Region X	25	732	15	44	2	4	13	40
Alaska								
Idaho								
Oregon	11	269	6	16			6	16
Washington	14	463	9	28	2	4	7	24

TABLE 6.—NUMBER OF HOSPITALS REPORTING INTERNS AND RESIDENTS AND NUMBER OF INTERNS AND RESIDENTS BY RACE, 1969 REPORTS

State and region	Total		Minorities					
			Total		Negro		Other	
	Hospitals	Interns and residents	Hospitals	Interns and residents	Hospitals	Interns and residents	Hospitals [1]	Interns and residents
Total	1,129	48,325	821	9,838	299	1,047	.....	8,791
Region I	108	3,498	74	612	23	39	.....	573
Connecticut	29	849	26	237	6	15	.....	222
Maine	6	58	1	3	.....	.....	.....	3
Massachusetts	59	2,016	38	290	12	18	.....	272
New Hampshire	3	206	2	8	2	2	.....	6
Rhode Island	9	220	6	71	2	3	.....	68
Vermont	2	149	1	3	1	1	.....	2
Region II	214	10,921	189	3,456	85	351	.....	3,105
New Jersey	63	1,131	53	518	10	17	.....	501
New York	151	9,790	136	2,938	75	334	.....	2,604
Region III	185	6,749	141	1,656	49	219	.....	1,437
Delaware	5	81	2	31	1	1	.....	30
District of Columbia	10	928	8	277	6	121	.....	156
Maryland	31	1,359	29	416	11	31	.....	385
Pennsylvania	108	3,554	75	750	29	63	.....	687
Virginia	22	642	19	123	2	3	.....	120
West Virginia	9	185	8	59	.....	.....	.....	59
Region IV	109	4,703	70	405	12	49	.....	356
Alabama	11	384	4	8	2	3	.....	5
Florida	27	1,087	20	55	2	3	.....	52
Georgia	19	769	12	69	1	1	.....	68
Kentucky	13	424	7	81	1	2	.....	79
Mississippi	3	143	1	11	.....	.....	.....	11
North Carolina	15	883	11	40	4	4	.....	36
South Carolina	5	212	3	12	.....	.....	.....	12
Tennessee	16	801	12	129	2	36	.....	93
Region V	215	10,671	164	2,384	57	199	.....	2,185
Illinois	59	2,339	49	603	16	53	.....	550
Indiana	15	552	7	34	4	7	.....	27
Michigan	27	2,730	22	705	13	70	.....	635
Minnesota	20	1,498	13	175	4	14	.....	161
Ohio	76	2,964	59	778	19	53	.....	725
Wisconsin	18	588	14	89	1	2	.....	87
Region VI	73	3,164	38	393	12	23	.....	370
Arkansas	5	171	1	4	.....	.....	.....	4
Louisiana	11	745	5	57	1	3	.....	54
New Mexico	4	127	3	18	.....	.....	.....	18
Oklahoma	12	357	3	20	1	1	.....	19
Texas	41	1,764	26	294	10	19	.....	275
Region VII	66	2,341	49	364	18	41	.....	323
Iowa	11	435	8	60	1	2	.....	58
Kansas	8	324	7	49	4	8	.....	41
Missouri	38	1,393	30	245	13	31	.....	214
Nebraska	9	189	4	10	.....	.....	.....	10
Region VIII	29	818	17	56	3	3	.....	53
Colorado	15	698	11	43	1	1	.....	42
Montana	.....	.....	.....	.....	.....	.....	.....	.....
North Dakota	3	16	1	1	1	1	.....	.....
South Dakota	3	14	1	1	.....	.....	.....	1
Utah	8	90	4	11	1	1	.....	10
Wyoming	.....	.....	.....	.....	.....	.....	.....	.....

See footnote at end of table.

TABLE 6.—NUMBER OF HOSPITALS REPORTING INTERNS AND RESIDENTS AND NUMBER OF INTERNS AND RESIDENTS BY RACE, 1969 REPORTS—Continued

State and region	Total		Minorities					
			Total		Negro		Other	
	Hospitals	Interns and residents	Hospitals	Interns and residents	Hospitals	Interns and residents	Hospitals[1]	Interns and residents
Region IX	105	4,497	63	451	37	120	.....	331
Arizona	13	364	8	67	2	3	.....	64
California	92	4,133	55	384	35	117	.....	267
Nevada	.....	.....	.....	.....	.....	.....	.....	.....
Region X	25	963	16	61	3	3	.....	58
Alaska	.....	.....	.....	.....	.....	.....	.....	.....
Idaho	.....	.....	.....	.....	.....	.....	.....	.....
Oregon	12	661	11	47	3	3	.....	44
Washington	13	302	5	14	.....	.....	.....	14

[1] The number of hospitals reporting participation in the intern and resident training program by minority group persons other than Negro was not available.

TABLE 7.—NUMBER OF HOSPITALS REPORTING STUDENT NURSES AND NUMBER OF STUDENT NURSES BY RACE 1966 REPORTS

State and region	Total		Minorities					
			Total		Negro		Other	
	Hospitals	Nurses	Hospitals	Nurses	Hospitals	Nurses	Hospitals	Nurses
Total	1,009	81,670	525	2,608	461	2,278	153	330
Region I	104	8,950	39	78	36	68	7	10
Connecticut	22	2,268	10	21	10	18	2	3
Maine	6	526	1	2	1	1	1	1
Massachusetts	59	4,925	23	39	20	33	4	6
New Hampshire	10	567	1	2	1	2	.....	.....
Rhode Island	6	646	4	14	4	14	.....	.....
Vermont	1	18	.....	.....	.....	.....	.....	.....
Region II	126	11,984	83	533	80	491	21	42
New Jersey	32	2,908	24	44	23	43	1	1
New York	94	9,076	59	489	57	448	20	41
Region III	116	10,189	49	230	44	216	10	14
Delaware	4	221	1	1	1	1	.....	.....
District of Columbia	4	349	3	11	3	11	.....	.....
Maryland	16	1,765	12	148	12	145	1	3
Pennsylvania	53	5,229	21	54	18	46	6	8
Virginia	24	1,702	6	8	4	5	3	3
West Virginia	15	923	6	8	6	8	.....	.....
Region IV	117	8,000	56	412	52	404	6	8
Alabama	13	978	6	31	6	30	1	1
Florida	19	1,144	11	53	11	53	.....	.....
Georgia	14	1,361	6	157	6	157	.....	.....
Kentucky	22	1,031	17	46	17	44	1	2
Mississippi	6	182	3	18	3	18	.....	.....
North Carolina	21	1,643	6	92	4	89	2	3
South Carolina	9	732	3	4	2	3	1	1
Tennessee	13	929	4	11	3	10	1	1
Region V	217	22,377	107	419	94	376	27	43
Illinois	79	6,523	41	240	35	219	10	21
Indiana	19	1,925	11	22	11	22	.....	.....
Michigan	27	2,826	11	38	11	37	1	1
Minnesota	21	2,683	5	13	3	6	4	7
Ohio	49	5,992	33	98	32	89	8	9
Wisconsin	22	2,428	6	8	2	3	4	5

27-401 O - 74 - 21

TABLE 7.—NUMBER OF HOSPITALS REPORTING STUDENT NURSES AND NUMBER OF STUDENT NURSES BY RACE, 1966 REPORTS—Continued

State and region	Total		Minorities					
			Total		Negro		Other	
	Hospitals	Nurses	Hospitals	Nurses	Hospitals	Nurses	Hospitals	Nurses
Region VI	107	5,187	72	344	68	294	19	50
Arkansas	9	542	3	21	2	19	1	2
Louisiana	13	1,354	10	78	10	78	----	----
New Mexico	1	49	1	3	1	2	1	1
Oklahoma	11	602	8	44	7	24	6	20
Texas	73	2,640	50	198	48	171	11	27
Region VII	69	6,685	31	235	26	223	8	12
Iowa	17	1,543	6	9	3	6	3	3
Kansas	13	785	7	14	7	10	2	4
Missouri	25	3,005	17	210	15	205	3	5
Nebraska	14	1,352	1	2	1	2	----	----
Region VIII	40	2,515	20	46	12	16	15	30
Colorado	11	984	8	25	7	11	5	14
Montana	6	321	3	4	2	2	2	2
North Dakota	10	566	2	2	1	1	1	1
South Dakota	6	383	2	6	----	----	2	6
Utah	6	255	5	9	2	2	5	7
Wyoming	1	6	----	----	----	----	----	----
Region IX	72	3,283	53	281	43	180	29	101
Arizona	1	17	1	2	----	----	1	2
California	68	3,182	50	273	41	175	27	98
Nevada	3	84	2	6	2	5	1	1
Region X	41	2,500	15	30	6	10	11	20
Alaska	----	----	----	----	----	----	----	----
Idaho	1	4	----	----	----	----	----	----
Oregon	21	716	2	5	1	1	1	4
Washington	19	1,780	13	25	5	9	10	16

TABLE 8.—NUMBER OF HOSPITALS REPORTING STUDENT NURSES AND NUMBER OF STUDENT NURSES BY RACE, 1969 REPORTS

State and region	Total		Minorities					
			Total		Negro		Other	
	Hospitals	Nurses	Hospitals [1]	Nurses	Hospitals	Nurses	Hospitals [1]	Nurses
Total	1,102	81,145	----	4,459	572	2,887	----	1,572
Region I	99	8,038	----	264	44	82	----	182
Connecticut	23	1,520	----	26	14	21	----	5
Maine	5	389	----	2	1	1	----	1
Massachusetts	54	4,789	----	219	25	51	----	168
New Hampshire	10	676	----	1	----	----	----	1
Rhode Island	4	482	----	12	4	9	----	3
Vermont	3	182	----	4	----	----	----	4
Region II	132	10,777	----	857	82	624	----	233
New Jersey	36	2,633	----	285	26	205	----	80
New York	96	8,144	----	572	56	419	----	153
Region III	170	14,595	----	598	91	427	----	171
Delaware	5	447	----	12	2	12	----	----
District of Columbia	5	388	----	187	5	114	----	73
Maryland	20	1,311	----	125	18	117	----	8
Pennsylvania	106	10,401	----	239	48	154	----	85
Virginia	24	1,341	----	24	11	19	----	5
West Virginia	10	807	----	11	7	11	----	----

See footnote at end of table.

TABLE 8.—NUMBER OF HSOPITALS REPORTING STUDENT NURSES AND NUMBER OF STUDENT NURSES BY RACE, 1969 REPORTS—Continued

State and region	Total		Minorities					
			Total		Negro		Other	
	Hospitals	Nurses	Hospitals	Nurses	Hospitals	Nurses	Hospitals [1]	Nurses
Region IV	126	7,836	.....	633	87	561	.....	72
Alabama	16	1,065	.....	136	14	135	.....	1
Florida	19	1,324	.....	120	14	110	.....	10
Georgia	18	1,406	.....	150	14	99	.....	51
Kentucky	12	682	.....	36	9	36	.....	.....
Mississippi	7	250	.....	22	6	22	.....	.....
North Carolina	28	1,849	.....	132	14	124	.....	8
South Carolina	6	422	.....	6	4	6	.....	.....
Tennessee	20	838	.....	31	12	29	.....	2
Region V	236	20,546	.....	667	97	435	.....	232
Illinois	61	4,235	.....	184	26	79	.....	105
Indiana	23	2,418	.....	117	8	42	.....	75
Michigan	40	3,543	.....	193	19	163	.....	30
Minnesota	26	2,095	.....	16	5	12	.....	4
Ohio	63	5,991	.....	136	35	128	.....	8
Wisconsin	23	2,264	.....	21	4	11	.....	10
Region VI	116	4,239	.....	541	74	286	.....	255
Arkansas	9	393	.....	19	5	14	.....	5
Louisiana	11	544	.....	75	7	75	.....	.....
New Mexico	3	144	.....	4	.....	.....	.....	4
Oklahoma	11	554	.....	41	7	18	.....	23
Texas	82	2,604	.....	402	55	179	.....	223
Region VII	83	7,124	.....	202	30	159	.....	43
Iowa	22	1,636	.....	7	3	4	.....	3
Kansas	18	1,122	.....	34	8	17	.....	17
Missouri	29	2,765	.....	153	16	134	.....	19
Nebraska	14	1,601	.....	8	3	4	.....	4
Region VIII	32	1,838	.....	51	9	17	.....	34
Colorado	10	559	.....	31	8	15	.....	16
Montana	5	262	.....	4	.....	.....	.....	4
North Dakota	8	334	.....	.....	.....	.....	.....	.....
South Dakota	5	448	.....	8	.....	.....	.....	8
Utah	4	235	.....	8	1	2	.....	6
Wyoming	.....	.....	.....	.....	.....	.....	.....	.....
Region IX	85	4,535	.....	601	52	282	.....	319
Arizona	4	266	.....	26	3	5	.....	21
California	78	4,233	.....	569	47	271	.....	298
Nevada	3	36	.....	6	2	6	.....	.....
Region X	23	1,517	.....	45	6	14	.....	31
Alaska	.....	.....	.....	.....	.....	.....	.....	.....
Idaho	2	122	.....	1	.....	.....	.....	1
Oregon	5	646	.....	22	3	9	.....	13
Washington	16	749	.....	22	3	5	.....	17

[1] The number of hospitals reporting participation in student nurse training by minority group persons other than Negro was not available.

TABLE 9.—NUMBER OF HOSPITALS REPORTING OTHER TRAINING PROGRAMS AND NUMBER OF TRAINEES BY RACE, 1966 REPORTS

State and region	Total		Minorities					
			Total		Negro		Other	
	Hospitals	Trainees	Hospitals	Trainees	Hospitals	Trainees	Hospitals	Trainees
Total	1,321	25,193	829	4,849	718	4,010	244	839
Region I	99	1,874	42	115	32	83	13	32
Connecticut	17	347	12	46	10	29	4	17
Maine	9	110						
Massachusetts	59	1,074	27	54	20	40	8	14
New Hampshire	5	93	1	1	1	1		
Rhode Island	5	77	2	14	1	13	1	1
Vermont	4	173						
Region II	120	2,501	95	688	72	465	47	223
New Jersey	43	683	36	131	28	74	15	57
New York	77	1,818	59	557	44	391	32	166
Region III	105	2,543	70	555	66	537	12	18
Delaware	3	95	3	13	3	13		
District of Columbia	5	112	5	65	5	64	1	1
Maryland	9	316	8	98	8	94	2	4
Pennsylvania	41	995	23	111	20	104	5	7
Virginia	29	744	22	243	21	239	3	4
West Virginia	18	281	9	25	9	23	1	2
Region IV	206	3,928	156	1,007	146	960	15	47
Alabama	22	444	15	161	15	156	1	5
Florida	34	833	32	208	28	190	6	18
Georgia	35	501	27	159	25	146	3	13
Kentucky	25	555	17	114	14	104	4	10
Mississippi	11	173	11	55	10	54	1	1
North Carolina	23	432	17	122	17	122		
South Carolina	12	235	9	71	9	71		
Tennessee	44	755	28	117	28	117		
Region V	278	6,139	137	915	121	658	49	257
Illinois	85	1,727	57	530	48	361	23	169
Indiana	29	692	14	61	13	57	3	4
Michigan	49	1,082	13	93	17	79	6	14
Minnesota	30	856	4	5	2	2	3	3
Ohio	54	1,212	37	195	33	136	9	59
Wisconsin	31	570	12	31	8	23	5	8
Region VI	227	3,434	158	832	153	781	23	51
Arkansas	33	271	20	55	19	54	1	1
Louisiana	16	438	11	111	11	111		
New Mexico	5	104	3	11	3	8	1	3
Oklahoma	20	382	12	69	12	60	4	9
Texas	153	2,239	112	586	108	548	17	38
Region VII	69	1,336	43	168	35	137	14	31
Iowa	15	374	5	24	4	23	1	1
Kansas	7	120	6	22	5	17	2	5
Missouri	38	606	25	110	22	91	7	19
Nebraska	9	236	7	12	4	6	4	6
Region VIII	47	720	13	50	9	26	9	24
Colorado	17	347	7	38	6	23	4	15
Montana	9	113	1	5			1	5
North Dakota	5	114	2	2			2	2
South Dakota	4	13						
Utah	10	115	3	5	3	3	2	2
Wyoming	2	18						

TABLE 9.—NUMBER OF HOSPITALS REPORTING OTHER TRAINING PROGRAMS AND NUMBER OF TRAINEES BY RACE, 1966 REPORTS—Continued

State and region	Total		Minorities					
			Total		Negro		Other	
	Hospitals	Trainees	Hospitals	Trainees	Hospitals	Trainees	Hospitals	Trainees
Region IX	108	2,112	94	483	70	340	52	143
Arizona	9	153	6	19	5	13	4	6
California	90	1,873	80	442	61	315	42	127
Nevada	9	86	8	22	4	12	6	10
Region X	62	606	21	36	14	23	10	13
Alaska								
Idaho	9	89	2	7	1	6	1	1
Oregon	16	198	8	11	4	5	5	6
Washington	37	319	11	18	9	12	4	6

TABLE 10.—NUMBER OF HOSPITALS REPORTING OTHER TRAINING PROGRAMS AND NUMBER OF TRAINEES BY RACE, 1969 REPORTS

State and region	Total		Minorities					
			Total		Negro		Other	
	Hospitals	Trainees	Hospitals	Trainees	Hospitals	Trainees	Hospitals [1]	Trainees
Total	2,252	67,257	1,515	12,655	1,241	9,061		3,594
Region I	172	5,754	77	336	66	193		143
Connecticut	33	1,133	24	112	23	75		37
Maine	16	206	2	2				2
Massachusetts	92	3,321	44	188	40	108		80
New Hampshire	15	192	2	2				2
Rhode Island	9	326	4	31	2	9		22
Vermont	7	576	1	1	1	1		
Region II	213	6,976	151	1,951	120	1,264		687
New Jersey	70	2,320	50	678	42	445		233
New York	143	4,656	101	1,273	78	819		454
Region III	268	9,580	181	1,701	169	1,445		256
Delaware	6	253	6	91	6	90		1
District of Columbia	8	277	8	171	8	151		20
Maryland	33	718	27	218	26	192		26
Pennsylvania	148	6,566	90	877	82	689		188
Virginia	45	1,196	40	326	39	307		19
West Virginia	28	570	10	18	8	16		2
Region IV	367	9,645	291	2,319	280	2,202		117
Alabama	43	968	38	321	37	310		11
Florida	55	2,114	45	404	43	373		31
Georgia	53	1,134	41	320	41	303		17
Kentucky	37	964	26	104	23	92		12
Mississippi	29	648	24	157	22	152		5
North Carolina	52	1,349	37	312	37	306		6
South Carolina	31	728	26	219	26	218		1
Tennessee	67	1,740	54	482	51	448		34
Region V	388	13,215	246	1,878	153	1,365		513
Illinois	107	3,248	75	701	57	457		244
Indiana	43	1,146	34	140	31	99		41
Michigan	41	2,524	28	432	24	355		77
Minnesota	31	1,938	19	57	8	12		45
Ohio	97	2,657	64	438	58	362		76
Wisconsin	69	1,702	26	110	15	80		30

See footnote at end of table.

TABLE 10.—NUMBER OF HOSPITALS REPORTING OTHER TRAINING PROGRAMS AND NUMBER OF TRAINEES BY RACE, 1969 REPORTS—Continued

State and region	Total		Minorities					
			Total		Negro		Other	
	Hospitals	Trainees	Hospitals	Trainees	Hospitals	Trainees	Hospitals[1]	Trainees
Region VI	316	7,172	253	2,213	213	1,449	.....	764
Arkansas	39	959	26	232	24	215	.....	17
Louisiana	36	1,258	30	361	30	358	.....	3
New Mexico	13	252	12	139	5	13	.....	126
Oklahoma	36	1,210	30	194	23	147	.....	47
Texas	192	3,493	155	1,287	131	716	.....	571
Region VII	156	5,414	85	460	69	376	.....	84
Iowa	36	726	8	26	4	12	.....	14
Kansas	36	2,026	23	164	16	124	.....	40
Missouri	63	1,790	44	236	43	219	.....	17
Nebraska	21	872	10	34	6	21	.....	13
Region VIII	88	1,764	47	209	22	56	.....	153
Colorado	31	867	22	155	13	45	.....	110
Montana	16	240	9	24	3	3	.....	21
North Dakota	15	222	5	9	1	2	.....	7
South Dakota	12	194	1	1	.....	.....	.....	1
Utah	8	197	5	10	2	2	.....	8
Wyoming	6	44	5	10	3	4	.....	6
Region IX	213	6,661	158	1,503	94	678	.....	825
Arizona	20	355	16	105	3	3	.....	102
California	185	6,217	137	1,387	90	673	.....	714
Nevada	8	89	5	11	1	2	.....	9
Region X	71	1,076	26	85	15	33	.....	52
Alaska	1	105	1	18	1	14	.....	4
Idaho	18	198	3	6	1	1	.....	5
Oregon	18	292	7	18	3	4	.....	14
Washington	34	481	15	43	10	14	.....	29

[1] The number of hospitals reporting participation in other training programs by minority group persons other than Negro was not available.

1969 TITLE VI COMPLIANCE SURVEY—ECF

TABLE 11.—NUMBER OF EXTENDED CARE FACILITIES AND NUMBER OF PATIENTS BY RACE OF PATIENTS, 1967 REPORTS

State and region	Total number of		Serving minority patients									
			Total		Negro		Indian		Oriental		Spanish surnamed Americans	
	Extended care facilities	Patients	Extended care facilities	Patients	Extended care facilities	Patients	Extended care facilities	Patients	Extended care facilities	Patients	Extended care facilities	Patients
Total	3,748	260,983	1,374	11,836	902	8,392	225	506	261	639	524	2,299
Region I	304	18,137	87	264	82	253	2	2	6	6	2	3
Connecticut	138	7,730	56	198	54	192	2	2	1	1	2	3
Maine	17	753	2	3	2	3						
Massachusetts	110	7,963	25	56	22	51			5	5		
New Hampshire	9	427										
Rhode Island	19	871	4	7	4	7						
Vermont	11	393										
Region II	266	29,286	124	2,095	114	1,850	4	12	22	100	33	133
New Jersey	59	5,103	25	348	23	342			2	3	3	3
New York	207	24,183	99	1,747	91	1,508	4	12	20	97	30	130
Region III	314	26,320	75	1,542	69	1,511			8	24	7	7
Delaware	7	941	1	2	1	2						
District of Columbia	6	1,262	4	471	4	454			1	17		
Maryland	41	3,762	14	228	12	224			2	2	2	2
Pennsylvania	199	17,206	34	598	31	590			3	3	5	5
Virginia	42	2,180	12	192	11	191			1	1		
West Virginia	19	969	10	51	10	50			1	1		
Region IV	433	24,135	103	1,186	95	1,168	3	5	3	3	6	10
Alabama	80	4,405	17	144	16	143			1	1		
Florida	127	7,110	33	240	27	229			2	2	5	9
Georgia	66	4,011	11	171	10	170					1	1
Kentucky	35	2,058	11	70	11	70						
Mississippi	14	434										
North Carolina	28	1,731	10	117	10	114	1	3				
South Carolina	48	2,409	11	261	11	260	1	1				
Tennessee	35	1,977	10	183	10	182	1	1				

1969 TITLE VI COMPLIANCE SURVEY—ECF—Continued

TABLE 11.—NUMBER OF EXTENDED CARE FACILITIES AND NUMBER OF PATIENTS BY RACE OF PATIENTS, 1967 REPORTS—Continued

State and region	Total number of		Serving minority patients									
			Total		Negro		Indian		Oriental		Spanish surnamed Americans	
	Extended care facilities	Patients	Extended care facilities	Patients	Extended care facilities	Patients	Extended care facilities	Patients	Extended care facilities	Patients	Extended care facilities	Patients
Region V	708	58,647	183	1,806	141	1,652	47	91	18	33	19	30
Illinois	147	14,160	31	621	29	609	2	3	5	6	2	3
Indiana	54	3,809	16	101	14	96	1	1	1	1	2	3
Michigan	109	10,358	49	644	39	589	14	23	6	20	10	12
Minnesota	126	9,540	27	71	15	37	13	23	4	4	1	2
Ohio	136	8,894	36	288	35	284			2	2	2	7
Wisconsin	136	11,886	24	81	9	37	17	41			2	3
Region VI	365	20,890	121	1,318	65	712	21	80	6	9	60	508
Arkansas	31	1,644	6	163	5	162					1	1
Louisiana	81	4,177	12	9	9	87	1	1			2	2
New Mexico	16	857	16	262	4	8	5	25			15	229
Oklahoma	28	1,714	12	128	6	80	9	47			1	1
Texas	209	12,498	75	675	41	384	6	7	6	9	41	275

Region VII	200	12,844	42	222	41	216	2	2	1	1	3	3
Iowa	68	3,792	4	8	4	8						
Kansas	50	2,011	16	65	15	61	1	1			3	3
Missouri	59	5,365	17	139	17	138			1	1		
Nebraska	23	1,676	5	10	5	9	1	1				
Region VIII	189	11,806	74	368	32	76	28	53	11	22	45	217
Colorado	85	6,230	46	290	25	68	9	11	7	14	36	197
Montana	32	1,571	9	25	1	1	7	21			2	3
North Dakota	23	1,431	2	3	1	1	2	2				
South Dakota	17	714	4	9			4	9				
Utah	24	1,468	9	23	2	2	4	4	3	7	5	10
Wyoming	8	392	4	18	3	4	2	6	1	1	2	7
Region IX	718	43,072	460	2,758	228	378	67	145	157	375	331	1,360
Arizona	31	1,766	24	160	17	35	7	29	3	3	18	93
California	676	40,791	427	2,548	204	817	55	104	152	370	309	1,257
Nevada	11	515	9	50	7	26	5	12	2	2	4	10
Region X	251	15,846	105	277	35	67	51	116	29	66	18	28
Alaska	6	249	5	36	2	2	5	33			1	1
Idaho	40	2,273	15	25	2	2	8	15			6	8
Oregon	60	3,671	19	53	9	18	7	10	7	22	2	3
Washington	145	9,653	66	163	22	45	31	58	22	44	9	16

TABLE 12.—NUMBER OF FACILITIES AND NUMBER OF PATIENTS BY RACE OF PATIENTS, 1969 REPORTS

State and region	Total		Serving minority patients									
			Total		Negro		Indian		Oriental		Spanish surnamed American	
	Extended care facilities	Patients	Extended care facilities	Patients	Extended care facilities	Patients	Extended care facilities	Patients	Extended care facilities	Patients	Extended care facilities	Patients
Total	4, 401	395, 340	2, 504	20, 668	1, 840	14, 033	340	786	398	969	1, 036	4, 880
Region I	344	28, 255	161	572	141	467	12	12	9	11	38	82
Connecticut	141	11, 294	86	345	79	303	4	4	2	2	30	36
Maine	20	1, 198	6	9	4	5	3	3	1	1		
Massachusetts	142	13, 315	54	190	48	144	2	2	5	7	6	37
New Hampshire	7	384										
Rhode Island	23	1, 472	15	28	10	15	3	3	1	1	2	9
Vermont	11	592										
Region II	325	41, 800	206	2, 989	186	2, 412	11	28	31	117	82	432
New Jersey	79	8, 393	58	362	55	336	1	1	3	3	12	22
New York	246	33, 407	148	2, 627	131	2, 076	10	27	28	114	70	410
Region III	396	37, 518	175	2, 329	171	2, 260	6	19	10	30	14	20
Delaware	9	1, 022	6	24	5	22			1	2		
District of Columbia	4	1, 343	4	567	4	551			1	15	1	1
Maryland	55	6, 479	37	548	36	533			2	3	7	12
Pennsylvania	227	23, 075	81	788	79	774	3	3	3	7	4	4
Virginia	50	4, 326	35	367	35	347	2	15	2	2	2	3
West Virginia	24	1, 273	12	35	12	33	1	1	1	1		
Region IV	565	43, 713	360	2, 826	339	2, 600	13	60	6	8	44	158
Alabama	89	6, 247	51	397	50	391	1	1	1	1	4	4
Florida	163	14, 005	96	842	80	642	6	52	4	5	32	143
Georgia	83	6, 767	56	374	55	370	1	1			3	3
Kentucky	54	3, 965	37	169	37	169						
Mississippi	26	1, 553	22	103	20	100					2	3
North Carolina	42	3, 257	27	203	27	195	3	4	1	2	1	2
South Carolina	53	3, 549	37	527	37	526	1	1				
Tennessee	55	4, 370	34	211	33	207	1	1			2	3

Region V	844	88, 814	362	2, 876	301	2, 466	65	141	32	86	60	183
Illinois	156	16, 728	70	576	65	482	4	5	11	16	20	73
Indiana	71	7, 364	40	211	36	199	2	2	1	1	5	9
Michigan	131	15, 955	77	1, 032	65	896	13	23	9	57	14	56
Minnesota	130	12, 419	37	119	23	74	19	26	4	4	8	15
Ohio	185	16, 746	93	708	89	693	2	2	7	8	5	5
Wisconsin	171	19, 602	45	230	23	122	25	83			8	25
Region VI	393	33, 212	264	2, 877	200	1, 701	35	136	13	17	134	1, 023
Arkansas	37	2, 765	17	192	17	189					2	3
Louisiana	70	5, 789	34	537	29	471	4	44	2	3	8	19
New Mexico	18	1, 498	18	274	9	30	10	39	1	1	17	204
Oklahoma	33	3, 076	17	125	11	79	11	41			2	5
Texas	235	20, 084	178	1, 749	134	932	10	12	10	13	105	792
Region VII	231	21, 086	80	473	71	443	8	10	5	5	11	15
Iowa	78	5, 763	17	26	15	23			1	1	1	2
Kansas	51	3, 322	19	80	16	71	3	3			4	6
Missouri	73	8, 720	31	258	28	254	1	1	2	2	1	1
Nebraska	29	3, 281	13	109	12	95	4	6	2	2	5	6
Region VIII	178	13, 633	97	445	32	77	23	60	16	59	71	249
Colorado	82	7, 533	64	334	26	66	4	8	6	48	54	212
Montana	31	1, 675	11	35			10	32	1	1	2	2
North Dakota	22	1, 731	3	4	1	1	1	2			1	1
South Dakota	15	930	1	3			1	1			1	2
Utah	20	1, 178	14	46	3	6	16	13	7	8	11	19
Wyoming	8	586	4	23	2	4	1	4	2	2	2	13
Region IX	881	67, 157	672	4, 736	351	1, 507	111	172	241	561	544	2, 496
Arizona	39	2, 656	28	183	14	49	6	7	3	3	27	124
California	832	63, 965	636	4, 529	334	1, 454	103	160	236	555	512	2, 360
Nevada	10	536	8	24	3	4	2	5	2	3	5	12
Region X	271	20, 152	127	545	48	100	56	148	35	75	38	222
Alaska	10	287	8	72	5	9	6	60	1	2	1	1
Idaho	37	2, 468	16	42	2	2	7	18	3	4	7	18
Oregon	80	6, 110	30	80	13	24	9	16	10	25	14	15
Washington	144	11, 287	73	351	28	65	34	54	21	44	16	188

[The report referred to in this letter has been retained in committee files.]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF THE SECRETARY,
Washington, D.C., October 31, 1973.

Hon. DON EDWARDS,
Chairman, Subcommittee No. 4, Committee on the Judiciary, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: The Assistant Attorney General, Civil Rights, has referred your letter of September 17 to this Office for further reply.

In accordance with your request, we are forwarding herewith for your background information the draft summary report prepared by the Civil Rights Division of the Department of Justice, relative to OCR's initial State agency reviews of South Carolina and Mississippi, undertaken in 1968. The report outlines the findings and recommendations emerging from the Civil Rights Division's evaluation of the OCR reviews. As indicated, the report constitutes a draft and an internal working paper made available to OCR for purposes of improving the Title VI compliance program where appropriate. We have not forwarded the more detailed back-up material itemizing each finding.

At the time the draft report was forwarded to OCR in November 1972, Mr. Louis H. Rives, Jr., Director of OCR's Health and Social Services Division, prepared some brief written comments for Mr. J. Stanley Pottinger, who was then Director of the Office for Civil Rights. A copy of Mr. Rives' comments, in the form of a memorandum to Mr. Pottinger dated November 17, 1972, is enclosed for your information. I am also enclosing a copy of a memorandum from the Atlanta Regional Office for Civil Rights to Mr. Rives, dated October 15, 1973. This memorandum briefly outlines the extent to which OCR has undertaken follow-up reviews of State agency programs in South Carolina and Mississippi since 1971. The memorandum is particularly important in assessing the Civil Rights Division draft report because to a large extent the deficiencies noted in the report can be attributed to a lack of prompt and diligent follow-up work by OCR in assuring that the State agencies involved moved to remedy problems identified during the initial OCR reviews. As indicated in the memorandum, such follow-up activity has since taken place in large measure, much of it subsequent to the preparation and completion of the draft report.

Following receipt of the draft report and Mr. Rives' comments, Mr. Pottinger asked Bill van den Toorn of his immediate staff to review the recommendations contained in the draft report and, to the extent they had merit, to prepare a plan of action to carry them out. A summary of Bill van den Toorn's report (hereafter referred to as the OCR report), embodying such a plan of action, is also enclosed. In substance, this plan has been adopted by OCR and the specific measures necessary to implement it are reflected in the Division's Operational Planning System (OPS) objectives and in the Division's FY '74 annual enforcement plan, both of which have been forwarded to Ms. Chavez of the Subcommittee staff.

In brief, as indicated in the OCR report, we have acted to implement the major recommendation of the Civil Rights Division draft report; namely, to shift the emphasis away from the review of individual facilities and State agency compliance work *per se* and toward the investigation of possible discrimination in the delivery of services, in referral patterns, and in the impact of certain programs on minorities. This shift of focus was underscored in my testimony of October 1. The plan of action outlined in the OCR report sets forth, in part, auxiliary measures necessary to enable OCR to implement this key objective. While OCR agrees with the Civil Rights Division draft report that State agencies cannot perform a compliance role which by statute is the responsibility of OCR and other Federal agencies, State agencies do have responsibility to meet their Title VI assurances, and we will continue to ensure that they carry out clearly defined compliance tasks that can be monitored consistently and effectively by OCR regional offices.

It would be helpful at this point to expand somewhat on the more specific comments contained in Mr. Rives' memorandum of November 17, 1972.

The 1968 State agency reviews were initiated at the start of the State agency review process which, as indicated in my testimony and in the OCR report, will

draw to a close this calendar year except for a reporting and monitoring function. We agree with the Civil Rights Division report that there were shortcomings in the conduct of these early reviews. Many of these shortcomings, as well as the failure to follow up promptly, were in part attributable to organizational and staff difficulties in the Atlanta Regional Office for Civil Rights at that time. However, we do not believe these early reviews are representative of the review process as a whole and as it evolved throughout the country. (See page 3 of the Civil Rights Division report.) In addition, we believe the health and social services staff in the Atlanta Regional Office has markedly improved in skill, leadership, and effectiveness since the intial South Carolina and Mississippi reviews were conducted.

At the same time, State agencies must be responsible for undertaking specific and meaningful compliance tasks to give effect to their Title VI assurances and to supplement OCR's compliance activity. In accordance with the OCR and Civil Rights Division reports, one of our objectives this fiscal year is to clearly and specifically define and make uniform the State agency compliance role, revising and updating the appropriate written documents. However, the State agency review process as applied thus far may not be the most effective vehicle for identifying and correcting certain patterns of discrimination, and the new direction of the program was decided upon in light of this experience.

We also agree with the Civil Rights Division report on the need to strengthen and update existing guidelines and policy positions. You will note that the OCR report recommends this and it is reflected as an objective for this fiscal year in the Division's FY '74 enforcement plan.

I indicated above that the State agency review process was designed in part to assess the extent to which State agencies were carrying out certain compliance tasks alluded to on page 12 of the Civil Rights Division report and set forth in the Methods of Administration. The Civil Rights Division report claims that no further written instructions were provided to the State agencies, at least in South Carolina and Mississippi to detail these compliance tasks. In the main, following the review of agencies in a particular State, written reports are submitted by OCR regional staff in which requirements and recommendations are made in this regard. I pointed this out in my October 1 testimony. The State agency review process has in most cases involved an ongoing dialogue between OCR regional staff and State agency staff to clarify the compliance role of the State agencies and to train their staff to perform this role adequately. At the same time, some agencies have made more progress than others. Our experience in assessing the capability of State agencies in this regard will be the basis for the design of uniform, clear-cut, and reliable compliance tasks to be determined this fiscal year, and the development of reporting forms for monitoring purposes. It should be understood, however, that OCR regional staff are already requiring State agencies to submit data and other information on an as-needed basis when the reviews and problem areas uncovered during the reviews warrant such a requirement.

The Civil Rights Division report indicates that at least with respect to the South Carolina and Mississippi reviews, OCR staff frequently did not appear to be knowledgeable about the administration of particular health and welfare programs and indices of possible discrimination. As mentioned above, we believe the competence of staff in the Atlanta office has improved since the conduct of these two 1968 reviews. At the same time, however, we recognize a compelling need to strengthen the investigative skills, technical assistance capability, and legal knowledge of all health and social services staff. This is particularly important as the office shifts its primary focus to the indepth review of less overt discriminatory practices. The on-site field reviews forecast in the OCR report and in the enforcement plan will be preceded by careful planning and training of the staff who will participate, and a continuing division-wide training program will be emphasized this fiscal year and in the years ahead.

If you have any questions, we would be happy to discuss these matters with you at your convenience.

Sincerely yours,

PETER E. HOLMES,
Director, Office for Civil Rights.

Enclosure.

○